JERSEY WELLNESS CENTER

25 Orchard Street, Suite 103, Denville, NJ 07834 T: 973-625-7800/F: 973-627-6982 info@jerseywellnesscenter.com

NEW PATIENT FORMS

Please complete the attached forms and bring them with you on your first appointment to our office. Also, please bring your insurance card, a photo identification, current medication list and any recent lab work, x-rays, mri, etc.

This office is a participating provider with Aetna, BC/BS, Cigna and Medicare.
Although we participate with the above plans, occasionally some policies may exclude our office or require you to pay higher deductibles and out of pocket expenses. For example: BC/BS Omnia: We are a tier 2 provider with this plan. If you have this plan and you choose to be treated in our office, you will be subject to higher out of pocket expenses. (high deductible and coinsurance)
All other insurance plans are accepted and your out of network benefits (if applicable) will apply.

Attention Managed Care Plans:
If your insurance plan requires a referral to see a Specialist, please contact your primary care Physician to obtain one prior to your first visit.

They can fax the referral to our office at 973-627-6982, email to info@jerseywellnesscenter.com or you can bring it with you on your first visit.

Here are some numbers you may need for your referral:
Dr. Jersey Wulster Individual NPI#: 1982776233/Jersey Wellness Center- Group NPI#: 1881966547

PATIENT INFORMATION

Last name: ______________________________________ Date of birth: __________ SS#: _____________________
First name: ______________________________________ Gender: [ ] Male [ ] Female Height: ______ Weight: _______
Address: ______________________________________ Marital status: [ ] single [ ] married [ ] divorced [ ] widowed
______________________________________ [ ] separated [ ] other
City: ______________ State: ____ Zip: _______ Ethnicity: [ ] Hispanic [ ] Non-Hispanic [ ] Decline
Email address: ______________________________________ Race: [ ] Caucasian/White [ ] African American/Black
Home #: _________________________ [ ] American Indian/Alaskan Native [ ] Asian
Work #: _________________________ [ ] Pacific Islander [ ] Other [ ] Decline
Cell #: _________________________ Your preferred language: _________________
Emergency Contact: _________________________ Number: __________________________
Primary Care Physician: ____________________________ Address and number: ____
Who referred you to our office: ____________________________

EMPLOYMENT INFORMATION

[ ] Employed [ ] Unemployed [ ] Retired [ ] Other

Employer: ______________________________________ Your Occupation: ______________________________
Address: ______________________________________ Years in this field of work: ________________________

INSURANCE INFORMATION

Primary Insurance Company : ________________________ Insurance ID#: ________________________ Group#:_________
Policy Holders Name: ______________________________ Policy Holders DOB: _________ Gender: male / female
Your relationship to the Policyholder: [ ] Self [ ] Spouse [ ] Child [ ] Other
Do you have a secondary insurance: [ ] YES [ ] NO Secondary Insurance Companies Name: ___________________
Policy Holders Name: ______________________________ Policy Holders DOB: _________ Gender: male / female
Your relationship to the Policyholder: [ ] Self [ ] Spouse [ ] Child [ ] Other
NOTE: As a policy our office typically does not submit to your secondary insurance and it is your responsibility to do so.
Sometimes special insurance related circumstances may apply, so please inform the front desk if you have a secondary insurance.
****

Patient Signature: ____ **Date:** _____________

Guardian Signature (if patient is a under 18): ____ **Date:** _____________

LAST NAME: ______________________________, FIRST NAME: ___________________ DATE: _______

WHAT BRINGS YOU HERE TODAY?

What is your current complaint that brings you to our office today? ____

Pain or discomfort in: Head / Neck / Shoulder / Arm / Upper Back / Mid Back / Low Back / Hip / Groin / Buttocks / Leg / Knee / Ankle / Foot

Date problem began? __________ Describe how the problem began? ____

Describe the pain: ache / burning / dull / numb / radiating / sharp / shooting / sore / spasm / stabbing / stiff / throbbing / tingling / weak

Rate the intensity of your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

How often in the pain present? 0% - 25% 26% - 50% 51% - 75% 76%-100%

In the past week, how much has you pain interfered with your daily activities (e.g. work, social, household, sports, etc)

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on activities

In general, how would you describe your overall health: Excellent / Very Good / Good / Fair / Poor

Does it bother your: [ ] work [ ] sleep [ ] other (specify) ________________________

Is the condition: [ ] job related [ ] auto related [ ] other __________________________________

Is this the first time that you experienced this complaint? Yes / NO Explain: ____

What treatment, tests, medications have you had to date for this complaint? Include dates if known___________________________________

____

Name of Physicians, Labs, Testing Facilities, Hospitals you have been to for this condition.

Name: ___________________________________ Date: ______________

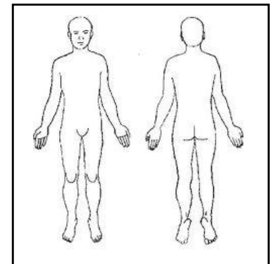
Name: ___________________________________ Date: ______________

What makes it better? ____

What makes it worse? ____

What is your current stress level? no stress / minimal stress / moderate stress / greatly stressed

On the body diagram, please mark the area/s of your discomfort and describe your pain at their locations.



