NMR
NATURAL MEDICINE & REHABILITATION

Date: _____

BETTER HEALTH. BETTER LIFE.

First Name: _____ **Last Name:** _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SS#: _____ **Gender:** Male Female **Language**: English Spanish Other:_____

Marital Status: Single Married Widowed Divorced Separated **Spouse Name**: _____
Do you have children? Yes No **List their ages:** _____ **Ethnicity (Italian, Polish, etc.):** _____
Race: Caucasian African Am. Hispanic Asian Middle Eastern Pacific Is. Native Am.

Home Phone: _____ **Work/Cell Phone:** _____

Email Address: _____ **Contact Pref.:** Home Cell

Occupation: _____ **Employer:** _____

Emp. Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Reason for today's visit: _____

Have you had: ☐ X-Ray ☐ MRI ☐ CT **If so, at which facility?** _____

How did you hear about our office? ☐ Corporate event at work: _____ ☐ Internet/Google
☐ The Connection Magazine ☐ e-newsletter ☐ Dr. _____ ☐ Friend: _____
☐ Community event: _____ ☐ Other: _____

Primary insurance: _____ **Policy owner is your:** ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Policy Owner's Name & DOB: _____

Secondary insurance: _____ **Policy owner is your:** ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Policy owner's name & DOB: _____

Primary care physician: _____ **Phone #:** _____

DO YOU HAVE A PACEMAKER: Yes No **ARE YOU PREGNANT:** ☐ Yes No

List ALL medication with dosage:

_____ _____ _____

_____ _____ _____

List ALL allergies (include medication, food, & environment):

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

List ALL hospitalizations:

Date	Reason	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Family Medical History (include relationship to you on the line provided):

□ Cancer _____ □ Diabetes _____ □ Heart Disease _____ □ Depression _____
□ Seizure _____ □ Hepatitis _____ □ Thyroid Disease _____ □ Alcoholism _____
□ High Blood Pressure _____ □ High Cholesterol _____ □ Stroke _____
□ Other: _____

Have you had or currently have any of the following conditions?

Gastrointestinal
Irritable Bowel Syndrome
Inflammatory Bowel Disease
Crohn's
Ulcerative Colitis
Gastritis or Peptic Ulcer Disease
GERD (reflux)
Celiac Disease
Other _____

Cardiovascular
Heart Attack
Stroke
Elevated Cholesterol
Hypertension (blood pressure)
Other _____

Metabolic/Endocrine
Type 1 Diabetes
Type 2 Diabetes
Hypoglycemia
Metabolic Syndrome
Hypothyroidism
Hyperthyroidism
Endocrine Problems
Infertility
Weight Gain
Weight Loss
Frequent Weight Fluctuations
Bulimia
Anorexia
Other _____

Cancer
Lung Cancer
Breast Cancer
Colon Cancer
Ovarian Cancer
Prostate Cancer
Skin Cancer
Other _____

Genital and Urinary Systems
Kidney Stones
Erectile or Sexual Dysfunction
Frequent Yeast Infections
□ Gout
Other _____

Musculoskeletal Pain/Problem
Osteoporosis/Osteopenia
Scoliosis
Muscle Cramps
Numb/Tingling
Neck
Back
Shoulder
Elbow
Hand/Wrist
Hip
Knee
Ankle/Foot
Other _____

Inflammatory/Autoimmune
Chronic Fatigue Syndrome
Autoimmune Disease
Rheumatoid Arthritis
Lupus SLE
Immune Deficiency Disease
Frequent Infections/Cold
Food Allergies
Environmental Allergies
Multiple Chemical Sensitivities
Latex Allergy
Other _____

Respiratory Diseases
Asthma
Chronic Sinusitis
Bronchitis
Emphysema
Pneumonia
Tuberculosis
Sleep Apnea
Other _____

Skin Diseases
Eczema
Psoriasis
Acne
Melanoma

Neurologic/Mood
Depression
Anxiety
Bipolar Disorder
Headaches
Migraines
ADD/ADHD
Memory Problems
Parkinson's Disease
Multiple Sclerosis
Other_____

Preventative Tests & Date of Test
Full Physical Exam _____
Bone Density _____
Colonoscopy _____
Cardiac Stress Test _____
EBT Heart Scan _____
EKG _____
Hemoccult Test (stool test for blood) _____
Upper Endoscopy _____
Upper GI Series _____
Ultrasound _____
Other _____

Surgical Procedures & Date of Op.

