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: ______________________

Notify In Case of Emergency:

____

Emergency Contact Number:

____

Relationship to Patient: ______________________

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'sDate of Birth:______________

ATTORNEY INFORMATION (If applicable):

Attorney Name:______________________

Address:______________________

Telephone Number: ______________________

AdvancedWellness

Assignment of Benefits and Authorization to Pursue Appeal And/Or Denial of Benefits

Patient Name: ______________________________

Insurer: ______________________________

Claim #: ______________________________

In consideration of the professional services rendered by Advanced Wellness Center of Marlboro, employees, contracts, agents of assigns (AWC), I hereby irrevocably direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for insurance benefits with regard to the above-captioned claim to AWC, including but not limited to chiropractic fees, acupuncture fees and any other fees related to my claims.
2. The authorization of AWC to act as my agent-in-fact with regard to all aspects of the above-captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim.
3. The authorization of AWC to initiate and prosecute any and all appeals and/or arbitration or legal action on the denial of my claim, including but not limited to internal appeals with the insurer, as well as arbitrations.
4. The authorization of AWC to obtain and/or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.
5. The authorization of AWC to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.
6. The authorization for payment of any and all insurance benefits directly to AWC to which I might be entitled under the above-captioned claim.

Patient:

By: ______________________________

Date: ______________________________

Witness:

By: ______________________________

Date: ______________________________

Original on file

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

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