Have you had any of the following? Indicate your age or the year it was performed.

Appendectomy ________ Hysterectomy __________ Broken Bones __________ Cancer _________ Hernia __________ Gall Bladder _________

Back Surgery ___________ Tonsillectomy __________ Other __________

Accident or Major Falls (include auto/job accidents): ___________________________________ Date: _________________

Hospitalization (other than above): Reason: ____ Date: _________________

Reason: ____ Date: _________________

Previous Chiropractic Care: YES / NO Doctor's name and approximate date of last visit: _________________________ Treated for: ________________

Family M.D. ____

Are you under the care of a physician? YES / NO If yes, for what: ____

Medications you are currently taking:

Medication: ______________________________ Taking for: _________________________________

Medication: ______________________________ Taking for: _________________________________

Medication: ______________________________ Taking for: _________________________________

Do you take vitamins, herbs or supplement: YES / NO

Do you have any allergies? (drugs or other) YES / NO If yes, to what: ____

Do you have any other non-drug related allergies? YES / NO If yes, to what: ____

Do you have a family history of: low back pain / neck pain / headaches / migraines / shoulder pain / bursitis / sciatica / heart problems / cancer /diabetes

INITIAL:

LAST NAME: ______________________________, **FIRST NAME:** ____________________ **DATE:** ________

MEDICAL HISTORY

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
mumps			heart disease			cancer		
small pox			hardening of arteries			hyperthyroid		
chicken pox			anemia			hypothyroid		
measles			kidney problems			other thyroid issues		
polio			tuberculosis			immune disorder		
whooping cough			lymes disease			AIDS		
rheumatic fever			mental disorder			HIV		
pneumonia			arthritis			liver disease		
venereal disease			epilepsy/convulsions			migraines		
shingles			high blood pressure			drug addiction		
hepatitis			diabetes			alcoholism		

CURRENT MEDICAL COMPLAINTS/ISSUES

MUSCULO-SKELETAL

- low back pain
- upper back pain
- neck pain
- arm pain
- joint pain/stiffness
- walking problems
- difficulty chewing
- clicking jaw
- general stiffness
- shoulder pain
- leg pain
- knee pain

ENDOCRINE

- fatigue
- hair thinning
- thyroid problems

NERVOUS SYSTEM

- nervous
- numbness
- paralysis
- dizziness
- forgetful
- confusion
- depression
- fainting
- cold hands
- cold feet
- stress

GENITO-URINARY

- bed wedding
- blood in urine
- frequent urination
- bladder control issues
- painful urination
- prostate trouble
- pus in urine
- bladder infections

CARDIOVASCULAR

- chest pain
- shortness of breath
- blood pressure problems
- irregular heartbeat
- heart problems
- lung problems/congestion
- varicose veins
- ankle swelling
- stroke
- heart attack

ENT

- vision problems
- dental problems
- sore throat
- ear aches
- hearing difficulties
- recurrent stuffy nose
- sinus infections
- ringing in ears

GASTRO-INTESTINAL

- poor appetite
- excessive appetite
- frequent nausea
- vomiting
- diarrhea
- constipation
- hemorrhoids
- liver problems
- gall bladder problems
- weight troubles
- abdominal cramps
- gas/bloating
- heartburn
- black/bloody stools
- colitis
- lactose intolerant
- gluten problems
- digestive issues
- irritable bowel syndrome
- ulcer

GENERAL

- fatigue
- allergies
- loss of sleep
- sleep apnea
- headaches
- hair thinning

WOMEN ONLY

- congested breasts
- cycle cramps
- abnormal periods
- excessive bleeding
- irregular cyle
- lumps in breast
- menopause
- painful menstruation
- vaginal discharge

Last menstrual period:_______

Are you pregnant: YES / NO

If yes, how far along: _______

Number of children: ________

Last gyno exam: ___________

OB/GYN name: ___________

PRESENT INTAKE OF:	PER DAY
reg coffee	________
dec coffee	________
reg tea	________
dec tea	________
alcohol	________
cigarettes	________
white sugar	________

SMOKING STATUS (circle)

PRESENT

PAST

NEVER SMOKED

INITIAL:

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AUTHORIZATION TO TREAT & EXAMINE

I hereby authorize consultation, examination and treatment by the Doctors at Jersey Wellness Center as they determine appropriate for me and my health concerns.

