Atlantic
Medicine & Wellness

HISTORY OF COMPLAINT

Name_____ **Date**_____ **DOB** _____

Circle One : Is this an **Automobile Accident** • **Work Related** • **Fall Down** • **Regular Visit**

How did your condition come about? _____

_____

_____

When did it first occur?_____ _____

How often does it occur? _____

How long does it last? _____

Please describe the condition. List the areas of discomfort/pain, where does it start, is it the left side, right side or both and where does it travel? _____

_____

_____

_____

What brings it on? _____

_____

_____

Does anything aggravate it, increase it or make it worse? _____

_____

_____

What lessens the problem? _____

What previous treatments have you had for the condition? _____

_____

What could you do before the onset of the problem? _____

_____

What can you **not** do when you have the symptoms? _____

_____

Have you ever had these exact symptoms before? _____ If yes, when? _____

_____

MEDICAL HISTORY

List allergies: _____

_____

List all past medications: _____

_____

List all present medications: _____

_____

Previous surgeries with dates and doctors: _____

_____

_____

List any previous accidents with dates: _____

_____

Patient Signature _____ Date _____

Patient Name Case #

PERSONAL HISTORY

PERSONAL	YES	WHEN	NO	FAMILY	YES	SPECIFIC MEMBER	NO
Abdominal Bleeding							
Allergies							
Anemia							
Arthritis							
Asthma/Emphysema							
Back Disorders							
Backache							
Bleeding Diseases							
Blood in Stool/Black Stool							
Blood in Urine							
Cancer							
Change in Bowel Habits							
Chest Pain							
Colitis							
Constipation							
Cough							
Coughing Blood							
Depression							
Diabetes							
Diarrhea							
Difficulty Swallowing							
Dizziness							
Enlarged Heart							
Double Vision							
Epilepsy/Seizures							
Fainting Spells							
Gallstones							
Gall Bladder Disorder							
Glaucoma							
Headaches							
Heart Disease							
Heart Murmur							
Hepatitis							
Hoarseness							
High Blood Pressure							
Indigestion							
Irregular Heart Beat							
Kidney Infection							
Kidney Stone							
Leg Pain							
Lung Disease							
Lyme Disease							
Nocturia							
Nosebleeds							
Nervous Disorder							
Painful Urination							
Paralysis							
Phlebitis							
Pleurisy							
Pneumonia							
Rheumatic Fever							
Shortness of Breath							
Stroke							
Swelling of Feet							
Swollen/Painful Joints							
T.B.							
Thyroid Disease							
Ulcer							
Venereal Disease							
Vomited Blood							
Other							

Atlantic Medicine & Wellness

PATIENT INFORMATION (Please Print) 2018

Patient's Last Name		First		Middle
❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. ❑ _____	❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Unknown	Birth Date / /	Age	❑ Male ❑ Female
Spouse's Name	Children ❑ No ❑ Yes	# ____	Other family members seen here at AMW	
Street Address		Social Security # -- --		Home Phone ( )
City	State	Zip Code		Cell Phone ( )
Occupation	Employer	Work Address		Work Phone ( )
Employment Status ❑ Full Time ❑Part Time ❑ Not Employed ❑ On Active Mil Duty ❑ Retired ❑ Self Employed ❑ Unknown				
Primary Care Physician	Address		Phone #( )	
Emergency Contact Name	Phone #( )		Relationship	
Referred by				
Email Address				

INSURANCE INFORMATION

Name of Insured	Birth Date / /	Address (if different)	Home Phone ( )
Occupation	Employer	Work Address	Work Phone ( )
Insurance Co	Insured's SS # - -	Policy #	Group #
Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of **secondary** insurance (if applicable)	Insured's Name	Policy #	Group #
Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child ❑ Other		Insured's SS#	Insured's DOB

This information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Atlantic Medicine and Wellness, LLC. I understand that I am financially responsible for any balance. I also authorize AMW, LLC or insurance company to release any information required to process my claims.

☐ Thank you for giving AMW permission to send you our newsletters, informational e-mails and promotions. AMW shall never share your email address with anyone outside the company without your permission. If you do NOT wish to receive our newsletters and other emails please check the box. Also, if at any point, you wish to unsubscribe, please contact the front desk.

Patient/Guardian Signature_____ **Date** _____

Atlantic
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2018 IMPORTANT FINANCIAL UPDATE

Making your way through the tightly regulated health system is difficult, especially in these dynamic times. Our belief is that a strong patient-provider relationship overcomes even the most challenging hurdles. To best serve your needs we appreciate your help with: 1) verifying your personal information; 2) knowing your insurance coverage benefits; and 3) ensuring that your payments are prompt.

