Plasker Family Chiropractic Center
(201) 505-WELL (9355)
www.drplasker.com

Main Office:
25 Philips Parkway Ste 102
Montvale NJ 07645
201.505.WELL (9355)
FAX: 201.505.1711

Welcome to the Plasker Family Chiropractic Center!

Thank you for giving us the opportunity to care for you.
We look forward to meeting you when you come for your exam.
Bringing the attached completed forms with you will speed your visit!

Why Do I Need Chiropractic Care?

When we experience stressful events in our lives, our body's natural ability to maintain its normal balance and wellness is also stressed and impaired. Being under chiropractic care is especially helpful at such times because it helps the body's immune and nerve systems to function at their very best. Chiropractic care enables us to weather these tough times with clearer minds and healthier bodies.

Patients report to us that when they are coping with the stresses of life, chiropractic care helps their body maintain its optimal functioning, so they can continue to perform at their best.

We'd love to support you in the best, most efficient way possible.

YOU are worth it!

Thank you for entrusting your health care to us. Our goal is to provide you and your loved ones with the best possible care for many years to come.

Please visit our websites, **www.drplasker.com** and **www.100ylnj.com**, to learn more about chiropractic and other health issues of interest to you.

01-2021

Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S. # _____-_____-_____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____/ _____/ _____ Cell phone_____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Names of Parents/ Guardians: _____

Purpose of contacting us: _____

Other doctors seen for this condition? _____Yes_____No, Doctor's Names and Prior Treatments:_____

_____

Other Health Problems? _____

Check any of the following conditions your child has suffered from during the past six months:

- ☐ Ear Infections
- ☐ Headaches
- ☐ Asthma/ Allergies
- ☐ Car Accident
- ☐ Scoliosis
- ☐ ADHD
- ☐ Digestive Problems
- ☐ Temper Tantrums
- ☐ Seizures
- ☐ Recurring Fevers
- ☐ Colic
- ☐ Other: _____
- ☐ Chronic Colds
- ☐ Growing/ Back Pains
- ☐ Bed Wetting

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____/ _____/ _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____/ _____/ _____ Reason: _____

Are you satisfied with the care that your child received there? _____Yes _____ No

Number of doses of antibiotics your child has taken:

During the past 6 months: _____ Total during His/ Her Lifetime: _____

Number of doses of other prescriptions medication your child has taken:

During the past 6 months: _____ Total during His/ Her Lifetime: _____

Vaccination History: _____

PRENATAL HISTORY:

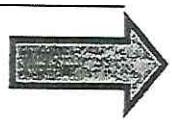
Name of Obstetrician/Midwife: _____

Complications during pregnancy: _____Yes _____No List: _____

Ultrasounds during pregnancy: _____Yes _____No Number: _____

Medications during pregnancy/ Delivery: : ___Yes ___No List: _____

Cigarette/ Alcohol use during pregnancy: : _____Yes _____No



Location of Birth: _____ Hospital _____Birthing Center _____Home

Birth Intervention: _____Forceps ____ Vacuum Extraction ____ Ceasarian (Emergency or Planned?)

Complications during deliver? _____Yes _____No List: _____

Genetic Disorders or Disabilities: _____Yes _____No List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

FEEDING HISTORY:

Breast Fed: _____Yes _____No How Long? _____

Formula Fed: _____Yes _____No How Long? _____ Type: _____

Introduced to Solids at: _____ months, Cow's Milk at _____ months

Food/ Juice Allergies: ___Yes ___No List: _____

_____

DEVELOPMENTAL HISTORY:

During the following times your child's spine most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxations (spinal nerve interface). At what age was your child able to:

_____Respond to Sound
_____Respond to Visual Stimuli
_____Hold Head Up
_____Sit up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council approximately 50% of children fall head first from a high place during their first year of life.(I.e., a bed, changing table, Stairs) Was this the case with your child? _____ Yes _____No

