



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 #: _____

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



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 NJ 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 provide 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 pays 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. REHABILITATION NJ 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: _____