Verona Spine & Wellness Center
80 Pompton Ave., 3rd Floor
Verona, NJ 07044 | 973-857-1119

Welcome to our office!

VERONA SPINE & Wellness Center

Name_____

Address _____City_____
State_____ Zip_____

Home Phone_____ Cell Phone _____
Email_____

Birth date _____ Martial Status; M D W S

Primary Insurance _____ Policy Holder_____DOB_____

Primary Care Physician
_____Phone_____

How did you hear about us?
Friend/Family_____ Doctor___Sign___ Internet ___Community Event_____ Other_____

Is this condition related to an automobile accident or injury suffered at your job?
_____

What is your major complaint?
_____

How long have you had this symptom?
_____

Do any positions make it feel worse?
_____

Do any positions make it feel better?
_____

Are you or could you be pregnant? Yes or No

Please indicate on a scale of 1-10, 10 being the worst and 1 being no pain, how your pain level has been on average over the past week.

Neck Pain ____ Neck Pain _____ Daily Activities _____During Work

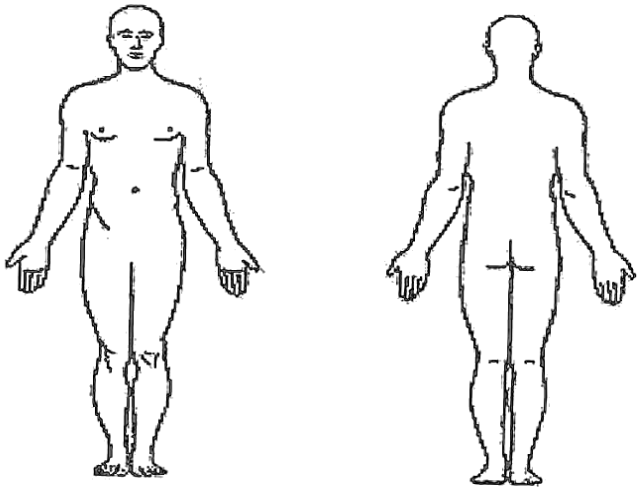
Lower Back Pain ____ Back Pain _____ Daily Activities Work_____

Circle what type of pain you experience: Dull Sharp Numbness Tingling Burning Shooting

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Please demonstrate on the following diagram where you experience pain by placing /// marks on the body images.
Please demonstrate on the following diagram where you experience soreness or stiffness by place in XXX on the effected area, on the images.

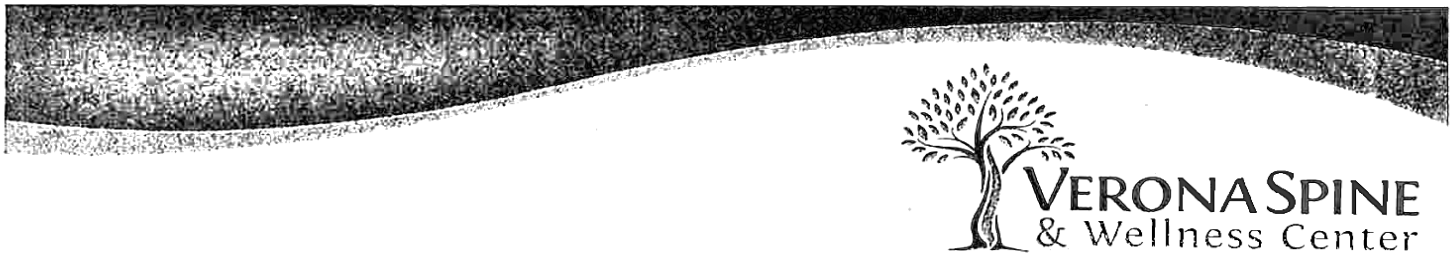


Please put an "X" next to any current conditions. Please put "P" next to past conditions:

___Hip Pain R/L	___Digestive Problems	___Headaches	__Cancer
___Foot Trouble R/L	___High-Low BP	__Tremors	__Arthritis
___Shoulder Pain R/L	___Sinus Problem	___Ear Infections	__Anemia
___Dizziness/fainting	___Allergies	__Chest Pain	__Stroke
___Convulsions/ Epilepsy	__Troubling Sleeping	__Bone FX	__Depression
___Trouble concentrating	___Accidents/Falls	__Loss of Balance	__Ulcers
___Pain/TMJ	___Pain w/ Cough/sneeze	__Skin Issues	__Diabetes
___ ringing In Ears R/L	___Asthma	__Heart Problems	

Patient Signature_____ Date_____

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ABBREVIATED NOTICE OF PRIVACY POLICY FOR VERONA SPINE & WELLNESS CENTER
EFFECTIVE OCTOBER 1, 2005

