Union Medical, LLC
Physical Medicine & Rehabilitation Center

2182 Morris Ave.
Union, NJ 07083
Ph.: (908) 851 – 2666
Fax: (908) 851 – 2299

COMPREHENSIVE HISTORY

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Date of Birth: _____ Age: _____
SS#: _____ Marital Status: Single Married Divorced Widowed
E-mail Address:_____

Employer: _____ Position: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____

Do you have Health Insurance? ____ No ____Yes, Name: _____
Emergency Contact Person: _____ Phone #: _____
Family Physician:_____ Ph._____ Notify of this visit? Yes / No

**** Please give us your insurance card(s) & License, so we can make a copy ****

Present Complaint(s): _____
_____

Are your complaints related to a: ____ Auto Accident ____ Work Related Accident
____ Slip/Fall ____ Other, _____
Date of Accident or Onset: _____

Past Medical History: (Please list as much information as possible; include: date(s), doctor(s) and hospital(s))

- Surgeries: _____
- Illnesses (past and present): _____
  _____
- Trauma (slips/falls, broken bones, etc.): _____
  _____
  Blood Transfusion (for any of above): _____
- Medications (past and present): _____
- Allergies (medication, pollen, food, etc.): _____

Please check all that apply; if you are ***NOW*** or ***EVER*** have been Diagnosed with any of the following:

_____ Asthma
_____ Diabetes
_____ Heart Disease
_____ Kidney Disease
_____ Lung Disease
_____ Hypertension
_____ Seizures
_____ Whiplash/Auto Accident
_____ HIV Exposure
_____ Digestive Disorder
_____ Respiratory Disorder
_____ Blood Disorder
_____ Headaches
_____ Vertigo
_____ Skin Disorder
_____ Hormone Disorder
_____ Cancer
_____ Other, _____

Family History: (check any of the following your immediate family has had, indicate relation)

____ Cancer, _____ ____ Blood Disorder, _____
____ Diabetes, _____ ____ Stroke, _____
____ Heart Disease, _____ ____ Tuberculosis, _____
____ High Blood Press._____ ____ Mental Illness, _____

Occupational History:

- Past Occupations (approx. dates): _____
- Current Occupation: _____
- Has your chief complaint affected any of the following? If so, how?
  ___ Activities of daily living, _____
  ___ Work, _____
  ___ School, _____

Social History: (check any of the following that apply)

___ Smoke/Tobacco use ____ Alcohol use ____Drug use

- Do you play any sports? ____ No ____ Yes, _____
- How many hours sleep per day do you get? _____hrs/day
- How many meals per day do you eat? _____meals/day
- How would you rate your diet? ____ Poor ____ Fair ____ Good ____ Excellent
- Have you ever engaged in risky or unprotected sex? ____ No ____ Yes
- How would you rate your current stress level? ___ Low ___ Moderate ____High

Review of Systems:

- Have any of the following systems been affected by your current complaint?(check all that apply)

  ____ Head/Neck ____ Chest/Heart/Lungs ____Kidney/Urinary/Bladder
  ____ Eyes/Ears/Nose/Throat ____Abdomen/GI ____Reproductive/Genital
  ____ Musculoskeletal
  Explain: _____
  _____

- Female patients:

  1. What was the date of your last NORMAL menstrual period? _____
  2. Do you suspect you may be pregnant? ___ Yes ___ No

**** If there is any chance you may be pregnant, please advise the doctor ****

***Who referred you to our office? _____**
(We would like the opportunity to thank them ☺!)

I hereby request and consent to the performance of all medical and/or chiropractic procedures necessary to evaluate and treat the condition with which I present, including, but no limited to, adjunctive therapies and diagnostic x-rays performed by any doctor employed by Union Medical, LLC. I wish to rely on the doctor to exercise his/her judgement during the course of treatment/procedures, based upon the facts then known, and understand it is in my best interest. I attest that all information given herewithin is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent / Legal Guardian: _____ Date: _____

PRIVATE AND GROUP ACCIDENT AND/OR HEALTH INSURANCE ASSIGNMENT OF BENEFITS AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name: _____
Employer: _____
Date of Injury: _____
Claim #/Group #: _____
SS#/ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed directly to:

Company Name: **Union Medical, LLC**
Address: **2182 Morris Avenue**
City/State/Zip: **Union, New Jersey 07083**

(OR)

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me as follows and mail it to me as follows:

Company Name: **C/O** Union Medical, LLC
Address: 2182 Morris Avenue
City/State/Zip: Union, New Jersey 07083

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information or medical records pertinent to my case to any insurance company, adjuster, or attorney involved in this claim in order to process same.

