Union Medical, LLC
Physical Medicine & Rehabilitation Center

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

CONSULTATION 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 #: _____

Referring Physician: _____ Attorney: _____ Ph: _____
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(n): ____ Auto Accident ____ Work Related Accident
____ Slip/Fall ____ Other, _____
Date of Accident/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 ****

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: _____

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PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( )_____
Address _____ City _____ State _____ Zip _____
Age _____ Birthdate _____ Sex _____ SS # _____
Employer _____ Work #: ( )_____
Employer's Address_____
Your Auto Insurance Co._____ Policy #:_____
Name Of Policy Holder / Owner On Vehicle You Were In (if other than self):_____

ATTORNEY

Name _____ Phone #: ( )_____
Address _____ City _____ State _____ Zip_____

Were there any witnesses? ( ) Yes ( ) No Name(s)_____

NATURE OF ACCIDENT

1. Date of Accident _____ Time of Day_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. # of people in your vehicle? ____ Were you wearing seatbelts? ( ) Yes ( ) No
4. What direction were you headed? ( ) North ( ) South ( ) East ( ) West
   on (name of street) _____
5. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of your car _____ mph other car _____mph
8. Were you knocked unconscious? ( ) Yes ( ) No
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident:
    _____
    _____
11. Did you have any physical complaints BEFORE the accident? ( ) Yes ( ) No
    If Yes, please describe in detail: _____
    _____
    _____
12. Please describe how you felt:
    a. DURING the accident:_____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
13. What are your PRESENT complaints and symptoms? _____
14. Where were you taken after the accident? _____
15. Have you treated or been seen by another doctor since the accident? ( ) Yes ( ) No
    If Yes, please list doctor(s) name and address: _____
    _____
16. Do you have any congenital (from birth) factors, which relate to this problem? ( ) Yes ( ) No
    If Yes, please describe: _____
17. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
    If Yes, please describe: _____
18. Have you ever been involved in an accident before? ( ) Yes ( ) No
    If Yes, please describe including date(s) and type(s) of accident(s), as well as injury(ies) received.
    _____
    _____

19**. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT**:

__ HEADACHE	__ IRRITABILITY	__ NUMBNESS IN TOES
__ NECK PAIN	__ CHEST PAIN	__ SHORTNESS OF BREATH
__ NECK STIFF	__ DIZZINESS	__ FATIGUE
__ SLEEPING PROBLEMS	__ HEAD SEEMS TOO HEAVY	__ DEPRESSION
__ BACK PAIN	__ PINS & NEEDLES IN ARMS	__ LIGHT BOTHERS EYES
__ NERVOUSNESS	__ PINS & NEEDLES IN LEGS	__ LOSS OF MEMORY
__ TENSION	__ NUMBNESS IN FINGERS	__ EARS RING
__ FACE FLUSHED	__ BUZZING IN EARS	__ LOSS OF BALANCE
__ FAINTING	__ STOMACH UPSET	__ CONSTIPATION
__ LOSS OF SMELL	__ FEET COLD	__ DIARRHEA
__ LOSS OF TASTE	__ HANDS COLD	__ COLD SWEATS
__ FEVER	__ OTHER_____	

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No
    If Yes, please complete the following:
    a. LAST DAY WORKED: _____
    b. TYPE OF EMPLOYMENT: _____
    c. PRESENT SALARY: _____
    d. ARE YOU BEING COMPENSATED FOR TIME LOST FROM WORK? ( ) Yes ( ) No
       If Yes, please state type of compensation you are receiving:
       _____
       _____

21. Have you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
    If Yes, please describe in detail _____
    _____

22. Other important information: _____
    _____

I attest that the above information has been provided by me, and that it is true and accurate to the best of my knowledge and recollection.

X _____ _____
PATIENT SIGNATURE DATE

X_____ _____
PARENT/ LEGAR GUARDIAN DATE

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ASSIGNMENT, LIEN, AUTHORIZATION OF INSURANCE BENEFITS AND POWER OFATTORNEY

Name of Patient: _____ DOA: _____

I hereby authorize and direct any insurance company and/or my attorney –to pay directly to the above noted office such sums as may be due and owning this office for services rendered to me, both by reason of accident or illness and by reasons of any other bills that are due to this office, and to withhold such sums from any disability benefits, or any other insurance benefits obligated to reimburse me or from any settlement, or judgment or verdict on my behalf as may be necessary to adequately protect said Office.

I hereby assign all of my interest and rights to PIP benefits, which shall include, but not be limited to the right to file arbitration for PIP benefits relative to treatment by said office. I hereby assign and transfer to this officer any and all causes of action that I might have or that might exist in my favor against any insurance carrier that may be liable for payment of PIP benefits, and authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit. Further, in the even that the within assignment is not consented to by an insurer or in any other manner is held invalid by any party, arbitrator or any other person, I hereby give this office the power of attorney to bring any arbitration proceeding or suit in my name on my behalf as if I had filed such action myself. I further agree to fully cooperate with regard to prosecuting such action or proceeding.

This Office agrees that it will as a condition of this assignment: follow all **legally valid** provisions of the insurer's Decision Point Review plan, hold the insured harmless for penalty co-payments **properly** imposed by the insurer based upon this Office's failure to follow the **legally valid** requirements of the Insurer's Decision Point Review Plan and that as a condition of this assignment this Office agrees to submit disputer to Alternatives Dispute Resolution pursuant to N.J.A.C. 11:3-5. Nothing contained in the preceding sentence shall in any manner be deemed to be a waiver of this office's right to contest the legal validity of any provision of the insurer's policy or Decision Point Review Plan or the insurer's application of the policy or Plan to your claim or to contest the imposition of penalty co-payments that this Office disputes.

I understand that I remain personally responsible for the total amount due to the Office for services, subject to the New Jersey Law. I further understand and agree that this Assignment, Lien and Authorization, so long as the request is submitted in writing. I agree that the above-mentioned Office is herby given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bill. I further authorize any insurance company and any other physicians who have treated me for this accident to provide this office with any documentation needed with regard to the payment of my bills.

Patient's Signature:_____ _____ Date_____

Parent/Legal Guardian:_____

Witness: _____

Union Medical

Physical Therapy and Rehabilitation Center
2182 Morris Ave
Union, NJ 07083
(908) 851-2666 Fax: (908) 851-2299

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: _____

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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 any applicable attorney fees and court costs that this office may incur. 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:_____

Patient's Guardian Signature:_____ Date:_____
(if patient is under the age of 18)

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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**