REHABILITY

Patient Information

Patient Name:_____ E-Mail Address: _____

Sex: M ❒ F ❒ Date of Birth: _____ Age: _____ Marital Status: S ❒ M ❒ D ❒ W ❒

Mailing Address: _____

Home Phone #: _____ Cell Phone #: _____

Employer/School: _____ Occupation: _____

How were you referred to our office? _____

Insurance Information

Primary Insurance Carrier: _____

Type: Medical ❒ Auto ❒ Workmans Comp ❒ Other ❒ _____

ID#: _____Group#: _____ Claim#:_____

Subscribers Name:_____ Subscribers DOB:_____

Subscribers SS#:_____ Relationship to patient: _____

Coverage Effective Date: _____

Secondary Insurance Carrier: _____

Type: Medical ❒ Auto ❒ Workmans Comp ❒ Other ❒ _____

ID#: _____Group#: _____ Claim#:_____

Subscribers Name:_____ Subscribers DOB:_____

Subscribers SS#:_____ Relationship to patient: _____

Coverage Effective Date: _____

In Case of Emergency

Name: _____ Relationship: _____

Home Phone #:_____Cell Phone #: _____

83 South Street. Suite 204
Freehold, NJ 07728
(732)-780-6230
www.RehabilityNJ.com

Name:_____ **Date:**_____

Please complete the following diagram by using the letters below to indicate the area and type of pain you are experiencing:

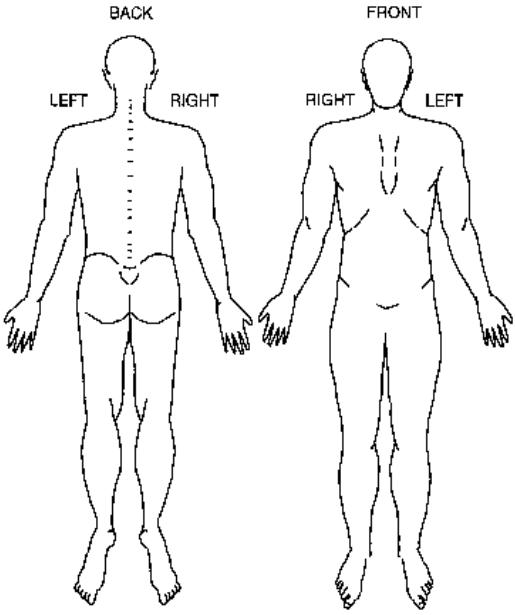
P. Pain

T. Tingling

B. Burning

N. Numbness

S. Stiffness



DOCTOR'S NOTES:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reason for today's visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Y □ N □

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain): _____

Type of pain: Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other □ _____

How often do you have this pain? Constant □ Occasional □ Intermittent □ Frequent

Does it interfere with your: Work □ Sleep □ Daily routine □ Recreation

Activities/Movements painful to perform:Sitting □ Standing □ Walking □ Bending □ Lying down □

What treatments have you already received for your condition?
Medication □ Physical Therapy □ Chiropractic □ Surgery □ None □ Other □ _____

Date of Last: Physical Exam_____**Blood Test**_____**Spinal X-rays/MRI**_____
Major surgeries/hospitalizations_____

I certify that the information provided is current and complete to the best of my knowledge.

Patient/Guardian Signature:_____ **Date:**_____

HEALTH HISTORY

Name:_____ **Date:**_____

GP/PCP Name/Location _____

Exercise : None □ Moderate □ Daily □ Heavy □

Are you pregnant? Y □ N □ Due Date: _____

Habits: Smoking: Packs/Day _____ Alcohol: Drinks/Week _____
Coffee/Caffeinated Drinks: Cups/Day _____ High Stress Level: Reason _____

Medications: _____ **Allergies:** _____ **Vitamins/Supplements:**_____
_____ _____ _____
_____ _____ _____

Please place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Y □ N □	Liver Disease	Y □ N □
Alcoholism	Y □ N □	Low Blood Pressure	Y □ N □
Allergies	Y □ N □	Measles	Y □ N □
Anemia	Y □ N □	Migraines	Y □ N □
Anorexia	Y □ N □	Miscarriage	Y □ N □
Appendicitis	Y □ N □	Mononucleosis	Y □ N □
Arthritis	Y □ N □	Multiple Sclerosis	Y □ N □
Asthma	Y □ N □	Mumps	Y □ N □
Bleeding Disorders	Y □ N □	Osteoporosis	Y □ N □
Breast Lump	Y □ N □	Parkinson's Disease	Y □ N □
Bronchitis	Y □ N □	Pinched Nerve	Y □ N □
Bulimia	Y □ N □	Pneumonia	Y □ N □
Cancer	Y □ N □	Polio	Y □ N □
Cataracts	Y □ N □	Prostate Problem	Y □ N □
Chemical Dependency	Y □ N □	Prosthesis	Y □ N □
Chicken Pox	Y □ N □	Psychiatric Care	Y □ N □
Diabetes	Y □ N □	Rheumatoid Arthritis	Y □ N □
Emphysema	Y □ N □	Rheumatic Fever	Y □ N □
Epilepsy	Y □ N □	Scarlet Fever	Y □ N □
Fractures	Y □ N □	STD	Y □ N □
Glaucoma	Y □ N □	Stroke	Y □ N □
Goiter	Y □ N □	Thyroid Problems	Y □ N □
Gonorrhea	Y □ N □	Tuberculosis	Y □ N □
Gout	Y □ N □	Tumors	Y □ N □
Heart Disease	Y □ N □	Typhoid Fever	Y □ N □
Hernia	Y □ N □	Ulcers	Y □ N □
Herniated Disk	Y □ N □	Vaginal Infections	Y □ N □
Herpes	Y □ N □	Whooping Cough	Y □ N □
High Blood Pressure	Y □ N □	Other: _____	Y □ N □
High Cholesterol	Y □ N □	Other: _____	Y □ N □
Kidney Disease	Y □ N □	* Pacemaker/Defibrillator	Y □ N □

Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

Effective August 1st 2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Our Responsibilities

REHABILITY, LLC. is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted on the practice website at www.RehabilityNJ.com and in our waiting room. The notice will include the effective date. In addition, we will make our best effort to prove you with a copy of this notice and we request you acknowledge receipt with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be made available to anyone who asks for it, and be posted on the practice website at www.RehabilityNJ.com and in the office waiting room. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other· doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile. We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pay for the health care services we recommend for you.

For Healthcare Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conduction or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include collections and software support. If their services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To

protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract. In addition, business associates are individually required to abide by the HIPPA Rules.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. Northeast Spine and Sports Medicine will provide the first accounting to you in any 12-month period will be the practice complies with state records release laws. We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing. *Except under Specific circumstances, we are not required to agree to your request.*

If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or is required by law. We must agree to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPPA) if the information pertains solely to a health care item or service for which we have been paid by you out-of-pocket, and in full.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit your request in writing.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling (732)-780-6230 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided you.

I acknowledge having received a copy of the practice's Notice of Privacy Policies.

Patient Name (Print): _____

Patient Signature: _____ Date: _____