Confidential Patient Information

Date_____

Name _____ Birth Date_____/_____/_____

Home # _____ Cell# _____ Email _____

Address_____ Apt# _____

City _____ State _____ Zip Code _____ Marital: **M S W D**

Employer _____ Occupation _____

Address _____ Work Phone _____

Name of Insurance Company_____ Insured name _____

Secondary Insurance _____ Insured name _____

Relationship to Insured _____

Emergency Contact _____ Phone Number _____

Is this a worker's compensation case, a motor vehicle accident case? ☐ **YES** ☐ **NO** _____ **Initials**

Date symptoms appeared or accident occurred _____

Primary Care Physician Name _____ **Physician Office Number**_____

Have you lost any days from work? _____

Date of last physical exam _____

Purpose of this appointment (Major Complaint)

_____

_____

What aggravates your discomfort?_____

What relieves your discomfort?_____

Have you had this condition before ☐ **YES** ☐ **NO** **If yes,** when: _____

Is this condition interfering with the following? ☐ Work ☐ Daily Routine ☐ Sleep ☐ Other tasks_____

Please rate your current discomfort 0 - 10 (10/10 being most severe) 0 1 2 3 4 5 6 7 8 9 10

What is the frequency of your discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Have you been treated by a Medical Doctor/Chiropractor/Physical Therapist/Acupuncturist for this condition? ☐ Yes ☐ No

If yes, by who?_____

Personal Health History Height _____ Weight _____

Allergies: _____ Reaction: _____

Major Hospitalization/Infections/Trauma: _____

Current Medications: _____

Injury History/Surgeries: ☐ Neck/Back ☐ Shoulder ☐ Elbow ☐ Hand ☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Other:

_____

_____

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Family History Check & Circle all of the following that apply to your FAMILY MEMBERS (Mother/Father/Brother/Sister):

- ☐ Cancer: M / F / B / S List Type(s): _____
- ☐ Blood Pressure: M / F / B / S
- ☐ Arthritis/Rheumatoid Arthritis: M / F / B / S
- ☐ Autoimmune Disorder: M / F / B / S
- ☐ Heart Disease: M / F / B / S
- ☐ Diabetes: M / F / B / S
- ☐ Neurological Disorder: M / F / B / S
- ☐ Stroke: M / F / B / S

Have you ever suffer from the following: Check all that apply

Constitutional
__ Weight Loss
__ Weight Gain
__ Loss of Appetite
__ Recent Fever/Chills
__ Fatigue
__ Cancer:_____
__ Change in Bowel or Bladder Function
__ Fainting or Loss of Consciousness
__ Recent Falls

Skin
__ Frequent Rashes
__ Open Wounds
__ Skin Lesion
__ Itchy/Red Skin
__ Skin Cancer

Eye
__ Blurred Vision
__ Vision Loss
__ Double Vision

ENT
__ TMJ / Jaw Pain
__ Nose Bleeds
__ Hearing Loss
__ Ringing Ears
__ Hoarseness/Sore Throat
__ Difficult Swallowing
__ Sinus Infections

Lung/Respiratory
__ Short of Breath
__ Wheezing
__ Chronic Cough
__ Exercise Intolerance
__ Asthma

Cardiovascular
__ Chest Pain
__ Irregular Beat
__ Calf Pain
__ High Cholesterol
__ High Blood Pressure
__ Pacemaker/Stents

Digestive
__ Heartburn
__ Nausea/Vomiting
__ Blood in Stool
__ Liver/Gallbladder

Kidney/Bladder
__ Painful Urination
__ Problems Urinating
__ Incontinence
__ Kidney Stones
__ Kidney Problems
__ UTI
__ Dialysis

Glands
__ Excessive Thirst
__ Frequent Urination
__ Diabetes
__ Always Hot/Cold
__ Thyroid problems
__ Swelling

Blood
__ Anemia
__ Easy Bruise/Bleeding
__ Clotting Disorders
__ Blood Transfusion

Neurological
__ Headaches
__ Migraines
__ Dizziness
__ Vertigo
__ Weakness
__ Change in Sensation
__ Epilepsy
__ Stroke
__ Concussion

Skeletal
__ Arthritis
__ Osteoporosis
__ Broken Bones
__ Painful Joints
__ Sports Injury

Psychiatric
__ Drug/Alcohol Abuse
__ Depression
__ Anxiety
__ Phobias

Male Reproductive
__ Erectile Dysfunction
__ Prostate Problems
__ Dribbling Urine
__ Low Testosterone
__ Infections/STDs
__ Discharge
__ Pain in genitals

Female Reproductive
Last cycle: _____
__ Pregnancies #_____
__ Pain/Discharge
__ Yeast Infections
__ Birth Control or Hormone Replacement
__ Irregular Cycles
__ Post-Menopause

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports or forms to assist me making collections from the insurance company and then any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered are to be charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

In accordance with Education Law section 6731 (d), a physical therapist providing treatment in the practice of physical therapy without a referral from a physician, dentist, podiatrist, or nurse practitioner, in accordance with Education Law section 6731 (d) and the requirements of this section shall advise the patient in writing prior to beginning treatment of the possibility that treatment may not be covered by the patient's health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner and that treatment may be a covered expense if rendered pursuant to such referral For your convenience we have a medical doctor on staff that can evaluate you and prescribe physical therapy if necessary.

