

Name: _____



Patient Information:

Last Name:	First Name:	Date of Birth:
Address:		Apt #:
City:	State:	Zip Code:
Contact #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Marital Status:
Email:		
Employer:		Occupation:
Primary Language:	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social Security # (optional):		
Who may we thank for referring to our office?		

Emergency Contact Name:
Relationship:
Emergency Contact Phone #:

Primary Care Physician (if applicable):
Pharmacy Name, Address and Phone #: _____
Do you use any pharmacy discount cards (GoodRX, SingleCare, etc.)?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you authorize Madison Medical to send electronic prescriptions to your listed pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescription Card Information:
Rx Card Number:
Rx BIN:
PCN:

I authorize the office to share my prescription and pharmacy details with my medical providers for coordination of care

I prefer to manage prescription and pharmacy information on my own

Name: _____



Insurance Information:

Primary Insurance Holder Name:		Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
Policy Holder's Employer:		
Primary Insurance Company Name:		Company Phone #:
Policy #:		Group #:
Address:		Apt #:
City:	State:	Zip Code:

Do you have a secondary insurance? Yes No

Secondary Insurance Holder Name:		Relationship: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
Policy Holder's Employer:		
Secondary Insurance Company Name:		Company Phone #:
Policy #:		Group #:
Address:		Apt #:
City:	State:	Zip Code:

If applicable:

Do you have FSA, HSA or HRA? <input type="checkbox"/> FSA <input type="checkbox"/> HSA <input type="checkbox"/> HRA Plan Holder's Name: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent _____ Company Name: _____ ID/Account #: _____
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Reason for Visit:

Brief description of your main concern today and time frame:

Have you seen any other provider/specialty for this? Yes No

Have you had any imaging or blood work within last 3 months? Yes No

Date of last physical (if applicable): _____

Any imaging or bloodwork done at outside facility, please provide at time of appointment.



Is this related to an accident or injury?

No Work-Related Auto Accident Other: _____

Date of Accident (If Applicable): _____

If applicable:

PIP/Worker's Comp Claim opened? Yes No

PIP/Worker's Comp Carrier:	Contact/Adjuster:
Claim #:	Adjuster's Phone #:
Lawyer's Name:	Lawyer's Phone #:

Medical History:

Do you currently have or been previously diagnosed with:	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Low energy
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Low libido
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Low testosterone
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Brain fog	<input type="checkbox"/> Muscle aches
<input type="checkbox"/> Bunions	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Cancer	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Decreased muscle mass	<input type="checkbox"/> Numbness/tingling
<input type="checkbox"/> Depression	<input type="checkbox"/> Osteopenia/Osteoporosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Plantar fasciitis
<input type="checkbox"/> Erectile Dysfunction	<input type="checkbox"/> Poor diet
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Poor recovery
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Pre/post-menopausal symptoms
<input type="checkbox"/> Flat feet	<input type="checkbox"/> Reflux (GERD)
<input type="checkbox"/> Hair loss/thinning	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Headaches	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Snoring
<input type="checkbox"/> Herniated disc	<input type="checkbox"/> Thyroid
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Toe Deformities
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Inflammation	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Other: _____

Name: _____



Do you have pain in any of these areas (acute or chronic): Check all that apply

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Ankle/foot | <input type="checkbox"/> Hip | <input type="checkbox"/> Mid/lower back | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Jaw/TMJ | <input type="checkbox"/> Neck | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Pelvic | <input type="checkbox"/> Spider Veins |
| <input type="checkbox"/> Hand/wrist | <input type="checkbox"/> Knee | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg discomfort/pain | <input type="checkbox"/> Other: _____ | |

Females:

Are you currently pregnant? Yes No

Are you trying to get pregnant? Yes No

Recent pregnancy in the past 6 months? Yes No

LMP: _____

Mammogram (Year): _____

Pap (Year): _____

Would you be interested in learning more about other services offered here? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Allergy testing | <input type="checkbox"/> Regenerative medicine (PRP) |
| <input type="checkbox"/> Bracing (knee, ankle, wrist, back) | <input type="checkbox"/> Shockwave therapy (EPAT) |
| <input type="checkbox"/> Chiropractic/Adjustments | <input type="checkbox"/> Spine procedures (facet, RFA, epidural) |
| <input type="checkbox"/> Custom orthotics | <input type="checkbox"/> Sports medicine |
| <input type="checkbox"/> Hormone therapy | <input type="checkbox"/> Stress/anxiety support |
| <input type="checkbox"/> IV therapy | <input type="checkbox"/> Vitamin injections |
| <input type="checkbox"/> Men's health | <input type="checkbox"/> Weight loss program |
| <input type="checkbox"/> Pain injections | <input type="checkbox"/> Wellness Memberships |
| <input type="checkbox"/> Podiatry | <input type="checkbox"/> Women's health |