We collect your personal health information from you through treatment, payment or other means as applicable. Your personal health information is protected by federal law. Generally we do not use or disclose your information without your permission. Once permission has been obtained, we must disclose your personal health information in accordance with the specific terms of permission. The following is an outline of the circumstances under which we are permitted by law to use or disclose your personal health information. You may request a copy of the detailed privacy policy with a written request sent to: Verona Spine & Wellness Center – 80 Pompton Ave Verona NJ 07044

1. Without your consent we may use or disclose your personal health information in order to provide you with services and treatments you may require or request, or to collect payment for services and/or to conduct other operations otherwise permitted or required by law. We can also disclose your personal health information within and among our workforce to accomplish the same purposes.
2. As required by law we may use or disclose your personal health information to the extent that such use or discloser as required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.
3. All other situations with your specific authorization. Except as otherwise permitted or required, as outlined above, we may not use or disclose your personal health information without your written permission. You may revoke your authorization at any time except in some circumstances.
4. Miscellaneous activities NOTICE: We may contact you to provide appointment reminders or information about treatments or other health related benefits and services that may be of interest to you.

YOUR RIGHTS WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION

1. Right to request restrictions on use or disclosure
2. Right to receive confidential information
3. Right to receive confidential communications
4. Right to inspect and copy your personal health information
5. Right to amend your personal health information
6. Right to receive accounting of disclosures of your personal health information
7. Right to file a complaint with us and the secretary of the DHHS if you believe your privacy rights have been violated. You may submit your complaint in writing by mail to our privacy officer, Verona Spine & Wellness Center, within 180 days of when you knew or should have known the act of omission complained of occurred. You will not be retaliated against for filing any complaint.

We reserve the right to amend this privacy policy at any time for which we will provide you with notice within 60 days of the effective date of such revision, amendment or change.

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PRIVACY PRACTICES ACKNOWLEDGMENT

I. ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE

I have received/reviewed a copy of Verona Spine & Wellness Center's Notice of Privacy Practices:

Patient's Name Date of Birth Signature of Patient/Parent Date

II. DESIGNATION OF RELATIVES, FRIENDS AND OTHER CAREGIVERS FOR HEALTHCARE DISCLOSURE

I agree that Verona Spine & Wellness Center may disclose certain healthcare information to persons involved with my healthcare decisions or payment. I designate the following person(s) listed below as being involved with my healthcare for the purpose of Verona Spine & Wellness Center making limited information disclosure for the above purpose. I UNDERSTAND I AM NOT REQUIRED TO LIST ANYONE. I also understand I may change the designees in writing at any time.

Print Name_____ Relationship _____ Last 4 Digits of SS#_____

INFORMED CONSENT

I hereby request and consent to the performance of: physical examination and any other diagnostic tests such as x-rays to diagnose my condition(s), and of spinal adjustments, extremity adjustments, physical therapy, and axial decompression. If during the course of care the doctors encounter non-chiropractic or unusual findings, they may recommend I consult a specialist for the area in question. I have had the opportunity to discuss with the doctor or office personnel that results are not guaranteed and the rare risks of treatment. I do not expect the doctors to be able to anticipate and explain all risks and complications and wish to rely upon the doctor's judgment during the course of treatment, based upon the facts, than known, that is in my best interest. This consent will cover the entire course of my treatment for present conditions or any future conditions for which I seek treatment.

I have read and understand the terms above and grant permission for care:

Patient's Signature _____ Date _____

In case of emergency, contact _____ Phone # _____

Complete of patient is under 18 years of age:

Child Name: _____

As parent/legal guardian of above child, I understand the terms above and grant permission for treatment.

Parent/Guardian Signature _____ Date _____

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ASSIGNMENT OF BENEFITS

Patient Name _____

Address _____ City _____ State_____ Zip_____

Insurance Company _____

Name of Policyholder _____ Policy Number _____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to Verona Spine & Wellness Center, hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier.
2. I, irrevocable assign to the medical provider all my rights and benefits under the insurance contract for payment for services rendered to me.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests for the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
4. **I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on behalf directly to the medical provider. The check should be made payable to the medical provider. Furthermore, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.**

Signed _____

Patient's Name _____ Dated _____

Witness _____

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Authorization For Payment

DATE:_____

Patient: _____

Insurance Co. _____

ID # _____

Based on our experience with your insurance company, payment for services rendered to you may be sent directly to you (the patient) instead of us. If you receive any type of correspondence from the above named insurance company for services rendered in this office, please bring the information to us as soon as possible and **DO NOT** deposit the check without speaking to us first.

STATEMENT OF AGREEMENT:

I, _____ (patient name) hereby agree to endorse any checks received by me from the above named insurance company for services rendered in this office within 3 weeks of receiving or I will deposit the check and immediately reimburse this office. If for some reason, I do not abide by these terms, I authorize this office to charge my credit card for the balance due in relation to payments I have received from the above named insurance company.

Patient or Guardian Signature

_____ Date _____

Payment Method: Visa MasterCard AMEX Discover

Name as it appears on card: _____

Card Number: _____ Exp Date:_____

Billing Zip Code: _____