About You: Date: __/____/____

First Name: _____ Middle Initial: ____ Last Name: _____
Nickname: _____ DOB: _____ Age: _____ Sex: M F
Address: _____ City: _____ Zip: _____
Email: _____ Referred by: _____
Best Contact #:_____ (Cell/ Home/ Work)
Emergency Contact: _____ Emergency Contact Phone #:_____
Social Security #:_____ Marital Status: _____
Primary Care Physician: _____ Phone #:_____ City: _____

Insurance Information:

Co. Name: _____ Insurance Billing Address: _____
Provider Phone #: _____ ID #:_____
Insured's Name: _____ Relation: _____ DOB: _____
Insured's Employer: _____
I certify that I, and/or my dependent(s) have insurance coverage with _____ (Name of Company) and assign directly to Marron Wellness Center all insurance benefits, if any. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Reason for Visit:

The reason for your visit today is a result of (please circle): work, sports, auto, trauma, or chronic
(Explain what happened):_____
_____

What is the severity of your pain (Circle one)?
(Best) 1 2 3 4 5 6 7 8 9 10 (Worst)

When did your condition begin? ___/___/___

How often does the pain occur (Circle one)? Constant Episodic Occasional

Type of pain (please circle) Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Swelling Other

What treatment have you had for this condition? _____

Habits

☐ Smoking Packs/Day:_____
☐ Alcohol Drinks/Week:_____
☐ Coffee Cups/Day:_____

Health History

Please circle if you have/had the following:

AIDS/HIV	Diabetes	Miscarriage	Shingles
Alcoholism	Emphysema	Mononucleosis	Stroke
Artificial Bones/Joints	Epilepsy	Multiple Sclerosis	Thyroid Problems
Anemia	Fractures	Osteoporosis	Tumors,Growths
Anorexia	Goiter	Pacemaker	Ulcers
Appendicitis	Gout	Parkinson's	Other: _____
Arthritis	Heart Disease	Pinched Nerve	
Asthma	Hernia	Prostate Problem	
Bleeding Disorders	Herniated Disc	Prosthesis	
Bronchitis	High Blood Pressure	Psychiatric Care	
Cancer	Kidney Disease	Rheumatoid Arthritis	
Chemical Dependency	Migraines	Sinus Problems	

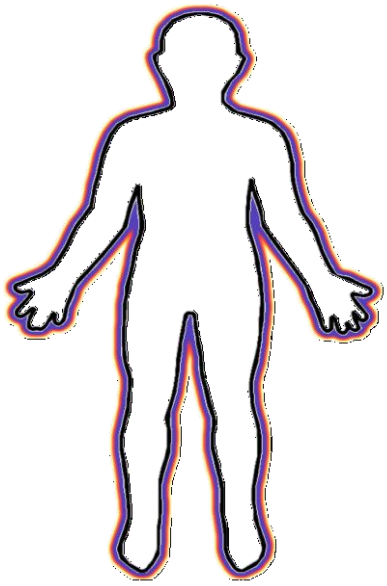
Please list anything you may be allergic to: _____

Please list previous surgeries with dates: _____

_____

Are you pregnant (circle one)? Yes / No Due date? ___ / ___ / ____

Mark with and X on the picture where you have pain.



Medications/Vitamins:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Marron Wellness Center

179 Avenue at the Commons
Shrewsbury, New Jersey 07702
Tel: 732-542-1272 * Fax: 732-542-2315

Consent to Use or Disclose Health Information

(HIPAA Disclosure)

I authorize **Marron Wellness Center** to use and disclose the health and medical information of (PATIENT'S NAME) _____ for the purposes of Treatment, Payment and Health Care Operations.*

*__Treatment__ (includes activities performed by a health care provider, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

*__Payment__ (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

*__Health Care Operations__ (includes the necessary administrative and business functions of our office).

You may review **Marron Wellness Center** "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. **Please verify that you have received a copy of our Notice of Privacy Practices by placing your initials here _____.**

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change also. A summary of the notice will be posted in our office indicating the effective date of the notice in the upper right hand corner. We will offer you a copy of the notice on your first visit to us after the effective date of the then current notice. We will also provide you with a copy of the notice upon your request.

