INFORMED CONSENT FOR PROCEDURE

I hereby consent to the performance of medical procedure, including diagnostic x-rays and various forms of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor named below, and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serve as back up for the doctor names below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of procedures.

I understand and am informed that, in the practice of medicine, there are some risks to treatment including, but not limited to sprains, fractures, strokes, disc injuries, and dislocations. I do not expect the doctor to be able to anticipate all the risks and complications, judgment during the course of the procedure which the doctor feels at the time, based upon the facts they know, and is in my best interest.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its consent, and by signing below I agree to the above-mentioned procedures. I intend this consent from to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient’s Name X ___________________________ Signature of Patient X ___________________________

Date Signed X ___________________________ Witness or Patient’s Signature ___________________________

TO BE COMPLETED BY PATIENT’S REPRESENTATIVE IF PATIENT IS A MINOR OR LEGALLY OR PHYSICALLY INCAPACITATED

Patient’s Name X ___________________________ Signature of Patient X ___________________________

Date Signed X ___________________________ Signature of Representative X ___________________________

Relationship or Authority of Patient’s Representative ___________________________

Translated by ___________________________ Date ___________________________

TO BE COMPLETED BY DOCTORS OR STAFF

Name of clinic or office ___________________________

Address ___________________________

Name of Doctor’s treating this Patient ___________________________

1. ___________________________ Pin #
2. ___________________________ Pin #
3. ___________________________ Pin #
## Fall Prevention, Balance and Dizziness Survey

Prior to you Balance Trak 500™ test, please take a moment to answer this short survey about unsteadiness, balance and dizziness. Thank You.

<table>
<thead>
<tr>
<th>Name (Please Print)</th>
<th>Age</th>
<th>Sex</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td></td>
<td></td>
<td>Height</td>
</tr>
</tbody>
</table>

Please circle your answer

1. Do you ever lose your balance or feel dizzy or unsteady?  
   - Often  
   - Sometimes  
   - Never

2. Are you dizzy or unsteady when you first get up?  
   - Often  
   - Sometimes  
   - Never

3. Do you worry that you may fall and hurt yourself?  
   - Often  
   - Sometimes  
   - Never

4. Does walking down the aisle of a supermarket or stopping next to a moving object, make you dizzy?  
   - Often  
   - Sometimes  
   - Never

5. Does moving your head quickly make you dizzier?  
   - Often  
   - Sometimes  
   - Never

6. Does bending over make you dizzy?  
   - Often  
   - Sometimes  
   - Never

7. Do dizziness or imbalance interfere with your job or you household responsibilities?  
   - Often  
   - Sometimes  
   - Never

8. Do people seem to mumble when they speak?  
   - Often  
   - Sometimes  
   - Never

9. Do your spouse or friends want the TV volume turned down to low or make remarks about your hearing?  
   - Often  
   - Sometimes  
   - Never

### Release

Release: I consent to the fall risk screening, which may include taking a history of fall risks, a computerized Balance test on hard and perturbed surfaces. I expressly acknowledge and agree to release Denville Medical & Sports Rehabilitation Center, their staff and all representatives from any and all responsibilities and/or liabilities, and expressly waive any and all rights and privileges.
Office Financial Policy

Patients are required to complete ALL necessary paperwork.

Changes in appointments require advance notice. Please notify the office as soon as possible to reschedule your appointment. This will insure you get the treatment results you deserve.

Patients without insurance coverage are expected to pay (in form of cash, check or credit card) the same day services are rendered.

For our patients with assignable insurance coverage we have made an effort to remove the financial burden of your health care bills. We are one of the few health care providers that will accept assignments of benefits our center will render treatment and wait to be reimbursed by your insurance company.

We will assist you in any way we can with your insurance carrier, but any insurance or financial obligations are the full responsibility of the patient.

MHO/PPO’s please be secure that we are participating your plan, any precertification/referrals are the patients responsibility.

This office is unique in its ability to offer Medical, Chiropractic, and Physical Therapy services. Please understand that if any treatment is prescribed, it is done on the basis of medical necessity, in order to resolve your condition and prevent recurrence.

Please feel free to ask any questions that remain unanswered, we wish to be of assistance in any way we can.

THANK YOU FOR CHOOSING DENVILLE MEDICAL AND SPORTS REHABILITATION CENTER FOR YOU HEALTHCARE NEEDS!!!!!

X______________________________  X__________________________
Patients Signature                  Date
PATIENT PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radical exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays at this time and give my permission for this procedure. In doing so, I release the doctor from responsibility of potential damage arising from this procedure.

At the present time:

( ) I am sure that I am NOT pregnant.

( ) It is possible that I could be pregnant.

( ) I am pregnant.

______________________________  X___________________
Signature of Patient                Date

______________________________
Witness
NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

I, ___________________________ acknowledge that I have read and understood the notice of Privacy Practices posted in the waiting room of Denville Medical & Sports Rehabilitation Center.

____________________________
Patient Signature

___________________________
Date
Credit Card Authorization

As a courtesy to our patients, Denville Medical and Sports Rehabilitation Center will submit insurance claims on your behalf. Once payment has been made to you or an EOB has been issued by the insurance carrier, we require that you bring such payment along with the entire EOB to our office upon receipt. If we do not receive payment once you have been paid, we will charge your credit card for any open balance due to Denville Medical and Sports Rehabilitation Center. For this purpose, we will take your credit card information and leave it on file.

By signing this Authorization, I, ________________________________, give Denville Medical and Sports Rehabilitation Center permission to charge my credit card for any unpaid balances due to them if I fail to pay such balance as set forth herein.

