

## NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**WELCOME:** The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

**INSTRUCTIONS:** Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

### PERSONAL INFORMATION:

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_ Jr., II, III, IV  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Marital Status (Circle): Divorced Married Single Separated Widowed  
Gender (Circle): Male / Female Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_ @ \_\_\_\_\_  
Spouses Name: \_\_\_\_\_ Names & Ages of Children: \_\_\_\_\_  
Is your spouse a patient in our office?  Yes  No

**Employer /Employment Status**  Employed  Unemployed  Full Time /  Part Time Student  Other

Business Name: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type of Work: \_\_\_\_\_  
Is it ok to contact you at work?  Yes  No

### Emergency Contact Information

Name: (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_ Jr., II, III, IV  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?

Yes  No

Who besides yourself is responsible for your bill?  Self-Pay  Health Insurance

Medicare  Medicaid  Worker's Comp

Auto Insurance  Other (Be Specific): \_\_\_\_\_

Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_

Insured Person's Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured Person's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured Person's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Auto or Workers' Comp Insurance Carrier & Claim #: \_\_\_\_\_

### PRIMARY COMPLAINT:

When did it start? \_\_\_\_\_

Describe the condition: \_\_\_\_\_

What do you think caused the problem? \_\_\_\_\_

Rate the pain from 1-10: At it's worst \_\_\_\_\_ At the present time \_\_\_\_\_ At least severe \_\_\_\_\_

Does the pain travel?  Yes  No If yes, from where to where? \_\_\_\_\_

Is condition getting worse?  Yes  No

List the activities that this condition prevents you from doing? \_\_\_\_\_

List past treatment for this condition and if they helped \_\_\_\_\_

**SECOND COMPLAINT:**

When did it start? \_\_\_\_\_  
Describe the condition: \_\_\_\_\_  
What do you think caused the problem? \_\_\_\_\_  
Rate the pain from 1-10: At it's worst \_\_\_\_\_ At the present time \_\_\_\_\_ At least severe \_\_\_\_\_  
Does the pain travel?  Yes  No If yes, from where to where? \_\_\_\_\_  
Is condition getting worse?  Yes  No  
List the activities that this condition prevents you from doing? \_\_\_\_\_  
List past treatment for this condition and if they helped \_\_\_\_\_

**LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any other information that you feel would be relevant to your current condition(s) that was not covered?  
Please explain in the following section any information that you feel would be helpful to the doctor.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION:**

I authorize the release of any medical information necessary to process my insurance claims.

**AUTHORIZATION OF ASSIGNMENT:**

I authorize payment of medical benefits to Manalapan Spine Care for services rendered to me.

**REIMBURSEMENT POLICY:**

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

**ACCEPTANCE AS A PATIENT:**

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

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**PATIENT PRINTED NAME**

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**PATIENT SIGNATURE**

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**DATE**

# Manalapan Spine Care & Rehabilitation

94 Bridge Plaza Drive  
Manalapan, NJ 07726

Tel: (732) 972-5900

## AUTHORIZATION FOR ASSIGNMENT & RELEASE

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

### AUTHORIZATION OF ASSIGNMENT:

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### REIMBURSEMENT POLICY:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

\_\_\_\_\_  
**PATIENT PRINTED NAME**

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**

# Manalapan Spine Care & Rehabilitation

94 Bridge Plaza Drive  
Manalapan, NJ 07726

Tel: (732) 972-5900

## PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

### **Notice to Patient:**

We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

### **OPTIONAL:**

- |   |     |    |
|---|-----|----|
| 1) May we confirm your appointments by email, text or phone?              | Yes | No |
| 2) May we leave a message on your answering device at home or cell phone? | Yes | No |
| 3) May we discuss your condition with any members of your family?         | Yes | No |

If yes, provide names: \_\_\_\_\_

### **Patient Acknowledgement:**

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature or legal representative

\_\_\_\_\_  
If legal representative, state relationship

\_\_\_\_\_  
Date

### **FOR OFFICE USE ONLY:**

We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

- the patient refused to sign  
 we were not able to communicate with the patient  
 due to an emergency situation it was not possible to obtain a signature  
 other (please provide details):

\_\_\_\_\_  
Name of patient

\_\_\_\_\_  
Name of staff member

\_\_\_\_\_  
Signature of staff member

\_\_\_\_\_  
Date

# Manalapan Spine Care & Rehabilitation

## **NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)**

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### **Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

### **Get an electronic or paper copy of your medical record:**

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct your medical record:**

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications:**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

### **Ask us to limit what we use or share:**

You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

### **Get a list of those with whom we’ve shared information:**

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice:**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

### **Choose someone to act for you:**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated:**

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints). We will not retaliate against you for filing a complaint.

## **Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

### **In these cases, you have both the right and choice to tell us to:**

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

### **In these cases we never share your information unless you give us written permission:**

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

### **In the case of fundraising:**

We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **Our Uses and Disclosures**

How do we typically use or share your health information? We typically use or share your health information in the following ways:

### **Treat you:**

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

### **Run our organization:**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

### **Bill for your services:**

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues:**

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

### **Do research:**

We can use or share your information for health research.

### **Comply with the law:**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests:**

We can share health information about you with organ procurement organizations.

### **Work with a medical examiner or funeral director:**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests:**

We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

**Respond to lawsuits and legal actions:**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

**Changes to the Terms of This Notice:**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

**OPTIONAL Additional Items:**

- |   |     |    |
|---|-----|----|
| 1) May we confirm your appointments by email, text or phone?              | Yes | No |
| 2) May we leave a message on your answering device at home or cell phone? | Yes | No |
| 3) May we discuss your condition with any members of your family?         | Yes | No |

If yes, provide names: \_\_\_\_\_

4) We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested.

**Contact information:**

Paul Battipaglia, Director, [manalapanpine911@gmail.com](mailto:manalapanpine911@gmail.com), Tel: 732-972-5900

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