Thompson Healthcare
& Sports Medicine
ATLANTIC HEALTH SYSTEM

424 South Main Street, Forked River, NJ 08731
P (609) 971-3500 ~ F (609) 971-3545

General Information

Patient Name:		Social Security #:
Preferred name:		
Sex M / F Other:	Date of Birth:	Age:
Mailing Address:	City: State:	Zip code:
Email Address:	May we contact you via email?: Y / N	May we contact you via text Message?: Y / N
Home Phone #:	Cell Phone #:	Work Phone #:
Employer:	Occupation: Part Time Full Time	
Have you ever been to a Chiropractor ? Y / N	Is Todays Visit related to a Motor Vehicle Accident? Y / N	
Number of Children:	Marital Status: S / M / D / W	
Primary Care Physician:	PCP Phone:	

In Case of Emergency

Contact name:		
Relationship:	Address:	
Home Phone:	Cell Phone:	Work Phone:

How did you hear about our office?
Who may we contact regarding your care/billing? Contact Name: Phone:

Primary Insurance Information

Primary Insurance Company Name:		Subscriber Address:	
ID#:	Group #:	Subscriber Name:	Subscriber SSN:
		Subscriber Phone:	Subscriber Dob:

Secondary Insurance Information

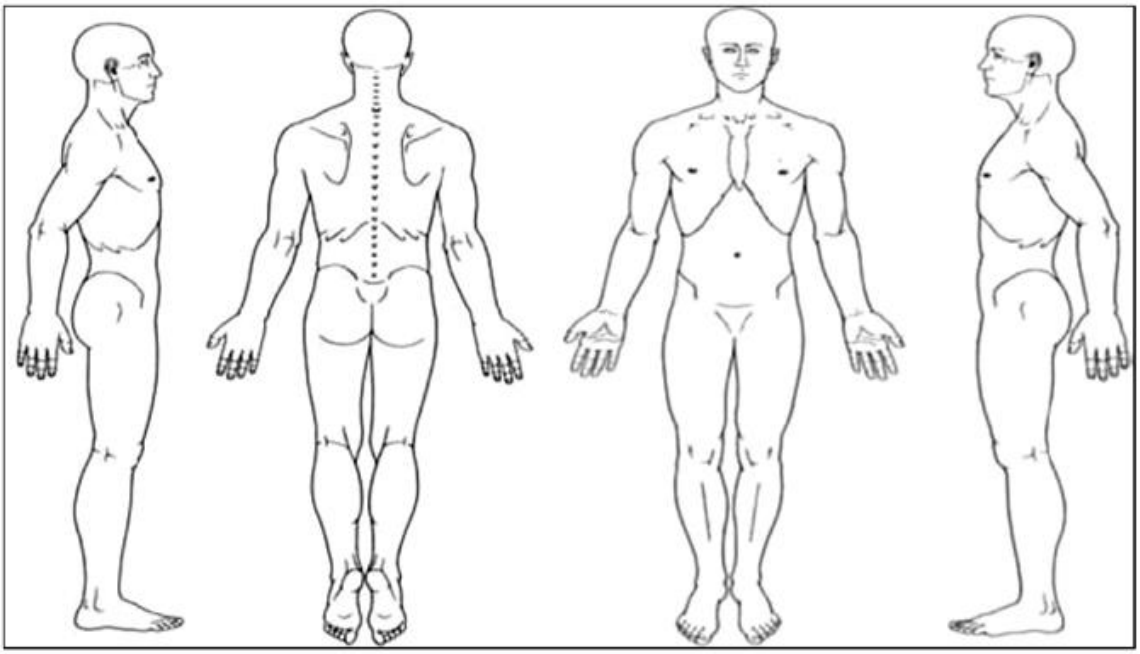
Secondary Insurance Company Name:		Subscriber Address:	
ID#:	Group #:	Subscriber Name:	Subscriber SSN:
		Subscriber Phone:	Subscriber Dob:

Todays Visit

Reason for Today's Visit:			
How long have you had this problem:	YEARS	MONTHS	WEEKS

What makes it better or worse:	Rate the Pain : _____ (0 = nothing, 10 = worst imaginable)

On the diagram below, please indicate where you are experiencing pain right now. Please use key to the right of the diagram to further explain what type of sensations you are experiencing in each area.