I have been given the opportunity to review the HIPAA Patient Privacy Policy

Patient Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Confidential Patient Information

BACK & BODY MEDICAL, P.C.

SHAN SIVENDRA, M.D.
DAVID PERNA, D.C., C.C.S.P., C.C.E.P.
ANJHANAA SAI KUMAR, P.T.

133 EAST 58TH STREET,STE.708
NEW YORK, NY 10022
PHONE: 212-371-2000
FAX: 212-371-2250

Sign below if you have Horizon Blue Cross Blue Shield or Anthem Blue Cross Blue Shield

This letter is to inform you that your insurance company will be mailing out checks with an EOB to you which are payments for the service we provided to you.

We would like to ask that you please sign the back of the checks and please keep it attached to the Explanation of Benefits, send all statements attached. If you would like copies, you can make them or we would be happy to provide them for you. You can either mail them to our office or drop them off whichever is more convenient for you.

We would like to thank you in advance for your cooperation.

P.S. Please forward to: Attn: Billing @ Back and Body Pain Relief, 355 US 22 East Springfield, NJ 07081on the outside of the envelope when mailing the checks or EOBs to our office.

Patient Signature Date

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Back and Body Medical
Release and Consent to Photograph and Publish

The undersigned hereby authorizes Back and Body Medical to photograph (print patient name)

_____ under the care of Back and Body Medical.

Scope of consent. The undersigned agrees that Back and Body Medical may use this photograph (s), written testimonials, audio, and transcripts for any and all purposes including, but not limited to, art, advertising, promotional, educational and medical office books and presentation used for patient decision-making and in all media, including electronic, digital and print media and that such distribution may be accomplished in a any matter and that such use is subject only to the following limitations.

Term. This release and consent shall remain in effect until rescinded at any time in accordance with the following "Notice and Termination Use" provision below, and some use may continue after that time, but only as provided in the "Notice and Termination Use."

Notes and Termination of Use. This release and consent may be rescinded at any time in accordance with the terms of this "Notice of Terms of Use" provision. Rescission of this consent must be in writing, requesting discontinuation of use of photographs, written testimonials, audio, and transcripts taken while under the care of Back and Body Medical. After receiving the written request, Back and Body Medical may continue using the photographs, written testimonials, audio, and transcripts until the existing inventory is depleted, or for television commercials, videos or similar materials, may continue using the photographs until as long as they were intended to be used at the time they were created. Back and Body Medical will not reprint existing materials or create new advertising or other materials incorporating the photographs unless otherwise allowed to do so under this "Notice and Termination of Use" provision.

Waiver. Except as specifically stated above. I hereby waive any and all other rights I may have in respect to any photographs taken of me by Back and Body Medical and all images created from them in accordance with the release and content. Without limiting the generality of the foregoing, I specifically waive any rights I may have had to be paid or otherwise compensated for the use of such photographs, and any rights I may have to inspect or approve the finished photographs, images, printed matter that that may be used in conjunction with any photographs taken of me.

Entire Agreement: This release and consent constitutes the sole agreement between Back and Body Medical and myself regarding my photographs and I am not relying on any other oral or written representation made by Back and Body Medical.

Release: The undersigned hereby releases and holds Back and Body Medical harmless from and against any claim or injury or compensation resulting from the activities authorized by this release and consent.

_____ _____

Patient name (print) Patient signature

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133 EAST 58TH STREET, 708
NEW YORK, NY 10022
PHONE: 212-371-2000
FAX: 212-3712250

Assignment of Benefits (AOB)
This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Back and Body Pain Relief for medical supplies and/or medication(s) furnished to me by Dr. Shan Sivendra

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

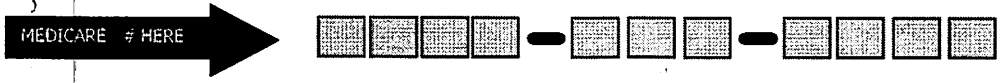
4. Back and Body Pain Relief to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. Back and Body Pain Relief to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # (___) _____

I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Back and Body Pain Relief for any medical supplies and/or medications furnished to me by Back and Body Pain Relief. I authorize any holder of medical information about me to release to Back and Body Pain Relief my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.



Insurer_____ **Policy #**_____

(other than or in addition to Medicare)

Insurer phone #_____