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Lifestyle

Have you experienced any significant weight change in the past six months? Yes No

If yes, please describe the change: _____

Do you drink alcohol? Yes No **How much/often?** _____

Do you drink caffeine everyday? Yes No **How many cups per day?** _____

Do you smoke? Yes No **How many packs per day?** _____

If no, have you quit within the past 24 months (2 years)? Yes No

Describe your daily energy levels:

_____

Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? Yes No

Do you crave certain foods? Yes No

If so, which foods and when? _____

Do you eat breakfast, lunch, & dinner every day? Yes No

Do you snack between meals? Yes No

Do you take any nutritional supplements or vitamins? Yes No

How is your dental health? Cavities Bleeding gums Periodontal disease

Other dental issues: _____

How many hours do you sleep? _____ **Do you sleep throughout the night?** Yes No

Rate your skin type without lotion: ☐ Very Dry ☐ Dry ☐ Normal ☐ Oily ☐ Combination

Do you do aerobic exercise? Yes No **Type:** _____ **Times/Wk:** ___ **Min./Session:** _____

Do you do strengthening exercise? Yes No **Type:** _____ **Times/Wk:** ___ **Min./Session:** _____

Do you do other types of exercise (Thai Chi, Yoga, etc) Type: _____ **Times/Wk:** ___ **Min./Session:** _____

Men's Health (Please check all that apply):

Frequent urination	Erectile dysfunction	Difficulty ejaculating
Enlarged prostate	Difficulty urinating	Loss of libido

Women's Health (Please check all that apply):

For ages 40 – 69, what was the date of your last mammogram? _____

Irregular menses	Endometriosis	Painful menses	Premenstrual syndrome
Ovarian cysts	Menopause	Loss of menses	Pelvic pain (unrelated to menses)
Fibrocystic breasts	Yeast infections	Loss of libido	Cervical dysplasia
Frequent urination	Difficulty urinating	Painful urination	Urinary incontinence

I certify that the aforementioned information is accurate.

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY					
Blood Pressure	Pulse	02 Sat	Height	Weight	BMI
Body Composition	Reactance:		Resistance:		

Natural Medicine & Rehabilitation
399 Campus Drive, Suite 110
Somerset, New Jersey 08873
P: (908) 252-0242 F: (908) 252-0243

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BETTER HEALTH. BETTER LIFE.

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use, and disclose, your protected health information (PHI) to carry out treatment, payment or health care operations (TPO), and for other purposes that are permitted, or required, by law. It also describes your rights to access, and control, your protected health information. "Protected health information" is information about you - including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request.

If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may file a complaint with us, or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

I authorize Natural Medicine & Rehabilitation to discuss my health care information with the individuals listed below.

Name:_____ Telephone #: _____ Relationship: _____

Name:_____ Telephone #: _____ Relationship: _____

Name:_____ Telephone #: _____ Relationship: _____

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ DOB: _____

Signature: _____ Date: _____

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Credit Card Authorization

BETTER HEALTH. BETTER LIFE.

Patient Name: _____ DOB: _____

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover

Card Number: _____ Expiration Date: _____

Cardholder Name (as it appears on the card): _____

I HEREBY AUTHORIZE NATURAL MEDICINE & REHABILITATION ("NMR") TO CHARGE THE PORTION OF MY BILL THAT IS MY FINANCIAL RESPONSBILITY TO THE CREDIT CARD LISTED ABOVE. I AGREE AS FOLLOWS:

- I have the right to dispute any and all charges and insurance claims.

- I agree that such charges may include: weekly patient cost obligations, the amount of any insurance benefits received by me directly, and penalties.

