AdvancedWellness

New Patient Health and Wellness Survey

Welcome to our office! We constantly strive to make sure we are meeting your health and wellness goals. Please help us serve you better by letting us know what is important to you. We want to customize your care in our office.

I am interested in the following (check all that apply):

- □ Pain relief only
- □ Correction and maintenance of my problem
- □ Weight loss
- □ Healthy eating for disease prevention
- □ Exercise/strength/flexibility programs
- □ Family wellness care
- □ Other _____

Thank you! It is a pleasure to be a part of your Healthcare Team!

AdvancedWellness

PATIENT INFORMATION:

Today's Date: _____

Name: _____

Address: _____

City:_____ State:_____Zip:_____

Home Phone: _____

Cell Phone: _____

Business Phone: _____

E-mail address: _____

Sex: □M □F Marital Status: _____

Social Security #: _____

Date of Birth: _____

Occupation/School: _____
Employer: _____

Emergency Contact :_____
Phone: _____
Relationship to Patient: _____

Primary Care Physician: _____
Address: _____

Whom may we thank for referring you?
_____

ACCIDENT INFORMATION:

Is condition due to an ACCIDENT? □ Y □ N

Type of Accident:
□Auto □ Work □ Home □ Other
Date of Accident: _____

To whom have you reported this accident?
□ Auto Insurance Carrier
□Workers Compensation Carrier
□ Employer □ other_____

INSURANCE INFORMATION:

Insurance Carrier: _____

Address: _____

City: _____ State: ____ Zip: _____

Telephone: _____

Policy #: _____

Effective Date:_____

Policyholder's Name:_____

Relationship to Patient: _____

Policyholder's Social Security #_____

Policyholder's Date of Birth: _____

Employer: _____

SECONDARY INSURANCE:

Name:_____

Address: _____

Telephone: _____

Effective Date: _____

Policy #:_____

Policyholder: _____

Policyholder's Social Security #:_____

Policyholder's Date of Birth:_____

ATTORNEY INFORMATION (If applicable):

Attorney Name:_____

Address:_____

Telephone Number: _____

ADVANCED WELLNESS

Initial Medical Intake PIP

Date: _____

Name:_____ **DOB:**_____

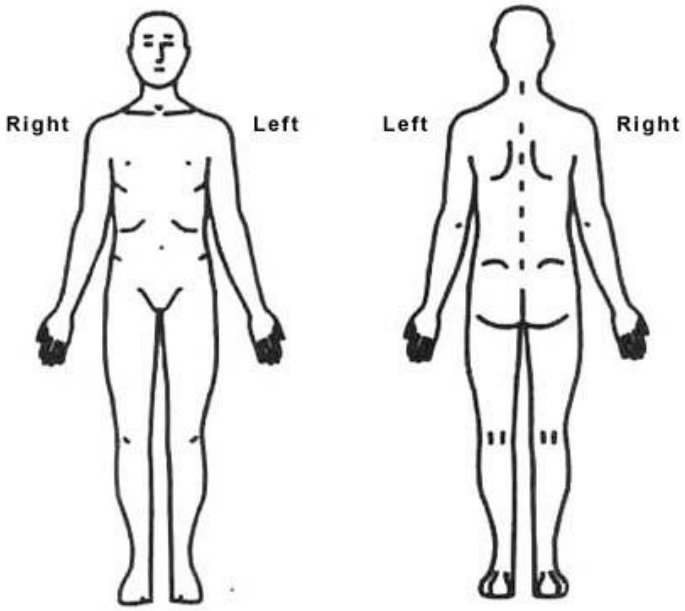
Age: _____ **REFERRING PHYSICIAN:** _____

What is the reason for your visit today:_____

PAIN DRAWING

/// STABBING **XXX BURNING** ***** TINGLING** **❍❍❍ NUMBNESS** **+++ ACHING**

Where is your pain:



Rate your pain level from 0-10 (0=no pain, 1-3=mild, 4-6=moderate, 7-9=severe, 10=worst pain possible)

Neck Pain:	0	1	2	3	4	5	6	7	8	9	10
Midback Pain:	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain:	0	1	2	3	4	5	6	7	8	9	10
_____ Joint Pain:	0	1	2	3	4	5	6	7	8	9	10

