BACK & BODY
PAIN RELIEF

Confidential Patient Information

Name____ Date_________________________

Home #_____________________Cell#____________________Email_________________________________

Address____ Apt#______________City_______________State___________Zip Code__________

Birth Date_______/_______/__________ Marital: **M S W D** How Many Children? _______

Height______ Weight_______ Occupation_____________________________

Employer_____________________________

Address______________________________ ______Work Phone____________________________

Name of Insurance Company_______________________________________

Insured name ______________________________ Insured DOB_______/_________/_________

Secondary Insurance ________________________ Insured Name___________________________

Relationship to Insured __________________________________

Emergency Contact________________________ ___Phone# ____________________________

Whom may we thank for referring you____

Is this a worker's compensation case or direct result of a no-fault accident? ____YES ____NO

Date symptoms appeared or accident occurred____________________

Primary Care Physician Name____ Physician Number________________________________

Patient ever had same or similar condition ___YES ___NO If Yes, when and

describe____

Have you lost any days from work? _____________________________________

Date of last physical exam________________ Female: Are you pregnant? ______________________

What operations have you had? ________________________________ Serious Illness___________________________

HAVE YOU EVER SUFFERED FROM: Check all that apply

___Allergy ___Foot Trouble ___Sinus Infection ___Headache ___Dizziness

___Fatigue ___Low Back Pain ___High Blood Pressure ___Poor Posture ___Fatigue

___Neck Pain ___Low Blood Pressure ___Poor Circulation ___Loss of Sleep ___Sciatica

___Rapid Heart Beat ___Ulcers ___Arthritis ___Asthma ___Difficulty Breathing

___Spinal Curvature ___Bursitis ___Ear Noises ___Varicose Veins ___Slow Heart Beat

___Enlarged Thyroid ___Kidney Infection or Stone ___Depression ___Eye Pain ___Prostate Trouble

___Swollen Joints ___Failing Vision ___Irregular Cycle ___Stroke ___Venereal Disease

___Colon Trouble ___Tuberculosis ___Diabetes ___Chest Pain

Tingling or numbness in: Check all that apply

____Shoulders ____Hips ___Arms ____Legs ____Elbows ____Knees ____Hands

Additional Information:____
____

Please Print Clearly

Purpose of this appointment (Major Complaint)
____
____
____

What activities aggravate your condition?
____
____

Is this condition getting progressively worse? ____ Yes ____ No ___ Constant ____ Comes & Goes

Is this condition interfering with your work? ____ Work ____ Daily Routine ____ Sleep ____ Other

How long has it been since it really felt good? ____

What do you believe is wrong with you? ____

Have you seen other Doctors for this condition? ____

Have you been treated for any health conditions by a physician in the last year? ____ Yes ___ No Describe __________________

Please list all medications you are currently taking ____

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports or forms to assist me making collections from the insurance company and then any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered are to be charged to directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

In accordance with Education Law section 6731 (d), a physical therapist providing treatment in the practice of physical therapy without a referral from a physician, dentist, podiatrist, or nurse practitioner, in accordance with Education Law section 6731 (d) and the requirements of this section shall advise the patient in writing prior to beginning treatment of the possibility that treatment may not be covered by the patient's health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner and that treatment may be a covered expense if rendered pursuant to such referral **For your convenience we have a medical doctor on staff that can evaluate you and prescribe physical therapy if necessary.**

I have been given the opportunity to review the HIPAA Patient Privacy Policy

Patient Signature ____ Date ____________________

Guardian or Spouse's Signature Authorizing Care __________________________ Date ____________________

BACK & BODY PAIN RELIEF, P.C.

SHAN SIVENDRA, M.D.
DAVID PERNA, D.C., C.C.E.P.
JUSTIN JHAUJ, D.C.
OSCAR MUJICA, P.T
SEJIN PARK, L.A.c
SUSANNE OTTOMANELLI, OTR/L

355 US 22 EAST, STE. D
SPRINGFIELD, N.J. 07081
PHONE: 908-325-3000
FAX: 908-325-3232

Assignment of Benefits (AOB)
This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Back and Body Pain Relief for medical supplies and/or medication(s) furnished to me by Dr. Shan Sivendra

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. Back and Body Pain Relief to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. Back and Body Pain Relief to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # (   ) ____________________

SIGN YOUR NAME HERE ____________________ TODAY'S DATE   /   /

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Back and Body Pain Relief for any medical supplies and/or medications furnished to me by Back and Body Pain Relief. I authorize any holder of medical information about me to release to Back and Body Pain Relief my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

MEDICARE # HERE ☐☐☐☐ - ☐☐☐ - ☐☐☐☐

Insurer______________________________ **Policy #**______________________
(other then or in addition to Medicare)

Insurer phone #__________________________________

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This letter is to inform you that your insurance company will be mailing out checks with an EOB to you which are payments for the service we provided to you.

We would like to ask that you please sign the back of the checks and please keep it attached to the Explanation of Benefits, send all statements attached. If you would like copies you can make them or we would be happy to provide them for you. You can either mail them to our office or drop them off whichever is more convenient for you.

We would like to thank you in advance for your cooperation.

P.S. Please forward to: Attn: Florence @ Back and Body Pain Relief, 355 US 22 East Springfield, NJ 07081on the outside of the envelope when mailing the checks or EOB's to our office.

____

Patient Signature   Date

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Back and Body Pain Relief

Release and Consent to Photograph and Publish

The undersigned hereby authorizes Back and Body Medical to photograph (print patient name)

___________________________________ under the care of Back and Body Medical.

Scope of consent. The undersigned agrees that Back and Body Medical may use this photograph (s), written testimonials, audio, and transcripts for any and all purposes including, but not limited to, art, advertising, promotional, educational and medical office books and presentation used for patient decision-making and in all media, including electronic, digital and print media and that such distribution may be accomplished in a any matter and that such use is subject only to the following limitations.

Term. This release and consent shall remain in effect until rescinded at any time in accordance with the following "Notice and Termination Use" provision below, and some use may continue after that time, but only as provided in the "Notice and Termination Use."

Notes and Termination of Use. This release and consent may be rescinded at any time in accordance with the terms of this "Notice of Terms of Use" provision. Rescission of this consent must be in writing, requesting discontinuation of use of photographs, written testimonials, audio, and transcripts taken while under the care of Back and Body Medical. After receiving the written request, Back and Body Medical may continue using the photographs, written testimonials, audio, and transcripts until the existing inventory is depleted, or for television commercials, videos or similar materials, may continue using the photographs until as long as they were intended to be used at the time they were created. Back and Body Medical will not reprint existing materials or create new advertising or other materials incorporating the photographs unless otherwise allowed to do so under this "Notice and Termination of Use" provision.

Waiver. Except as specifically stated above. I hereby waive any and all other rights I may have in respect to any photographs taken of me by Back and Body Medical and all images created from them in accordance with the release and content. Without limiting the generality of the foregoing, I specifically waive any rights I may have had to be paid or otherwise compensated for the use of such photographs, and any rights I may have to inspect or approve the finished photographs, images, printed matter that that may be used in conjunction with any photographs taken of me.

Entire Agreement: This release and consent constitutes the sole agreement between Back and Body Medical and myself regarding my photographs and I am not relying on any other oral or written representation made by Back and Body Medical.

Release: The undersigned hereby releases and holds Back and Body Medical harmless from and against any claim or injury or compensation resulting from the activities authorized by this release and consent.

_______________________________ ____

Patient name (print) Patient signature

_____________________________ ____

Witness signature Date