- I have the right to cancel this authorization at any time by notifying NMR in writing. Cancellation shall be effective 10 days after NMR receives notice. I understand that my account must be current, or that I must provide an alternate credit card, for NMR to process my cancellation.

- I shall notify NMR of any changes to the credit card on file. Types of changes include: cancellation, loss/theft, or a newly issued card with a later expiration date. **There is a $25.00 service charge for "charged back" payments.**

- I understand refunds less than $25.00 will be issued as a credit to my account, unless I request a credit/refund to the credit card charged.

By signing this authorization, I certify that the credit card information listed above is my own credit card account, or one that I am authorized to use. I further certify that the credit card information listed above is accurate, and understand that if it is not accurate, NMR may not be able to charge the credit card, or the credit card company may refuse to accept the charge, either of which will result in a charge that is due and owed by me. Falsifying credit card information, providing cancelled credit card information knowingly, and/ or utilizing unauthorized credit card information fraudulently is illegal, and punishable in a New Jersey Court of Law.

The information on this form will be treated confidentially to the extent allowed under the Freedom of Information Act (5 U.S.C. § 552) and the Privacy Act (5 U.S.C. § 552(a)). The information on this form may be disclosed in the course of presenting evidence to a court, magistrate, or administrative tribunal. The information on this form may be disclosed to NMR employees, and the merchant service, known as X-Charge, and its affiliates in order to complete necessary transactions. Recipients of this information shall be required to comply with the requirements of the Privacy Act, pursuant to 5 U.S.C. § 552a(m). NMR will not liable in the event the credit card information becomes public knowledge due to precautions not taken by the cardholder and/or authorized users.

Patient Signature: _____ Date: _____

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Financial Policy

BETTER HEALTH. BETTER LIFE.

In consideration of Natural Medicine & Rehabilitation ("NMR") undertaking to provide services to me, I hereby agree that I am responsible to NMR for payment of all such services.

I understand that some, or perhaps even all, of the services provided by NMR may be considered uncovered services, and therefore not payable by my insurance company. In the event that I reach agreement with NMR's staff on a weekly patient cost obligation relating to services rendered, I shall pay such weekly patient cost obligation.

I hereby absolutely authorize NMR to apply for benefits on my behalf for services rendered to me and request that payment be made by my insurance company and that payments be sent directly to NMR. If I have active and valid insurance coverage, I have supplied NMR with the up-to-date and correct insurance identification card(s). In the event that payment of insurance benefits for services provided by NMR is made to me directly by my insurance company, I hereby agree that within thirty (30) days of receipt, I shall endorse the insurance company's check or other instrument to the payment of NMR and deliver it to NMR, along with any accompanying explanation of benefits ("EOB"). I further authorize NMR to charge any credit card that I have provided the full amount of any insurance benefits received by me directly, in the event I fail to endorse and deliver the endorsed insurance company's check or other instrument, along with the EOB, to NMR within thirty (30) days of receipt; and in each such event acknowledge that NMR will impose a surcharge of Five Percent (5%) of the amount of such insurance benefits to cover NMR's administrative costs. I hereby further irrevocably assign my rights to benefits under my contract of insurance or other third party payment to NMR, as well as all benefits payable to me under my insurance policy and health benefits plan.

I hereby authorize NMR to release any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. I may revoke this authorization at any time in writing.

I understand and agree that NMR may charge the credit card that I've provided for the following: (i) Fifty and 00/100 Dollars ($50.00) for any missed visit for specialty services, including acupuncture, aesthetics, clinical nutrition and massage, should I fail to provide notice of cancellation at least twenty-four (24) hours in advance of the visit, and (ii) One Hundred and 00/100 Dollars ($100.00) in the event that I fail to return to NMR within thirty (30) days, any original x-rays which I received, and understand that such charges are not covered by my insurance company. In the event I do not have a credit card on file with NMR, I am aware I will be billed directly for such charges.

I certify that I have read the above information, or that the information has been read or translated to me, and that I understand my rights and obligations as a patient of NMR under this agreement.

_____ _____

Patient's Signature Date

_____

Patient's Name (Please print)

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