____
Patient name (print)

_________________________________ __________
Patient signature/parent or guardian Date

RECORDS RELEASE

I hereby authorize copies of my medical records to be sent to Jersey Wellness Center. Records can include Doctors notes, x-rays, mri, CT scan or other pertinent medical information as requested by and released to: Jersey Wellness Center
25 Orchard Street, Ste 103
Denville, NJ 07834

Telephone: 973-625-7800/Fax: 973-627-6982/email: info@jerseywellnesscenter.com

____
Patient name (print)

_________________________________ __________
Patient signature/parent or guardian Date

PRIVACY PRACTICES

A copy of our Privacy Practices is on our website for viewing at www.drjersey.com in addition a hard copy is visible in our patient waiting room. You may request a copy of our Privacy Practices at any time from our front desk.
I have been provided with a copy of Jersey Wellness Center, LLC Notice of Privacy Practices, which describes Jersey Wellness Center, LLC use and disclosure of my Protected Health Information (PHI)

____
Patient name (print)

_________________________________ __________
Patient signature/parent or guardian Date

ASSIGNMENT OF BENEFITS TO OUR OFFICE

I hereby authorize direct payment of my insurance reimbursements to Jersey Wellness Center.
I am herein noticed that an insurance company, based on its own policies and guidelines, may make different determinations of the medical necessity of my treatments received at Jersey Wellness Center. This insurance company determination may result in decreased payment or non-payment of some or/all services from my insurance company. I acknowledge that I understand the above statement and agree to be personally responsible for payment of any service/s rendered to me (or my child) by Jersey Wellness Center that is NOT reimbursed by my Insurance Company. I hereby authorize the office of Jersey Wellness Center to release any healthcare information in compliance of HIPAA, to my insurance company, utilization review company or attorney that may be requested.

____
Patient name (print)

_________________________________ __________
Patient signature/parent or guardian Date

JERSEY WELLNESS CENTER - NO BILLING POLICY

PATIENT NAME: ______________________________________ DOB: _____________

Our office has a no billing policy. This simply means that our office makes every attempt to not have to bill patients for outstanding balances. Our billing policy is as follows and you must choose which financial plan to accept:

1. This can be payment in full at each visit (CASH PATIENT)
2. Payment paid ahead of services (PRE-PAY PATIENT)
3. Payment paid at the beginning of each month for the entire family (FAMILY PLAN)
4. Payment of co-pay, coinsurance, deductibles, charges above what your insurance company allows, etc (INSURANCE PATIENT).

Please circle your choice of payment to our office: cash, pre-pay, family plan or insurance option

CASH PATIENT

This means that you will pay in FULL at the time services are rendered. You will not carry a balance in this office. (If you have insurance, you can submit the claims to your insurance company or we can submit it for you and have payment be sent directly to you. Not valid with BC/BS, Aetna, Medicare or Cigna). You can leave a credit card on account to be billed at each visit or you can pay by cash, check or credit card at each visit. If you are experiencing significant financial difficulties and you have a true financial hardship, please advise the staff. You will then need to fill out financial hardship paperwork and a determination of the payment amount for your services will be based on your financial situation and your ability to pay.

PRE-PAY PATIENT

You can pre-pay in advance for your services. We have several pre-pay plans available. A pre-pay plan will give you a reduced fee structure for your services. This is a cost effective plan for patients that have no chiropractic coverage or no insurance at all. If you are interested in a pre-pay plan, please inform the front desk.

FAMILY PLAN

Our office does offer family plans to families that have no chiropractic coverage or no insurance. Family plans are a set amount paid monthly (prior to the month of services) that covers chiropractic services for your family. Please ask the front desk for more information.

INSURANCE OPTION

We encourage you to be fully aware of the provisions of your own insurance policy. You can do this by completing an Insurance Verification Form (that we will provide to you). As a courtesy to you, we will submit to your primary insurance company. You are responsible for any outstanding balances (services not paid by your insurance: co-pays, coinsurance, deductible, charges above what your insurance company allows, denials, etc). Outstanding balances or fees not covered are payable at your time of service and/or when an explanation of benefits (EOB's)/remittance advice are posted to your account**.** **If you choose the insurance option, our office requires that a credit card is on file to be used if there is an outstanding balance on your account that remains unpaid by you for 60 days.** Your credit card will be charged after all reasonable attempts have been made to collect from insurance companies and individuals alike. The only 60 day exception is when there is a problem with your insurance processing by our office, medical necessity issue that we are working on with your insurance company or if other financial arrangements are made with you in advance with our office. If you refuse to leave a credit card on file, please bring payment at each visit as you **MUST PAY** your portion of services or patient balance at time of each visit.

In absence of payment of any balances due by a patient beyond the 60 day period is sent to an outside collection agency for follow up unless special financial arrangements have been made in advance.

Please provide us with your credit card information: MC / VISA / DISCOVER (circle one)

Name on card: ______________________________________ Credit Card #: __________________________________

Expiration date: ____________________ CVN #:__________ (3 digit number on back of credit card)

I give my authorization for Jersey Wellness Center to charge my credit card listed above for any balance that is outstanding beyond the 60 day grace period. ____ _______________

Signature Date

The above information that I have provided is true and accurate and I have read and understand the above financial policy of Jersey Wellness Center. ____ ______________

Signature Date