Dated at Union County, this _____ day of _____, 2012

Signature of Policy holder _____Witness _____

Signature of Claimant, if other than Policy holder:_____

Signature of Parent/ Legal Guardian:_____

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Records Release Request:

To: _____
(Doctor or Hospital)

Address: _____

City: _____ State: _____ Zip: _____

I Hereby authorize and request the release of my _____
_____ or copies of such to the above named facility.

Date of Procedure / Records: _____

Patient Name: _____

Patient Signature: _____ Date: _____

Parent / Legal Guardian: _____ Date: _____

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OFFICE FINANCIAL POLICY

The following is an outline of the Terms and Conditions contained within the Financial Policy of this Office. Please read it carefully. It has been designed in an attempt to explain and to clarify how this facility will processes your bills, handle account balances, and our expectations of payment for professional services rendered. If you have any questions, please do not hesitate to ask, as one of our staff members will gladly review it with you.

Explanation of Insurance Coverage

Most insurance policies cover Medical/Chiropractic/Physical Therapy, but this office makes no representation that your particular policy does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for these services. On or prior to your first visit, we will try to verify your coverage with your insurance carrier, so that we can inform you of the portion of the bill for which you are responsible. Due to wide variations from one insurance policy to another, it is important to note that you, the patient, are ultimately responsible for payment of services rendered at this office. This includes: Deductibles, co-payments and any account balance that remains after reimbursement from your insurance carrier has been applied.

Payment Arrangements / Outstanding Account Balances

For your convenience, payment plans can be arranged. Patients who do not have health insurance, have a "limited" policy, or limited means of income may qualify. Our office manager will assist you in making appropriate payment arrangements. Otherwise, you will be billed monthly for any account balance due, payable in full. This office will hold you the insured accountable to the terms of your insurance policy, which include but are not limited to, deductibles and co-payments. Since most insurance companies require co-payments with each visit, and this is the case with your specific policy, **your co-payment is to be paid at each visit upon signing in.** You will be billed monthly for any co-insurance (ex: 80/20) account balance due. An interest charge of 5% per month will be applied to any account balance past due (30 days or more). Any account balance greater than 90-days past due is eligible to be sent to a collection agency. This office will attempt to collect debt owed on three (3) separate occasions (every 30-days). If payment is not received within the designated timeframe determined by the context of our bill and/or our internal collection department, your account will be turned over to a collection agency. If your account is put into collections, you are subject to a $250 fee for attorney and court costs. In addition a 21% interest rate will be assessed to a balance for every 30 days your account is in default. This office reserves the right to modify the collection process on an individual basis, determined at the sole discretion of our collection department.

Assignment of Benefits

For your convenience, this Office accepts insurance assignment. The purpose of the Assignment of Benefits Program is to provide you, the patient, with the courtesy of waiting for insurance reimbursement, rather than charge you up front for our services. This way, your out-of-pocket expenses are kept to a minimum. Enclosed is an "Assignment of Benefits" form which we request you sign. This form instructs your insurance company to send their payments directly to Union Medical, LLC. Your insurance company will send you an explanation of benefits (EOB), informing you of what they have paid to this office, and what your remaining responsibility is (if any).

Oftentimes, the insurance company will overlook our annotation that we accept assignment and they will send the check(s) directly to you the insured/patient. If this occurs, you are required to bring the original insurance check and accompanying explanation of benefits (EOB) immediately to this office. The check(s) is to be endorsed over to Union Medical, LLC for payment, so that your account can be properly credited. We will photocopy the EOB, the original may be kept for your records. Irregardless, whether your carrier accepts assignment, or the terms of your policy permits assignment, you are ultimately responsible for any/all unpaid account balances.

Original Claim Form

In order to initiate a claim with your insurance company, it is often necessary to obtain one of your insurance company's ORIGINAL CLAIM FORMS, fully completed and signed. Most insurance companies require this original form to be completed before they will release any benefits. If this is the case with your insurance company, you are responsible for obtaining this form (we will let you know as soon as possible). You should be able to obtain this claim form either directly from your employer or from your insurance company.