A = Ache

B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other

Are you a: (Please circle one) Current Smoker Former Smoker Never Smoked Pipe Smoker Cigar Smoker
If yes, how much did you smoke? 3 cigarettes or less per day ½ a pack per day more than a pack per day Vape Smokers+-

Do you drink alcohol? (Please circle one) YES NO
If yes, How frequently? Socially Only Several times per week Everyday

Do you or have you ever used illicit drugs? (Please circle one) YES NO
If yes, what kind? IV DRUGS PILLS MARIJUANA OTHER

Are you Currently participating in sports? (Please circle one) YES NO
If yes, what sport? GOLF TENNIS FOOTBALL SOCCER BASEBALL BASKETBALL OTHER

Please circle any of the following symptoms that you've experienced recently:			
Constitutional:	Fever	Night sweats	Weight Loss
Eyes:	Red Eyes	Blurred Vision	Vision Loss
Ears / Nose / Mouth:	Nose Bleeds	Sore Throat	Hearing Loss
Cardiovascular:	Chest Pains	Palpitations	Leg Swelling
respiratory:	Shortness of Breath	Chronic Cough	Wheezing
gastrointestinal:	Nausea	Vomiting	Diarrhea
genitourinary:	Burning w/ Urination	Blood in Urine	Urinary Inconsistency
skin:	Rash	Hives	Skin Infection
neurological:	Headache	Tremor	Seizures
psychiatric:	Depression	Panic Attacks	Suicidal Ideation
endocrine:	excessive Thirst	Cold Intolerance	Excessive Sweating
hematological:	Easy Bruising	Swollen Glands	Easy Bleeding
allergy / immune:	Runny Nose	Sinus Congestion	Itchy Eyes

Past Medical History (Please circle one)

High Blood Pressure	Coronary Artery Disease	Vascular Disease	Emphysema
Diabetes	Congestive Heart Failure	Heart Disease / Attack	Thyroid Disease
Lyme's Disease	Bleeding Disorder	Seizures	Gastric Reflux
Multiple Sclerosis	Enlarged Prostate	Hepatitis	Liver Disease
Osteoarthritis	Rheumatoid Arthritis	Stomach Ulcers	Kidney Disease
Asthma	COPD	Cancer	Scoliosis
Depression	Other:		

Family History (Please circle one)

Bleeding Disorder	Coronary Artery Disease	Hepatitis	Cancer
heart Disease / Attacks	Seizures	Lung Disease	Rheumatoid Arthritis
Kidney Disease	Malignant Hyperthermia	Scoliosis	Asthma
Other:			

Surgical History (Please Circle one)

SURGERY	DATE	SURGERY	DATE
Knee Arthroscopy (right / Left)		Shoulder Arthroscopy (right / Left)	
Spine Surgery		Joint Replacement Surgery	
Hernia Repair		Laparotomy	
Eye Surgery		Thyroid Surgery	
Peripheral Bypass Surgery		Cardiac Catheterization	
Coronary Artery Bypass Surgery		Hysterectomy	
Pacemaker		defibrillator	

Please list any other surgery you may have had in the past not previously mentioned:

_____

_____

_____

Please list any Medications you are on, or have taken in the past 6 months:

_____

_____

_____

Please list anything you may have an allergic reaction from:

_____

_____

_____

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Reviewed By Physician: _____ Date: _____

FINANCIAL POLICY AGREEMENT / ASSIGNMENT OF BENEFITS

Thank you for choosing Thompson Healthcare & Sports Medicine as your healthcare provider. We are committed to providing excellent care to all of our patients and we will always do our best to achieve this goal.

Thompson Healthcare & Sports Medicine is a private professional entity, is **NOT** contracted with **ANY** insurance plans other than Medicare. Even though we do not participate in your insurance plan's provider network, we pledge to help you understand and manage the financial aspects associated with providing you the very best care and attention you deserve.