Verify Your Personal Information
On your first visit in 2018, we will ask you to verify or provide: 1) your personal information; 2) complete and updated insurance information; and 3) updated photo identification. Please note it is critical to inform AMW about any insurance changes or changes to your personal information, as they may occur throughout the year.

Know Your Insurance Benefits
The rising cost of health care may cause employers to change your benefits packages. As a result, your insurance card may continue to look the same but the benefits may be very different. As a courtesy to you, AMW verifies your benefits and the extent of your coverage. Please note that we are a participating provider in Medicare and that for most other carriers, we accept your insurance as an out-of-network provider. This means that your insurance company will often send the payment for our services to you directly, instead of to us, along with a list of the services we rendered called an EOB (Explanation of Benefits).

Make Prompt Payments
When you receive a check for services rendered at AMW, please mail it or bring into our offices **promptly upon receipt** along with any documentation you receive. Your prompt payment helps us to continue providing services to you and helps you avoid additional charges. Often, AMW will not be your only provider - other providers may be listed on the EOB. Even if other providers or facilities are listed, AMW must obtain a copy of the entire EOB, including payments due to AMW. In such an instance, AMW offers four convenient payment options:

1. Endorse the insurance check sent to you and forward it to our office;
2. Write a personal check for the amount due AMW;
3. Pay with a credit card; or
4. Pay with cash.

Past Due Accounts; Returned Checks

In the event of any past due accounts, please be advised that AMW will avail itself of all remedies available at law and in equity, including, but not limited to dismissal from the practice and/or transferring unpaid balances to a collection agency for payment. In such an event, I agree to pay all attorney's fees, court costs, and all collections costs, up to 50% to the amount owed, which may be assessed by any collection agency retained to pursue the matter. In the event any check is returned to us as unpaid, we will charge a $25.00 fee.

By signing this Important Financial Update, I acknowledge that I have read and understood the foregoing notice. In 2018, AMW hopes you will continue to achieve your optimal wellness. For further questions or assistance, please do not hesitate to contact our Accounts Management team at (732) 528-5533.

Print Name: _____ **Signature:** _____

DOB: _____ **Date:** _____

Atlantic
Medicine & Wellness

2018 DISCLOSURE REGARDING HEALTH CARE SERVICES

The medical doctors of Atlantic Medicine and Wellness, LLC, ("AMW") are dedicated to providing the highest quality medical services to our patients in a unique multidisciplinary office setting. Given this unique setting, AMW differs from the traditional primary care medical practice in the following ways:

1. The medical services provided by AMW are exclusively office based. What this means is that the medical doctors of AMW only provide medical services to patients at the office of AMW during scheduled hours. **We do not provide services at a hospital nor do we provide emergency care.**

2. As AMW does not provide emergency care, calls made to the medical doctors of AMW after office hours will be forwarded to a voice messaging system as opposed to a physician answering service. If you experience a medical emergency, please call 911 and/or seek immediate treatment at the hospital or urgent care center nearest to you.

3. The medical doctors of AMW are dedicated to working in collaboration with the other primary care and specialist physicians involved in your care. As such, the medical doctors of AMW strongly recommend that you maintain a doctor-patient relationship with one or more physicians appropriate to your condition and/or situation even while seeking care at AMW.

4. Based on your condition, the medical doctors of AMW may refer you to one or more of the closely allied licensed health care professionals employed or engaged by AMW. These professionals include chiropractic physicians, physical therapists, nutritionist, acupuncturist, mental health counselor, massage therapist, etc.

5. Based on your medical condition, the doctors of AMW may order or perform certain diagnostic tests or studies. In order to maximize the effectiveness of your care, it is imperative that you schedule and honor a necessary follow up appointment with the medical doctor who ordered or performed the diagnostic test or study to both go over the results of the test and to adjust your plan of care accordingly.

By signing this Disclosure Regarding Medical Services, I acknowledge that I have read and understood the foregoing notice.

Print Name: _____ **Signature:** _____

DOB: _____ **Date:** _____

2018 CONSENT FOR TREATMENT AND DISCLOSURE OF PATIENT INFORMATION

I hereby authorize ATLANTIC MEDICINE & WELLNESS, LLC ("AMW") to perform the treatments and/or procedures advised by my provider. I acknowledge that no guarantees, either implied or expressed, have been made to me regarding the outcome of such treatments and/or procedures, as I fully understand it is impossible to make guarantees regarding such outcomes.

