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SHANNON B. RITTBERG, DO

PATIENT PERSONAL HISTORY FORM

NAME: _____
(PLEASE PRINT)

D.O.B.: ____/____/____

Phone Number: cell: _____ home: _____ bus: _____

Primary Care Physician: _____

Date of Last Physical: ____/____/____

Pharmacy name : _____ Phone no: _____

Address: _____

Reason for your visit today: *(please list all symptoms)*

1.	2.
3.	4.

PAST MEDICAL HISTORY: *please circle all that apply*

Circulatory system:

- | | |
|-----------------------------|-------------------------|
| High blood pressure | Atrial fibrillation |
| Heart attack | Coronary artery disease |
| Peripheral vascular disease | Deep vein thrombosis |
| Other: _____ | |

Pulmonary system:

- | | |
|--------------------|--------------|
| COPD/Emphysema | Asthma |
| Pulmonary Embolism | Sleep Apnea |
| Pneumonia | Tuberculosis |
| Asbestosis | |
| Other: _____ | |

Gastrointestinal:

- | | |
|-----------------|--------------------------|
| GERD | Ulcerative colitis |
| Crohn's disease | Irritable Bowel Syndrome |
| GI Bleeding | |
| Other: _____ | |

NAME: _____ DOB: _____ DATE: _____

Endocrine/Metabolic:

Diabetes	Hyperlipidemia
Hypothyroidism	Hyperthyroidism
Osteoporosis	Obesity
Other: _____	

Neurologic:

Stroke	TIA
Migraines	Seizure disorder
Tremors	Parkinson's disease
Dementia	Neuropathy
Vertigo	Restless leg syndrome

Hematologic:

Anemia	B12 deficiency
Thrombocytopenia	Leukemia
Other: _____	

Renal:

Renal Insufficiency	Renal Failure
Kidney stones	Pyelonephritis
Other: _____	

Urinary System:

BPH	Prostatitis
Incontinence	Hematuria
Erectile Dysfunction	
Other: _____	

Head and Neck:

Allergic rhinitis	Chronic sinusitis
Meniere's Disease	Hearing loss
Cataracts	Glaucoma
Macular degeneration	
Other: _____	

Infectious Disease:

Mononucleosis	Lyme disease
Hepatitis	HPV
Genital herpes	HIV
Chlamydia	
Other: _____	

Psychiatry:

Anxiety	Depression
Attention Deficit Disorder	Bipolar Disorder
Substance Abuse	
Other: _____	

NAME: _____ DOB: _____ DATE: _____

FAMILY HISTORY:

<u>Family Member</u>	<u>Illness</u>	<u>If deceased, age at death and cause</u>
Mother	_____	_____
Father	_____	_____
Sibling	_____	_____
Sibling	_____	_____
Child	_____	_____
Child	_____	_____
Child	_____	_____
Other	_____	_____
Other	_____	_____

MEDICATIONS: *please list all medications, including over the counter, vitamins and supplements*

<u>Drug</u>	<u>Dosage</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SPECIALISTS: *please include phone number*



PATIENT INFORMATION (Please Print)

2018

Patient's Last Name			First		Middle
<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Ms.	<input type="checkbox"/> Dr.	<input type="checkbox"/> _____	<input type="checkbox"/> Widowed	<input type="checkbox"/> Unknown	
Spouse's Name			Children <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> On Active Mil Duty <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of secondary insurance (if applicable)	Insured's Name	Policy #	Group #
Patient's relationship to insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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 _____



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:** _____



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: _____