Release of Information / Records

If your insurance company requires medical reports/records, documenting your treatment at this facility in order to process and pay a claim, your signature below authorizes the release of such medical information necessary to process any and all claims.

Missed Visits

This office reserves the right to charge you the patient personally for any appointment made with this office and missed, cancelled, or rescheduled with less than 48-hours notice provided to us. This fee represents compensation for the time set aside by the staff and physician you are scheduled to see. Additionally, this policy is made in an effort to allow this office sufficient time to schedule those patients requiring more immediate attention the option of being "bumped-up" into your cancelled time-slot. Currently this fee is $150.00.

Voluntary / Involuntary Termination of Care

It is also the policy of this Facility that if you should choose to suspend or to terminate your care and treatment, prior to the consent of or against the opinion of the attending physician, any outstanding fees for professional services rendered to you become immediately due and payable. This office also reserves the right to involuntarily discharge any patient not compliant with the treatment plan outlined by the staff physicians.

I have read the Terms and Conditions of this facility's Financial Policy. I have had an opportunity to review and ask questions regarding same, my signature below acknowledge my comprehension of these Terms and Conditions and represents my agreement to be legally bound to these Terms.

Patient Signature: _____ **Date:** _____

Parent/ Legal Guardian: _____ **Date:** _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE FORM

1. Acknowledgement of Privacy Practice Notice

I have received a copy of Union Medical, LLC Notice of Privacy Practices.

Patient Name	Date of Birth	Signature of Patient/Parent Guardian	Date
_____	_____	_____	_____

2 I wish to be contacted in the following manner (check all that apply)

☐ **Home Telephone _____**
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call back number only**

☐ **Written Communication**
- ☐ **OK to mail to my home address**
- ☐ **Ok to mail to my work/office**
- ☐ **OK to fax to this number**

☐ **Work Telephone_____**
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call back number only.**

☐ **EmailAddress:_____**

2. Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Union Medical, LLC may disclose certain of my health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relation to my health care. In that case, Union Medical, LLC will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below a persons involved with my healthcare or payment relating to my health care for the purpose of Union Medical, LLC to make the type of disclosures listed above. (I understand that I am not required to list anyone ad that I may change this list at any time in writing).

Print Name/Relationship/Telephone#_____

Print Name/Relationship/Telephone#_____

Print Name/Relationship/Telephone#_____

Print Name/Relationship/Telephone#_____

Print Name/Relationship/Telephone#_____

_____ _____

Signature of Patient/Parent/Guardian **Date**

INTERNAL PRIVACY PRACTICE POLICIES

For the office of:

Union Medical, LLC
2182 Morris Ave.
Union, NJ 07083

Union Medical, LLC
526 Bloomfield Ave.
Caldwell, NJ 07006

THE STAFF OF UNION MEDICAL MAY ONLY DISCLOSE PATIENT PERSONAL HEALTH INFORMATION IN THE FOLLOWING INSTANCES:

The staff will not disclose personal health information to any persons or location not approved by the patient.

The staff will keep sign sheets private as not to expose any one patient's name to others treating in our facility.

The staff when sending any information via mail will be secure and enclosed in security type envelopes.

The staff will not fax any health information without patient request/ permission or a HIPPA complaint cover sheet.

The staff will disclose personal health information in order to provide treatment to patients or to obtain payment for services rendered.

The staff may disclose health information with the patient consent only in the following instances:

Leave messages on answering machines
Leave messages at place of employment or through facsimile.
Send confidential reminder postcards.

The staff will disclose information as it is required by law.

The staff will only disclose personal health information if there is written consent to do so.

Effective Date: January 1, 2004

NOTICE OF PRIVACY PRACTICES

For the office of:

Union Medical, LLC
2182 Morris Avenue
Union, NJ 07083

Union Medical, LLC
526 Bloomfield Ave.
Caldwell, NJ 07006

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

By law, Union Medical, LLC is required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by Union Medical, LLC. It also tells you how you can obtain access to this information. Disclosure means: the release, transfer, provision of access to or divulging in any other manner, of information outside of the entity holding the information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical / protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, our contact person is:

Victor M. Fano
Union Medical, LLC
2182 Morris Avenue
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(908) 851-2666