I hereby further acknowledge and understand that the providers and medical staff of AMW shall explain to me the potential risks, benefits and alternatives of these treatments and/or procedures and shall outline and discuss the goals of my treatment plan and review the treatment options with me.

I hereby further acknowledge and understand that from time to time AMW may inform me of new treatments or other services that may be appropriate for my condition and/or from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc.) I consent to the use of my identifiable patient information to notify me of such new treatments, or other services that may be necessary for the continuity of my care or which may be of benefit in maintaining or improving my health, with the understanding that AMW will not provide such information to others for marketing, fund-raising, or similar purposes without my specific consent.

The Privacy Rule that is contained in the *Health Insurance Portability and Accountability Act Of 1996* ("HIPAA") establishes a federal requirement that health care providers must obtain a patient's written consent before using or disclosing the patient's personal health information to carry out any treatment, payment, or health care. This consent must be obtained before information may be used or disclosed, except in emergency situations.

I hereby acknowledge and understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment; it may also be used for payment and operational purposes. AMW reserves the right to change the terms of the notice of privacy practices; such changes in the privacy practices shall be made available to me. I may request additional restrictions on access to this information for treatment, payment or health care. I hereby acknowledge and understand that AMW may not be able to comply with this request. I request the following special restriction(s): _____.

I hereby acknowledge and understand that I am also granting consent for my personal health information to be disclosed to the following person(s): _____. This consent does not apply to disclosures of health care information unrelated to my current condition, nor does it apply to the provision of copies of health records; in both cases, a written authorization must be provided by me or my legal representative.

I acknowledge and understand that I, or my representative, promptly upon request, may inspect, request correction of and obtain information from my patient records. I further acknowledge and understand that I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this consent.

In the event the patient is a minor under the age of eighteen (18), I certify that I, the undersigned guardian, hereby consents to the foregoing on behalf of my minor child: _____.

By signing this Consent for Treatment and Disclosure of Patient Information, I acknowledge that I have read and understood the foregoing notice.

Print Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

2018 ASSIGNMENT OF BENEFIT FORM

Name (Last, First): _____

Policy#:_____ DOB: _____

I hereby authorize, instruct and direct my insurance carrier to issue and mail payment check(s) to Atlantic Medicine & Wellness, LLC, 2399 Route 34, Suite A-5, Wall Township, NJ 08736**. In the event my current policy prohibits direct payment to Atlantic Medicine & Wellness, LLC, I hereby understand and acknowledge that I am responsible to make payment(s) directly to Atlantic Medicine & Wellness, LLC for any and all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This assignment serves as my written authorization for assigning all my rights and benefits payable under my insurance coverage to Atlantic Medicine & Wellness, LLC. I further understand and acknowledge that I am responsible for any amount not covered by insurance for medical (including nutrition), chiropractic, physical therapy, mental health counseling, massage and/or acupuncture services rendered to me by Atlantic Medicine &Wellness, LLC in connection with any insurance policy and/or claim otherwise payable to me. This payment will not exceed my indebtedness to Atlantic Medicine & Wellness, LLC, and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment that is not prohibited by law.

This assignment is irrevocable. In the event I would like to revoke this assignment, I will request such revocation in writing to Atlantic Medicine & Wellness, LLC. In the event I should not receive a written confirmation from Atlantic Medicine & Wellness, LLC within ten (10) days of my request, it will be deemed that such request has been authorized.

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

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to my health insurance and/or the Insurance Commissioner or any other government agency for any reason on my behalf.

By signing this Assignment of Benefits Form, I acknowledge that I have read and understood the foregoing notice.

_____ _____

Signature of Policyholder **Date**

Atlantic Medicine & Wellness is now complying with Federal guidelines and utilizing Electronic Health Records. As part of the requirements of this conversion, we are also **mandated by Federal law** to capture more detailed information about you in the several questions noted below. Won't you kindly answer the questions below and sign where indicated. Your patience and cooperation are very much appreciated.

FIRST NAME: _____ **LAST NAME: _____**

DOB: _____ **GENDER:** ☐ **Male** ☐ **Female**

LANGUAGE: ☐ English ☐ Other: _____

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

ALLERGIES: ☐ No Known ☐ Other: _____

MEDICATIONS: ☐ None ☐ List name and dosage: _____

_____

(please use reverse side for more room)

TOBACCO USE:
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

_____ _____

Patient Signature **Date**

Office Signature: _____ **Date:_____**