When did your pain/symptoms begin:_____

Where you the: Driver___ Passenger_____ Pedestrian_____

Where you wearing your seat belt? Yes No

What type of vehicle were you in: _____

What type of vehicle was the other vehicle: _____

How did the accident happen: _____

_____

_____

Where did the accident occur: _____

Did any part of your body hit the interior of the vehicle? _____

Did you lose consciousness? YES NO **For how long?_____**

Did the air bags deploy? YES NO

Did you go to the emergency room? YES NO, Where?_____
Did you go: Right after the accident_____ The next day_____ Other_____

How did you go to the ER? By Ambulance Other:_____

Where you discharged home the same day? YES NO

Any motor vehicle accidents in the past? _____ If yes explain:_____

Other symptoms associated with pain: Numbness Tingling Muscle Spasm Weakness
Headache Dizziness Difficulty Walking Clicking/Grinding
Bowel/bladder leakage Decreased Movement Joint Swelling Joint Stiffness

Is the pain: Dull Aching Sharp / Stabbing Throbbing Burning Pins/Needles
Tight / Cramping Soreness Shooting

Does the pain: Radiate down the RIGHT or LEFT arm, down to the SHOULDER / ELBOW / HAND
Radiate down the RIGHT or LEFT leg down to the HIP / THIGH / KNEE / ANKLE / TOES

Is the pain: Constant Intermittent (comes and goes)

Is the pain getting: BETTER WORSE STAYING THE SAME FLUCTUATING

What makes the pain worse: Standing Sitting Walking Movement Lying down
Bending forward Bending Backwards Lifting Bowel Movement
Cough/Sneeze Hot weather Cold weather Other:_____

What makes the pain better: Standing Sitting Walking Movement Lying down
Rest Massage Elevating area Ice Heat Medications Other:_____

What treatments have you had for the pain: Physical therapy Chiropractic Acupuncture
Massage Trigger Point Injection Epidural Injection Facet Injections Joint Injections

What medications have you taken for the pain: _____

Does the pain affect your quality of life and/or physical functioning? YES NO

How is your sleep: Good Fair Poor

Any other Neck, Back, or Joint injuries in the past? _____

Have you had any tests in past 5 years: MRI CT Xrays Bone Density Bone Scan Other:_____
Where was this done:_____

Past Health History/Medical Conditions: _____

_____

Past Surgeries / Procedures: _____

_____

Drug/Environmental Allergies: _____

Current Medications: _____

_____

Family History: _____

Social History: Current Alcohol intake: _____ Past Alcoholism? _____
Tobacco Use: _____ How much? _____ Drug use: _____
Any past drug abuse or addiction issues? _____ Past drug rehab?_____
Occupation:_____; Full-time___ Part-time_____
If unemployed or on leave what was date you last worked: _____
Married____ Single____ Divorced____ Widowed_____; Do you have children?_____
Level of education: High School___ College____ Graduate School____ Other:_____

Do you have any of the following: (circle all that apply)

GENERAL: Changes in appetite or weight, Fatigue, Fever, Chills, Night Sweats, Weakness

MS: Bone Pain, Joint Stiffness, Red/Swollen joints, Deformed joints

Skin: Rashes, Lumps, Acne, Dryness, Discoloration, Changes in hair / nails / moles, Itching, Recurrent skin infections, Skin ulcers, Hypersensitivity

HEENT: Head injury, Visual changes, Double vision, Blurred vision, Earache, Eye pain, Glaucoma, Cataracts, Hearing changes, Runny nose, Toothaches, Hoarseness, Dentures, Ringing in ears, Vertigo, Dizziness, Frequent colds, Nose bleeds

Respiratory: Cough, Coughing up blood, Shortness of breath, Wheezing, Choking or Gasping for air at night, Exposure to Tuberculosis

Cardiovascular: Chest pain, Irregular heartbeat, Palpitations

Gastrointestinal: Abdominal pain, Changes in bowel movements, Constipation, Diarrhea, Heartburn, Blood in stools, Black stools, Nausea, Vomiting, Leakage of stool

Urinary: Pain or burning with urination, Sudden urge to urinate, Trouble starting urination stream, Leaking of urine, Pain in sides, Change in urination

Genital/Reproductive: Sexual difficulties, Painful sexual intercourse

Neurological: Seizures, Tremors, Memory loss

Endocrine: Cold intolerance, Heat intolerance, Excessive sweating, Excessive urination, Excessive thirst

Psychiatric: Anxiety, Sleep disturbance, Irritability, Depression, Mood swings, Suicide thoughts or actions