MADISON

MEDICAL SPORTS & WELLNESS

Last Name:	First Name:	DOB:
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EMG/NCV:	Rheumatology:	Allergies	Allergies: (continued)
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Joint Stiffness	Skin Reaction:	Environmental
<input type="checkbox"/> Radiating Pain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Hives/Rash/Itchy Skin	<input type="checkbox"/> Pollen (Trees/Grass/ Weeds)
<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Autoimmune Symptoms	<input type="checkbox"/> Eczema/Atopic Dermatitis	<input type="checkbox"/> Dust Mites
<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Swelling of lips/Eyes/Face	<input type="checkbox"/> Mold
<input type="checkbox"/> Grip Weakness	<input type="checkbox"/> Morning Stiffness	<input type="checkbox"/> Contact Dermatitis	<input type="checkbox"/> Pet Dander(Cat/Dog/Other)
<input type="checkbox"/> Prev Nerve Test	<input type="checkbox"/> Swollen Joints	Lower Respiratory:	<input type="checkbox"/> Cockroaches
Foot & Ankle Surgery:	<input type="checkbox"/> Headaches	<input type="checkbox"/> Shortness of Breath	Food
<input type="checkbox"/> Foot Pain	<input type="checkbox"/> Muscle Aches	<input type="checkbox"/> Cough(<input type="checkbox"/> Dry <input type="checkbox"/> Wet)	<input type="checkbox"/> Peanuts/Tree Nuts
<input type="checkbox"/> Flat Feet	<input type="checkbox"/> Other _____	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shellfish/Fish
<input type="checkbox"/> Plantar Fasciitis	Ortho Spine:	<input type="checkbox"/> Asthma/ Reactive Airway Disease	<input type="checkbox"/> Eggs/Dairy
<input type="checkbox"/> Arch Pain	<input type="checkbox"/> Spinal Injury	<input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Gluten/Wheat
<input type="checkbox"/> Ankle Instability	<input type="checkbox"/> Postural Issues	GI & Systemic	<input type="checkbox"/> Soy/Corn
<input type="checkbox"/> Heel Spurs	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Food sensitivities/intolerances	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bunions	<input type="checkbox"/> Back Surgery History	<input type="checkbox"/> Fatigue after meals	Medications
<input type="checkbox"/> Toe Deformities	<input type="checkbox"/> Radiating Limb Pain	<input type="checkbox"/> Fatigue- exposure to allergens	<input type="checkbox"/> Penicillin/Antibiotics
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Limited Range of Motion	<input type="checkbox"/> Anaphylaxis _____	<input type="checkbox"/> NSAIDS (e.g., ibuprofen)
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Bloating/Cramping/Nausea	<input type="checkbox"/> Local Anesthesia (ie Lidocaine)
		<input type="checkbox"/> Autoimmune Disease: Specify _____	<input type="checkbox"/> Latex

Medications & Treatment History: Please check if you have used any of the following in the past 12 months:

- Antihistamines (Zyrtec, Claritin, Allegra, Benadryl)
- Nasal Sprays (Flonase, Nasacort, Rhinocort, etc.)
- Montelukast (Singulair)
- Corticosteroids (Oral or Nasal)
- Allergy Shots (Immunotherapy)
- EpiPen or other epinephrine
- Biologics (e.g., Dupixent, Xolair)
- Other allergy treatments: _____

Impact On Daily Life

Rate how allergies impact the following areas on a scale from 1 (no impact) to 5 (severe impact):

Sleep: 1 2 3 4 5 Mood or Focus: 1 2 3 4 5

Work/School: 1 2 3 4 5 Exercise/Activities: 1 2 3 4 5

Signs and Symptoms That May Benefit from Acupuncture:

<input type="checkbox"/> Anxiety or Depression	<input type="checkbox"/> Insomnia or poor sleep quality	<input type="checkbox"/> Emotional Instability or Irritability	<input type="checkbox"/> Chronic fatigue or burnout
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Arthritis and joint pain	<input type="checkbox"/> Migraines or tension headaches	<input type="checkbox"/> Poor stress resilience
<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/> Post-Surgical pain	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Sclatica
<input type="checkbox"/> Nerve pain or neuropathy	<input type="checkbox"/> Post-stroke symptoms	<input type="checkbox"/> Bells's palsy	<input type="checkbox"/> Menstrual cramps
<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Constipation or diarrhea	<input type="checkbox"/> Tingling or numbness in extremities
			<input type="checkbox"/> Poor appetite or bloating

Name: _____



What are your health goals for the next 3-6 months?