Most insurance plans allow patients to select their own treating physician even if the physician they prefer is not in their insurance plan's network. To help you understand your responsibilities, we will inquire as to your plan's out-of-network benefits, and explain what, if any, financial obligations you will have for our services.

Our independence is a hallmark trait of our practice. As an out-of-network provider, the course of treatment we provide will NOT be limited to what an insurance plan representative will approve, but will instead be based solely upon the state-of-the-art care that your Physician recommends.

All charges will be submitted to your insurance carrier on your behalf as an out-of-network-provider. You may be responsible for your deductible and co-insurance on allowed payments up to your out-of-pocket maximum according to your out-of-network insurance policy. In a few cases, however, a particular plan may not provide reasonable and customary payment, in which case you may be responsible for some of the difference between what is billed and what your insurance plan allows for payment.

In addition, your insurance company may send payment for our services directly to you. You agree to relinquish all payments that you receive from your insurance company for our services to Thompson Healthcare & Sports Medicine. Failure to do so will result in legal action.

By signing below, you attest that you completely understand and agree with our financial policy as described above for the services provided by Thompson Healthcare & Sports Medicine and its professionals.

Assignment of Benefits

Patient name : _____ Date: _____

I irrevocably assign THOMPSON HEALTHCARE AND SPORTS MEDICINE all my rights and benefits under any insurance contracts for payment for services rendered to me by THOMPSON HEALTHCARE AND SPORTS MEDICINE. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by THOMPSON HEALTHCARE AND SPORTS MEDICINE to be released to THOMPSON HEALTHCARE AND SPORTS MEDICINE. I irrevocably authorize THOMPSON HEALTHCARE AND SPORTS MEDICINE to file insurance claims on behalf for services rendered to me. I irrevocably direct that all such payments to go directly to THOMPSON HEALTHCARE AND SPORTS MEDICINE. I irrevocably authorize THOMPSON HEALTHCARE AND SPORTS MEDICINE to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

X_____

Patient Signature

NOTICE OF PRIVACY PRACTICES

THOMPSON HEALTHCARE & SPORTS MEDICINE
424 S. MAIN ST. FORKED RIVER, NJ 08731
(609) 971-3500

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 SERVICE OR HEALTH CARE ITEM OUT-OF-PACKET 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/COMPLAINTS/INDEX.HTML. 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. CONTACT YOU FOR FUNDRAISING EFFORTS. 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. MOST SHARING OF PSYCHOTHERAPY NOTES. PERSONAL FINANCIAL INFORMATION SUCH AS: CANCELLED CHECKS, CREDIT CARD RECEIPTS, PATIENT STATEMENTS THAT A COST-SHARE WAS COLLECTED, OR OTHER PROOF WHICH CAN BE SUBJECT TO PATIENT VERIFICATION/AUDIT TO ANY THIRD PARTY ENTITIES OR VENDORS.

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 YOUR 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 FORM 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: HTTPS://WWW.HHS.GOV/HIPAA/FILING-A-COMPLAINT/WHAT-TO-EXPECT/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 HEATH 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

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.

CONTACT PERSON:

ALL QUESTIONS CONCERNING THIS NOTICE, OR REQUESTS MADE PURSUANT TO IT, SHOULD BE ADDRESSED TO: MEREDITH WENDT (COMPLIANCE OFFICER), EMAIL- MWENDT@THSM.INFO .

PATIENT ACKNOWLEDGMENT:

I ACKNOWLEDGE THAT I HAVE REVIEWED THIS OFFICE'S NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGE THAT I MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT IF I WISH, AND AGREE TO THE LIABILITY LIMITATIONS EXPLAINED THEREIN. I HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE.

_____

PATIENT PRINTED NAME

_____

PATIENT SIGNATURE OR LEGAL REPRESENTATIVE

_____

IF LEGAL REPRESENTATIVE, STATE RELATIONSHIP

_____

DATE