Height: _____feet, _____inches **Weight:_____lbs**

I have completed this form & carefully reviewed its contents. I attest to the accuracy & correctness of the information

Patient or Guardian signature:_____ Date:_____

Reviewed by: _____

NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT FORM
(TWENTY ONE DAY NOTICE)
(N.J.A.C. 11:3-25, et seq)

TREATING HEALTH CARE PROVIDER INFORMATION:

NAME: _____
ADDRESS: _____
_____
PHONE: _____FAX: _____

PATIENT INFORMATION:

NAME: _____
ADDRESS: _____
_____

INSURER INFORMATION:

NAME: _____
ADDRESS: _____
_____

POLICY NUMBER: _____
CLAIM NUMBER: _____
DATE OF ACCIDENT: _____
FIRST TREATMENT DATE: _____

ASSIGNMENT OF PIP MEDICAL BENEFITS FORM

PATIENT AUTHORIZATION:

I am the PATIENT described above and I authorize and direct the INSURER described above to pay the TREATING HEALTH CARE PROVIDER described above, the amount due under the terms of the policy described above for any PIP medical benefits rendered by the TREATING HEALTH CARE PROVIDER described above an/or all staff associated with that office.

I further authorize the TREATING HEALTH CARE PROVIDER described above to file a DEMAND FOR ARBITRATION (PIP) against the INSURER described above for any PAYMENT DISPUTE for PIP medical benefits rendered by the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office.

SIGNED: _____ DATE: _____

PAYMENT DISPUTE shall include a denial and/or non-payment by the INSURER described above for PIP medical benefits rendered by the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office. PAYMENT DISPUTE shall also include a denial and/or refusal to authorize by the INSURER named above any recommended medical benefits as part of the TREATMENT PLAN of the TREATING HEALLTH CARE PROVIDER described above and/or all staff associated with that office.

SIGNED: _____ DATE: _____

TREATING HEALTH CARE PROVIDER REPRESENTATION:

I am the TREATING HEALTH CARE PROVIDER described above and provide the following representations to the INSURER named above in order for the ASSIGNMENT OF BENEFITS executed by the PATIENT named above to be honored. Specifically:

All requirements of the DECISION POINT REVIEW PLAN and/or PRECERTIFICATION PLAN of the INSURER named above that are in accordance with the regulations promulgated by the Department of Banking and Insurance (DOBI) shall be complied with; and
In the event of a failure to comply with the aforementioned requirements, the PATIENT described above will not be held financially liable for any imposed penalty.

It is understood and an INSURER may apply to DOBI pursuant to N.J.A.C. 11:3-4.9 (a) for "approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage." As such please provide me within ten days of receipt of this form with any documentation required to effectuate the intent of the patient described above. Failure to provide any documentation will be construed as a constructive acceptance of this form and the intent of the patient described above.

Signed (AWC) _____ Date: _____

APPOINTMENT AND CANCELLATION POLICY

At Advanced Wellness, our goal is to provide quality care in a timely manner. We have implemented an appointment/cancellation policy which enables us to better utilize available appointments for our patients in need of care.

Scheduled Appointments

To schedule an in-office appointment by telephone, please call:

732-431-2155and select option #3

To schedule a surgery center/procedure appointment please call:

732-431-2155 and select option #5

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Cancellation of Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment.

Surgical Appointments

Cancellation of scheduled surgeries requires 24 hours' notice. Because of the necessary time, supplies and equipment allotted for surgical procedures, any cancellation not made prior to 24 hours will be subject to a fee of $100.00 ($50.00 for Iovera patients). If you are a "no show" after confirming your appointment, you will be subject to a $250.00 fee. This fee will not be billed to insurance and is payable prior to your next appointment.

Lateness

Please be courteous of all fellow patients and be on time for your appointments. If you are running late, kindly call the office and we will advise as to whether you should come in.
If you are more than 10 minutes late, it is possible that you may not be seen and will be scheduled at the next available appointment time.

No Show Policy

A "no show" is someone who misses an appointment without canceling it in advance. No-shows inconvenience those individuals who need access to care in a timely manner.

A failure to present at the time of a scheduled in-office appointment will be recorded in the patient's chart as a "no show". Three "no shows" may result in the temporary suspension of services.

I have read, understand and agree to this policy:

Patient Signature:_____ Date: _____

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZATION FORM
ADVANCED WELLNESS CENTER

Financial Responsibility

I have requested professional services from ADVANCED WELLNESS ("Provider") on behalf of 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 advance.

