Plasker
Family Chiropractic
Center

The 100 Year Lifestyle
adjust your lifestyle™
Licensed Affiliate

Dr. Noel Plasker, D.C.

Welcome to
Plasker Family Chiropractic

Thank you for choosing our center for your chiropractic care. We are committed to providing your family with the highest quality of corrective and lifestyle Care services available so that you and your family can enjoy an active, healthy life. We will be working together to help you and your family reach your health and lifestyle goals.

If you ever have any questions about your care, please don't hesitate to ask one of our highly educated lifestyle team members. All of your questions, even the ones you haven't thought of yet, will be answered during your Report of Findings and your 100 Year Lifestyle Workshop.

We look forward to a long, healthy relationship with you and your family.

In Good Health,

Dr. Noel Plasker

Dr. Noel Plasker & Staff

(over)

25 Sheridan Avenue, Ho-Ho-Kus, NJ 07423
Phone: (201) 444-4408 Fax: (201) 444-4497
www.PlaskerFamilyChiropractic.com
FrontDesk@PlaskerFamilyChiropractic.com

Office Fee Schedule and Financial Policy

Service	
Consultation (Chiropractic)	N/C
Initial Exam/Computer Scans Includes: Computerized Neuro-Spinal Exam Chiropractic Adjustment (3-4 Areas) Report of Findings with Initial Report and Recommendations	$200
Dynamic Exam with Computerized Re-scans	$95
Adjustment (1-2 Areas)	$65
Adjustment (3-4 Areas)	$75
Adjustment (5+ Areas)	$85
Extra Spinal Adjustment (Extremities)	$45
97140-97530 (Physical Modalities)	$25-65

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. **You will be expected to pay for your chiropractic care at the time service is rendered unless you arrange an Active Life Plan in advance.** Active Life Plans include yearly or monthly Corrective Adjustment Plans, or Lifestyle Adjustment Plans. These Active Life Plans are designed to be the most cost-effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Report of Findings.

Health Insurance:

Health Insurance plans may differ. If we are providers for your insurance plan, and you have chiropractic benefits, we will file the insurance for you. If you have insurance that covers chiropractic, and we are not a provider for that plan we will give you all of the information you will need to get reimbursed quickly. This includes your diagnosis, prognosis, copies of your records or reports and receipts. You will be able to just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement.

If you are like most of our patients and choose to participate in one of our Active Life Plans, there is a possibility that we may file your insurance for you if we are not a provider with that insurance. We will discuss this option with you during your Report of Findings.

We are a participating provider with Medicare. Medicare requires an initial and follow up exams, but does not cover them. The initial exam will be, in most cases, a charge of $115 and subsequent Dynamic Exams will be $95. Please let us know if you have secondary coverage.

If you acquire insurance for a specialized situation such as an auto accident or workers compensation injury, and you choose to utilize that coverage, you will be charged our regular office fees until such claim is settled. We will help you get reimbursed as quickly as possible on those claims. You are ultimately responsible for your balance should your insurance company not pay for any portion of your care.

I have read and I understand the above policies. _____

Patient Signature Date

Today's Date _____

PATIENT HEALTH RECORD - CHILD

ABOUT THE CHILD

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Date of Birth _____ Age _____

SS # _____ Weight_____ Height _____

Referred By _____

ABOUT THE PARENT

Name _____

Cell Phone _____

Email Address _____

INSURANCE INFO

Insurance Company _____

Insured Person _____

Insured's Date of Birth _____

VACCINATIONS

Have you chosen to vaccinate your child? **Yes No**

If yes, circle all that your child has received:

DPT MMR Chicken Pox Hepatitis Other _____

Describe any reactions to vaccine(s) _____

_____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

When did this condition begin? _____

Has this condition: (circle one)

Gotten Worse Stayed Constant Comes and Goes

Does this condition interfere with: (circle one)

Sleep Daily Routine School Other activities _____

Please explain _____

_____

Have you seen other doctors for this condition? **Yes No**

Type of treatment _____

Results _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Are you aware that.....	Yes	No
• Chiropractors work with the nervous system?	☐	☐
• The nervous system controls all bodily functions and systems	☐	☐
• Chiropractic is the largest natural healing profession in the world?	☐	☐
• If Chiropractic starts at birth, you can achieve a higher level of health throughout life?	☐	☐

EXPERIENCE WITH CHIROPRACTIC

Other Family Members	Previous Chiropractic Care? Yes	No	Reason	Date of last visit
Patient _____ Age _____	☐	☐	_____	_____
Parent _____ Age _____	☐	☐	_____	_____
Parent _____ Age _____	☐	☐	_____	_____
Child _____ Age _____	☐	☐	_____	_____
Child _____ Age _____	☐	☐	_____	_____

Oldest grandparent on record lived to the be the age of _____ ☐ still living ☐ deceased

CHILD'S HEALTH HISTORY

Please check all that apply

- ☐ Allergies
- ☐ Attention problems
- ☐ Sleeping problems
- ☐ Digestive problems
- ☐ Headaches
- ☐ Teeth problems
- ☐ Skin problems
- ☐ Eye problems
- ☐ Asthma
- ☐ Bed wetting
- ☐ Constipation
- ☐ Tubes in ears
- ☐ Frequent colds
- ☐ Hyperactivity
- ☐ Colic
- ☐ Ear problems