Credit Card Information

Name as it appears on credit card: __________________________________________

Type of credit card (circle one):   Visa   Mastercard   American Express   Discover

Credit Card Number: ________________________________

Expiration Date: ____________________________

3 Digit Code: __________

Address of card holder: ______________________________________________________
(Including Zip Code)

Patient’s or Authorized Person’s Signature  Date

____________________________________  ____________________________
Request for Personal Representative

Instructions: To request a personal representative, please complete the information below, sign in the space provided and return to: Horizon Blue Cross Blue Shield of New Jersey, Centralized Correspondence Unit, Attn: HIPPA Unit, P.O. Box 820, Newark, New Jersey 07101-0820 or via fax at 973-274-2358. A separate form is required for each member on the policy or coverage, as applicable. Please print legibly.

Member Information: (circle whether request is for subscriber or dependent)

Name (Subscriber/Dependent): ____________________________
Policy Identification #: ________________________________
Date of Birth: _______/_______/_______ Telephone #: ____________________
Address: __________________________________________________________________________
City: ____________________________ State: ______________ Zip: ________________

I, ____________________________, hereby appoint __________________________ to be (member) (personal representative)
designated as my personal representative. I understand this request applies to communications from Horizon and its business associates about my private information. I also understand the mental health and/or substance abuse private information may be disclosed if I have utilized such services.

Time Period for Representation: From: _______/_______/_______ To: _______/_______/_______
NOTE: If no time period is provided, this request will remain in effect until the member of his/her legal representative notifies Horizon in writing requesting a change.

Purpose of Representation: (select one)

x ___ Account Inquires Only: This mean that Horizon BCBSNJ is allowed to disclose private information to the individual selected. This individual would have access to information such as: claims, enrollment, premiums, appeals, etc.

___ Correspondence & Account Inquires: Not only can Horizon BCBSNJ disclose private information to the individual selected, but he/she will receive all correspondence that would normally go to the member, including EOBs, checks, etc. For that reason, this option should ONLY be chosen if the member is sure he/she no longer wants to receive relevant coverage information directly, since the personal representative will receive it instead (generally, only in circumstances of incapacity or incompetence (adults), or in the representation of a child; typically not for spouse-to-spouse representation).

Personal Representative Information: (required for privacy verification purposes)

Name (Last, First, MI): ____________________________
Social Security # (Last 4 Digits only): ______________________ Date of Birth: _______/_______/_______
Address: ____________________________
City: __________________________________________ State: ______________ Zip: ________________
Telephone #: ____________________________

NOTE: If the representative is court-ordered or has another legal designation (examples: power of attorney, living will, executor or administrator of probate estate), you must make this Request and sign this form below on behalf of the member.

Signature of Member / Requestor: ____________________________ Date: _______/_______/_______
(Circle whether member or other requestor)

Printed Name: __________________________________________________________________________
ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility
I have requested professional services from DENVILLE MEDICAL & SPORTS REHABILITATION (“Provider”) on behalf on myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advanced.

Assignment of Insurance Benefits
I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to the Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on mine and/or my dependent’s behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefits plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information
I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization
I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefits plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R 2560.5031 (b)(4) with respect to any healthcare expense incurred as a result of the services I received from the Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

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

Patient: ___________________________________________ Date: ______________
Policy Holder/Insured: _______________________________ Relationship to Insured: ____________
Carrier: ___________________________________________ ID#: ______________________________
Group #: __________________________________________

DENVILLE MEDICAL & SPORTS REHABILITATION
161 E. Main St. Denville, NJ 07834
(973) 627-7888
DENVILLE MEDICAL & SPORTS REHABILITATION
161 E. Main St. Denville, NJ 07834
(973) 627-7888

Communications Regarding Protected Health Information
Authorized Individuals

Date: __________________________

Patient Name: __________________________ Date of Birth: __________________________

I understand that Denville Medical & Sports Rehabilitation may release my PHI to a family member, friend or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable) to whom the information circle “yes” below may be released.

Name___________________________________ Relationship__________________________________
Address/Phone________________________________________________________________________
Health Info: Yes/No (circle as applicable) Payment Info: Yes/No (circle as applicable)

Name___________________________________ Relationship__________________________________
Address/Phone________________________________________________________________________
Health Info: Yes/No (circle as applicable) Payment Info: Yes/No (circle as applicable)

Name___________________________________ Relationship__________________________________
Address/Phone________________________________________________________________________
Health Info: Yes/No (circle as applicable) Payment Info: Yes/No (circle as applicable)


Contact Information

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

Home Telephone: __________________________detailed message or call back number only
Work Telephone: __________________________detailed message or call back number only
Cell Telephone: __________________________detailed message or call back number only

*If you check “call back number only” we will only leave a message to return the call or a message confirming an appointment with no detailed health information.
Knee osteoarthritis
Self-assessment

Do you have osteoarthritis? You may be suffering from knee osteoarthritis and not even know it. Do any of the following statements apply to you?

☐ Yes ☐ No I frequently experience stiffness in my knee after resting or when I wake up

☐ Yes ☐ No My knee is tender or sore after overuse

☐ Yes ☐ No I feel pain in my knee when I move

☐ Yes ☐ No I feel pain in my knee even when I am not active

☐ Yes ☐ No Getting up from a chair, out of a car, or going up or down stairs is difficult

☐ Yes ☐ No I hear a crackling sound in my knee when I move

☐ Yes ☐ No I experience a grating feeling in my knee when I move

☐ Yes ☐ No The area around my knee is red and swollen

☐ Yes ☐ No I am unable to do or enjoy certain activities because of pain or stiffness in my knee

☐ Yes ☐ No I feel less coordinated due to pain or stiffness in my knee

☐ Yes ☐ No I have noticed the muscles in my leg are not as strong as they used to be

Patient Signature_________________________________________ Date________________________