- Better recovery
- Better sleep
- Hormone balance
- Improved performance/fitness
- Improved mood
- Improved sexual health
- Increased energy
- More mobility
- Pain relief
- Reduce medications
- Strength/muscle gain
- Weight loss
- Other: _____

Current Medications/Supplements/Vitamins:

Name	Dose

Any discontinued (relevant) medications taken in the last 3 years: _____

Past Surgical History:

Procedure	Year



Social History:

Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No Current/packs per day: _____ Former/ quit date: _____	Alcohol: <input type="checkbox"/> Every day <input type="checkbox"/> Social/Occasional <input type="checkbox"/> Never # drinks in one setting: _____
Recreational drug use <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Frequency: _____	

Family History:

Circle family members with the following:					
Cancer	Father	Mother	Brother	Sister	Grandparent
Diabetes	Father	Mother	Brother	Sister	Grandparent
Heart Disease	Father	Mother	Brother	Sister	Grandparent
High Blood Pressure	Father	Mother	Brother	Sister	Grandparent
High Cholesterol	Father	Mother	Brother	Sister	Grandparent
Thyroid Condition	Father	Mother	Brother	Sister	Grandparent



Understanding Insurance Coverage for Weight-Loss Medications

Patient: _____ DOB: _____ Date: _____ Provider: _____

Why you're getting this

Insurance plans vary widely on coverage for weight-loss medications. This handout explains our policy for prior authorizations (PAs) and patient self-submissions.

Key points about coverage

- We use BMI ≥ 35 as a safe threshold to discuss coverage; some plans may differ.
- If BMI < 35 or not diabetic, our office will NOT submit a PA.
- We will provide your note and labs so YOU can self-submit to your insurance.
- PA timelines depend on the insurer (often up to 7 days).
- In-house weekly program available while awaiting insurance decision.

How to self-submit (checklist)

- Call your plan: ask what documents are needed for weight-loss medication coverage.
- Submit requested documents; keep copies.
- Ask for a reference number and timeline.
- Share any insurer responses at your next visit or via patient portal.

Communication & privacy

- Use phone line and patient portal only for clinical questions and follow-up.
- We do NOT handle medical matters via social media or side channels.

Acknowledgment (initial each line)

- ___ I understand that if my BMI is < 35 and/or I am not diabetic, the office will not submit a PA.
- ___ I understand I may self-submit using the note and labs provided.
- ___ I understand PA timelines are set by my insurer and may take up to 7 days or longer.
- ___ I understand the office offers an in-house weekly program as an option.
- ___ I understand communication is only through the phone line and patient portal.

Patient Signature: _____ Date: _____

Staff/Witness: _____ Date: _____



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) 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 or the Chapter 32 Independent Arbitration System, 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.



Horizon Blue Cross Blue Shield of New Jersey

WAIVER OF LIABILITY STATEMENT for Medicare Advantage appeals from Nonparticipating Providers

A completed and signed copy of the Waiver of Liability statement on the following page must be included as a part of a request for the reconsideration of our denial of a payment of a claim submitted for services or supplies provided by a nonparticipating provider to a patient enrolled in one of our Medicare Advantage plans. Horizon Blue Cross Blue Shield of New Jersey will not undertake a review of a request for reconsideration without this completed statement.

Requests for reconsideration (which should also include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records or other documentation that supports your appeal) may be mailed to:

**Medicare Advantage Provider Appeals
Mail Station - PP12L
3 Penn Plaza East
Newark, NJ 07105-2200**

By signing this Waiver of Liability statement, a non-participating provider formally agrees to waive any right to payment from the enrollee, regardless of the outcome of the appeal.

WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number

Enrollee's Name

Provider

Date(s) of Service

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature

Date



MERITAIN HEALTH® APPEALS AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Group Health Plan:
Claimant's Alternate ID:

Appointment of Authorized Representative for Meritain Appeal

I, _____, hereby appoint _____
([Name of Claimant]) (Authorized Representative)

to act on my behalf in connection with the appeal for claim(s) for date(s) of service _____ for coverage or benefits, including receipt of any approvals or authorizations that are required before medical services are provided under the plan named above ("Plan"). I authorize my representative to file appeals on my behalf in connection with the appeal for claim(s) for date(s) of service specified above for coverage or benefits. I authorize my representative to receive all information that is provided to me and to act for me (or my dependent, if named above as the patient), in providing any information to the Plan that relates to the appeal for claim(s) for date(s) of service specified above for coverage or benefits under the Plan.

IMPORTANT: All information and notifications from the Plan related to the appeal will be directed to the authorized representative appointed through this form and not to you, unless you direct otherwise by checking below:

- Distribute to my authorized representative and me: All information and notifications should be distributed to my authorized representative and me.

Claimant Signature

Date

Please return to:
Meritain Health Appeals Department
PO Box 41980
Plymouth, MN 55441

Waiver of Liability Statement

Enrollee's Name

Enrollee ID Number

Provider

Dates of Service

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature

Date



1. Consent to Treat

I hereby authorize **Madison Medical & Sports Rehabilitation Center** and its providers to evaluate and treat me for my medical condition(s). This may include physical examinations, diagnostic testing, procedures, therapies, or other medically necessary care.

I understand that:

- No guarantees have been made as to the results of treatment.
- I may withdraw my consent for treatment at any time.

Signature of Patient/Guardian: _____

Printed Name: _____

Date: _____

2. Patient Financial Policy & Assignment of Benefits

Out-of-Network Practice Statement

Madison Medical & Sports Rehabilitation Center is an **out-of-network practice**. We are currently In-Network with Medicare and Tricare. All other insurances are excepted with Out-of-Network Benefits.

Patient Responsibility

- I understand I am responsible for copays, deductibles, coinsurance, and any balance not covered by my insurance plan.
- If my insurance carrier issues payment directly to me for services provided by Madison Medical, I agree to **immediately endorse the check to Madison Medical** or provide payment in the same amount.
- Failure to forward such payments may result in **collections or legal action**.



Assignment of Benefits

I irrevocably assign to Madison Medical & Sports Rehabilitation Center all rights, benefits, and interests under my insurance plan(s) for services rendered. This assignment includes, but is not limited to:

- The right to collect benefits and payments directly from my insurance plan(s).
- The right to file claims and pursue appeals on my behalf.
- The right to recover penalties, statutory interest, or other remedies for delayed or improper payment. I authorize and instruct my insurance company to pay Madison Medical directly. If my insurance carrier issues payment to me, I agree to immediately endorse and forward it to Madison Medical.

This assignment remains valid for all past, present, and future claims unless revoked in writing. It may not be revoked for services already provided.

I acknowledge that this assignment does not relieve me of financial responsibility for the services provided. If my insurance plan fails to pay in whole or in part, I remain responsible for the balance due.

A photocopy of this assignment shall be considered valid as the original.

Acknowledgement of Financial Responsibility

I acknowledge that I understand the network status of the services and providers at Madison Medical Sports & Rehabilitation Center. I am aware that I should contact my insurance carrier to confirm my plan's coverage and potential costs. I understand that I knowingly and willingly accept full financial responsibility for any care, services, or treatment not covered by my insurance plan, or for which I am otherwise responsible under my policy. If no coverage exists, I agree to pay all charges for the services provided.

Release of Information

I authorize Madison Medical to release any medical or other information necessary to process claims, secure reimbursement, and pursue appeals.



Acknowledgement

I understand and accept financial responsibility for all services provided by Madison Medical & Sports Rehabilitation Center.

Signature of Patient/Guardian: _____

Printed Name: _____

Date: _____

3. BCBS Payment Acknowledgement (if applicable)

Certain **Blue Cross Blue Shield (BCBS)** plans may issue payment for services **directly to you, the patient**, instead of Madison Medical & Sports Rehabilitation Center.

- If you receive a BCBS check for services provided by Madison Medical, that payment is legally owed to Madison Medical.
- You must **immediately endorse the check to Madison Medical** or provide payment in the same amount.
- You must also provide a copy of the Explanation of Benefits (EOB).

▲ Important:

Failure to forward such payments may be considered **insurance fraud** and may result in **collections or legal action**.

Signature of Patient/Guardian: _____

Printed Name: _____

Date: _____