Circle all that Apply	***Patient***	***Child#2***	***Child#3***	***Mom***	***Dad***	***Chiropractor's Comments***
1. Was Child's Birth Traumatic?						
Long / Difficult Delivery?	Y	Y	Y	Y	Y	
Forceps?	Y	Y	Y	Y	Y	
Caesarian?	Y	Y	Y	Y	Y	
Breach/cephalic?	Y	Y	Y	Y	Y	
Home birth?	Y	Y	Y	Y	Y	
Mother given drugs during delivery	Y	Y	Y	Y	Y	
Induced Labor?	Y	Y	Y	Y	Y	
2. Growth and Development						
Did Child ever once...						
Fall out of bed?	Y	Y	Y	Y	Y	
Bang head?	Y	Y	Y	Y	Y	
Have any Accidents?	Y	Y	Y	Y	Y	
Have Surgery?	Y	Y	Y	Y	Y	
Taken Prescription medications?	Y	Y	Y	Y	Y	
Taken antibiotics?	Y	Y	Y	Y	Y	
Had surgery ?	Y	Y	Y	Y	Y	
Fall while learning to walk?	Y	Y	Y	Y	Y	
Bullied by siblings?	Y	Y	Y	Y	Y	
Spanked?	Y	Y	Y	Y	Y	
Pulled by ear/chin?	Y	Y	Y	Y	Y	
Chair pulled out when sitting?	Y	Y	Y	Y	Y	
Fall down the stairs?	Y	Y	Y	Y	Y	
Pulled by arm?	Y	Y	Y	Y	Y	
Experience other traumas?	Y	Y	Y	Y	Y	
3. Current Health Habits						
Is your Child currently...						
Taking prescription medicationss?	Y	Y	Y	Y	Y	
Accident prone?	Y	Y	Y	Y	Y	
Sleeping – side/stomach/back	_____	_____	_____	_____	_____	

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you and your family. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you and your family in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

☐ Feel better quickly ☐ Have a healthier spine and nervous system ☐ Live a healthier lifestyle

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Noel Plasker, and whomever he may designate as his assistant, to administer chiropractic care, through the use of adjustments and procedures as the doctor deems necessary.

_____ _____

Signature of Parent or Guardian Date

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New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

Plasker Family Chiropractic Center

PHILOSOPHICAL AGREEMENT

Wellness exists when all organs of the body function at 100% under the direction of the **Innate Intelligence of Life.** Wellness is a dynamic equilibrium between health & disease.

The **Nerve System** is the medium used to control and coordinate all body functions. Normal free transmission of neurological impulses between the brain and body is necessary for normal life expression, which is wellness.

Subluxations of the spine caused by dysfunction of vertebrae interfere with the normal physiology of the nerve system. Abnormal transmission of neurological impulses results. This causes **Dis-Ease** and ill health, which in time may lead to abnormal life expression, symptoms, sickness and loss of potential.

Chiropractic **Adjustments** allow the body to remove interference to the nerve system **Caused By Subluxations** of the spine. This leads to improved neurology, physiology and life expression. Each individual can then function and express life better, have a greater resistance to sickness and disease and gain the potential to heal and recover.

Chiropractic is not a form of medicine. Medicine specializes in the treatment of diseases. Chiropractic specializes in the restoration and expression of life.

We Do Not Diagnose, Prognose, Treat Or Cure Disease. We do not attack or suppress symptoms. If, during your care, you become concerned about your symptoms or your condition, we suggest you seek the help of a symptom, sickness and disease care professional.
Our only goal is to free interference to **Life Energy** caused by subluxations. The power that creates, which is the power that heals, is released.

I, the undersigned, have fully read and understand the above statement and agree to receive chiropractic care with this understanding.

Date:_____ Signature:_____

Name (please print):_____

Reason for seeking chiropractic care:_____

This Chiropractic Office of your choice...

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at the Family Chiropractic & Wellness Center we may use or disclose personal and health related information about you in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
2. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
3. Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact your regarding these mattes. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency.
3. If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
4. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
5. If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other then as outlined about, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care form us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be whom we provide the information and may no longer be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

_____

If you would like further information about our privacy polices and practices please contact:

Dr. Noel Plasker
Plasker Family Chiropractic
25 Sheridan Avenue
Ho-Ho-Kus, NJ 07423

This notice is effective as of ____June 1, 2010_____. The notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Printed Please) **Signature** **Date**

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative (Print) **Personal Representative Signature** **Date**

_____

Description of the authority to act on behalf of the patient

The Chiropractic Office of Plasker Family Chiropractic:

Patient Authorization regarding chiropractic care being provided in an "Open Adjusting" environment

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from the Plasker Family Chiropractic or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____	_____	_____
Name (printed)	Signature	Date

This Authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Assignment of Benefits from Insurance Carrier

I hereby assign payment directly to Dr. Noel Plasker for professional services rendered. I understand that I am financially responsible to Dr. Plasker for any unpaid balance. For purposes of payment or audit, I authorize the release of any information concerning my examination or treatment.

_____	_____
Signature	Date