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 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 my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to 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 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 benefit 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.

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 benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right to act on my behalf in respect to 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 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. Furthermore, the Provider shall have every right and I hereby authorize the Provider to request a Summary Plan Description ("SPD") on my behalf.

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

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

AdvancedWellness
A Comprehensive Wellness Approach

Office Policies

- Our office is a zero balance office. All services including copayments must be paid for at the time of service unless other arrangements have been made.
- All missed appointments must be made up according to your care plan.
- Please call 24 hours in advance if you need to reschedule your appointment.

ASSIGNMENT OF BENEFITS/HIPAA GUIDELINES

I certify that I, and /or my dependent(s) have insurance coverage with _____ and assign directly to Advanced Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

The above-named facility may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I am aware that Advanced Wellness Center (AWC) will abide by the HIPAA regulations for the purpose of keeping my records confidential and only upon my written consent will my records be allowed to leave AWC.

Signature of patient, parent or guardian Date

Print Name of patient, parent or guardian Date

Thank you and welcome to our office!

17 North Main Street, Marlboro, NJ 07746 Tel: (732) 431-2155; Fax: (732) 431-2889

AdvancedWellness
A Comprehensive Wellness Approach

X-RAY CONSENT FORM

I, _____, give consent to have an x-ray examination performed should x-rays be required to diagnose or assist in the diagnosis of my condition.

For Female Patients:

To the best of my knowledge I am not currently pregnant nor am I trying to become pregnant. I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With these factors in mind, I give informed consent to have an x-ray examination performed on me and hereby release this facility and any owner or representative from any responsibility.

Patient Name: _____

Patient Signature: _____

AWC Representative: _____

Date: _____

17 North Main Street, Marlboro, NJ 07746 Tel: (732) 431-2155; Fax: (732) 431-2889

AdvancedWellness
A Comprehensive Wellness Approach

AUTHORIZATION OF RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: _____

Date of Birth: _____

I hereby authorize medical providers and personnel of Advanced Wellness Center of Marlboro to discuss my protected health information with:

_____	_____
(Relationship)	(Name)
_____	_____
(Relationship)	(Name)
_____	_____
(Relationship)	(Name)

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
____ Psychotherapy notes from a Psychiatrist or Psychotherapist
____ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from _____ until _____ at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

_____
Signature of Patient

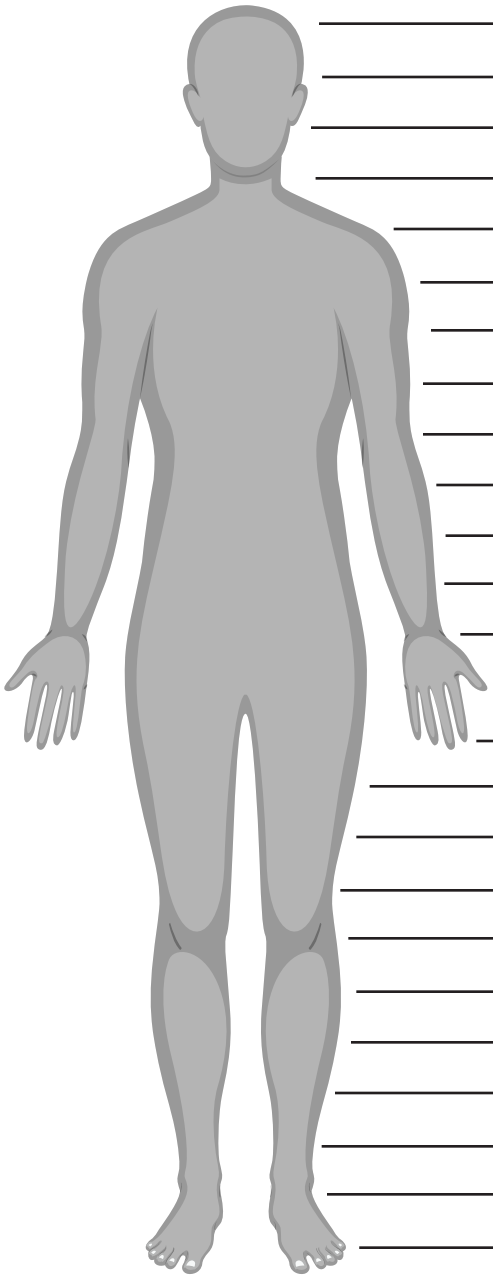
_____
Date

Healthy Body Checklist

AdvancedWellness

Name: _____ Date: _____

Please check all applicable conditions. Then, rate your pain, stiffness, weakness or discomfort on a scale of 1-10.
1 = Not Concerned and 10 = Extremely Concerned.