As more fully explained in the notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that MARRON WELLNESS CENTER has already used or disclosed the information in reliance on this Consent.

_____ _____

PATIENT'S SIGNATURE/SIGNATURE OF AUTHORIZED INDIVIDUAL **DATE**

_____

AUTHORIZED INDIVIDUAL'S RELATION TO PATIENT

Marron Wellness Center Office Policies

Welcome to Marron Wellness Center. We are pleased you have chosen our facility for your health and wellness needs. For your convenience we have listed our policies and procedures. If you have any questions regarding these policies, please let our staff know and we will be glad to clarify any questions you may have.

Cancellation/No Show

If you are unable to keep your scheduled appointment, we ask that you let us know as soon as possible. We require at least **24-hour notice**, so that your appointment time can be reallocated to someone else. Please notify the office at 732.542.1272 so we can reschedule your appointment more efficiently. If the office is closed, please leave a message on our answering machine and a staff member will return your phone call during office hours.

We understand that there are times when extenuating circumstances prohibit you from keeping a scheduled appointment. After three (3) missed or cancelled appointments (less than 24 hr) a fee of **$25.00** will be billed to you for any future missed and/or cancelled appointments (less than 24 hr). This amount cannot be billed to your insurance company.

Late Arrivals

Late arrivals create delays for both providers and other patients. If you see that you are running late, please notify the office as soon as possible. The provider may not be able to see you which may result in the rescheduling of your appointment for an alternate time. If you are late for an appointment, you will be seen as soon as possible, though your office visit may need to be shortened in length.

Sometimes for reasons beyond our control the office may run behind schedule. Emergencies may impact our schedules and result in unpredictable waiting periods. We make every effort to maintain our schedule and minimize any inconvenience to you. However emergencies do occur. If a delay occurs we will inform you upon arrival and gladly reschedule your appointment if it conflicts with your schedule.

Payments

Payment is due at the time of service. For your convenience we accept cash, check, debit and credit cards for payment.

Returned Check Policy: There is a **$35.00** fee for all returned checks. If we receive a returned check, you will be responsible for the balance, including the fee, by either cash or credit card.

Cell Phones

As a courtesy to our practitioners and other patients, please turn all phones to either vibrate or silent mode when coming into the office. If you need to take an important phone call just excuse yourself from the office and take the phone call in the hall way. We do not allow any phone calls to be taken in any of the treatment areas.

Please arrive 5-10 minutes before your scheduled appointment and notify the front desk of any insurance, phone number, or address changes.

I have read and understand the Office Policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Marron Wellness Center
179 Avenue at the Common
Shrewsbury, New Jersey 07702
Tel: 732- 542-1272 * Fax: 732-542-2315

Patient Information Release

Patient Name: _____ D.O.B: _____
I hereby give my permission to release medical information regarding myself to family, friends, physicians, or others listed below: (This would include appointment schedules, X-rays, receipts, health records, and any other information that pertains to your treatment)

_____
_____
_____

The following information will assist us in your care and in any communication with you while protecting your confidentiality.

Please circle "YES" or "NO" and fill in the necessary information. List only the phone # where you want to be notified.

I give my permission to:

YES NO Leave a MESSAGE to remind me of my appointments
Home # _____ Work # _____ Other # _____

YES NO Leave a MESSAGE requesting that you call our office back
Home # _____ Work # _____ Other # _____

YES NO Fax any information regarding my condition to my family doctor or a physician to whom I may be referred to

_____ _____
Patient's Signature/Signature of Authorized Individual Date

Patient Name: _____ Date: _____

Patient Doctors / Previous Care

(Please identify all doctors your currently see)

	Doctor Name	Town	Date of Last Visit
Medical/Primary			
OBGYN			
Orthopedist			
Pain Management			
Neurologist			
Cardiologist			
Podiatrist			
Chiropractic			
Physical Therapy			
Acupuncture			