	Rate On Scale of 1-10
☐ Headaches	_____
☐ Allergies	_____
☐ Neck Pain	_____
☐ TMJ	_____
☐ Thyroid Condition	_____
☐ Shoulder Pain	_____
☐ Upper Back Pain	_____
☐ Mid Back Pain	_____
☐ Elbow / Arm Pain	_____
☐ Gastrointestinal Issues	_____
☐ Fatigue	_____
☐ Low Back Pain	_____
☐ Wrist/Hand Pain	_____
☐ Numb/Tingling Hands	_____
☐ Hip Pain	_____
☐ Weight Concerns	_____
☐ Thigh Pain	_____
☐ Knee Pain	_____
☐ Calf Pain	_____
☐ Shin Pain	_____
☐ Autoimmune Conditions	_____
☐ Hormonal Issues	_____
☐ Diabetes	_____
☐ Foot / Ankle Pain	_____
☐ Numb/Tingling Feet	_____
☐ Balance Problems	_____

17 North Main Street • Marlboro, NJ 07746 | 732-431-2155
www.advanced-wellness.net

Patient No._____

Allergy History Survey

Clinic Name_____ **Date**_____

Patient Name_____ **Age** _____ **M/F**

COMPLAINTS:

Please circle the appropriate number 0-3 according to severity: **0 = absent** (no symptoms evident), **1 = mild** (symptoms present, but minimal awareness, easily tolerated), **2 = moderate** (definite awareness, bothersome, but tolerable), **3 = severe**

Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itching	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Chronic fatigue	0	1	2	3
Watery eyes	0	1	2	3	Frequent sinus or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Gritty feeling (eyes)	0	1	2	3	Learning disability	0	1	2	3
Cough	0	1	2	3	Poor memory or concentration	0	1	2	3
Wheezing	0	1	2	3	Hyperactivity	0	1	2	3
Shortness of breath, difficulty breathing	0	1	2	3	Arthritis or muscle aching	0	1	2	3
Asthma: Yes No	0	1	2	3	Food intolerance	0	1	2	3

Other symptoms or specific foods causing you problems?

_____

MEDICATIONS:

How often do you take medications for your allergy symptoms?

0 = never, 1 = occasionally (several times a month or less), **2 = frequently** (several times a week), **3 = daily**

Antihistamines (Claritin, Zyrtec, Benadryl)	0	1	2	3
Nasal Steroids (Flonase, Nasacort)	0	1	2	3
Oral Steroids (Prednisone)	0	1	2	3
Asthma medication (Albuterol inhaler, Singulair, Advair)	0	1	2	3
Eye drops (Patanol, antihistamine/allergy eye drops)	0	1	2	3

Other allergy-related medications _____

Does any medication give you relief of symptoms? _____

Which if any medications are you allergic to? _____

ALLERGY HISTORY:

How many months of the year do you have allergies? _____ What year did they begin?:_____

In what season are they worse: ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Have you been allergy tested before? ☐ Yes ☐ No

If yes, which type: ☐ Skin Prick/Puncture ☐ Serum-Specific IgE (blood draw)

Have you previously received allergy shots? _____ Allergy drops? _____If yes, when? _____

Do you smoke or use tobacco products? _____

List any animals you have in or around the home _____

Who else in your family has allergies? _____

How did you hear about us?

☐ Yellow Pages

☐ Friend (Name:_____)

☐ Newspaper/Magazine (publication name:_____)

☐ Physician (Name:_____)

☐ Website (Name:_____)

☐ Insurance (Co. Name:_____)

AdvancedWellness

Sign up for Dr. Cilea's FREE Health Tip of the Week! Get life changing information for you and your family on the following subjects:

- Weight loss
- Exercise
- Nutrition
- Supplements
- Wellness

You must print your e-mail address clearly to subscribe to this FREE service.

Your Name:

_____

_____

Your e-mail Address:

_____

PLEASE RETURN THIS SIGN UP SHEET TO THE FRONT DESK

*YOUR E-MAIL ADDRESS WILL NOT BE SHARED AND WILL BE KEPT CONFIDENTIAL.