Is/ has your child been involved in any high impact of contact sports (i.e. Soccer, Football, Gymnastics, Baseball, Dance, Cheerleading, Martial Arts, Etc.)? _____Yes _____No List: _____

Has your child ever been involved in a car accident? _____Yes _____No List: _____

Has your child been seen on an emergency basis? _____Yes _____No List: _____

Other traumas not described above? _____

Prior Surgery? _____Yes _____No List: _____

Menarche: _____Yes _____No List: _____

CHILDHOOD DISEASES:

Chicken Pox	N / Y Age ____	Mumps	N / Y Age ____
Rubella	N / Y Age ____	Whooping Cough	N / Y Age ____
Rubeola	N / Y Age ____	Other _____	N / Y Age ____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I herby authorize this office and its Doctors to administer care to my Son/ Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: _____

PLASKER FAMILY CHIROPRACTIC CENTER
Dr. Jordan Plasker
25 Philips Parkway
Montvale NJ 07645

NOTICE OF PRIVACY PRACTICES

(Our *Notice of Privacy Practices* can be viewed online at www.drplasker.com as well as in our office.)

Date: _____

I acknowledge that I was provided with the opportunity to review a copy of the **Plasker Chiropractic's Notice of Privacy Practices.** Upon my request I was provided a hard copy.

_____ _____

Patient's Printed Name

Patient's Signature
Personal Representative -- please sign below

If you are completing this form as the patient's personal representative, please print and sign your name below:

_____ _____

Personal Representative's Printed Name

Personal Representative's Signature

_____

Personal Representative's Relationship to Patient

For Staff Use Only:

Complete this section if this form is not signed and dated by the patient or the patient's Representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Plasker Chiropractic's Notice of Privacy Practices but was unable to do so for the following reason:

- Patient/Patient's representative refused to sign
- Patient unable to sign
- Other

_____ _____

Name

Date

AUTHORIZATION FOR CONTACT

Messages may be left on my: [ ] home phone [ ] cell phone
[ ] work phone [ ] email

If unable to reach me, please:

[ ] leave a detailed message on my voice mail [ ] or email [ ]
[ ] leave a detailed message with whomever answers the phone
[ ] leave a message asking me to return your call
[ ] other instructions _____

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of information to: (physician, spouse, friend, etc)

NAME	RELATIONSHIP	INFORMATION TO DISCLOSE

Your authorization decisions will have **no** adverse effect on your care from Dr. Plasker or your relationship with our staff. These authorizations will remain in effect until terminated by you in writing. Your signature indicates authorization of the above activities.

_____ _____
(Printed Name of Patient) **(Date)**

_____ _____
(Signature of Patient / Parent / Representative) **(Printed Name)**

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you of such. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. **Our only method is specific adjusting to correct vertebral subluxations.**

I, _____ have read and fully understand the above statements.
(Printed name of Patient)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature of Patient or Parent or Guardian for Minor) **(Date)**

_____
(Printed Name of Parent or Guardian for Minor)

Office Fee Schedule and Financial Policy

Service	Non PCD Member	**PCD Member
Consultation	No Charge	No Charge
Initial Chiropractic Examination	$136	$102
Dynamic Examination	$100	$75
X-Rays	$136 - $325	$102 - $244
Adjustment	$80	$60.00
Wellness Adjustment Plans	$175 - $600/month	
		**explained below

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 the service is rendered unless you arrange an Active Life Plan in advance. Active Life Plans include yearly or monthly **Corrective Adjustment Plans** (CAPs). 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 Chiropractic Report of Findings.

- **Health Insurance:** If you have insurance that covers chiropractic, we can file the claims for you. If you prefer to file for yourself, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis, and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement. Remember, your agreement with your insurance company is between you and them.

If you are like most of our patients and choose to participate in one of our Active Life Plans, we will discuss this option with you during your Chiropractic Report of Findings.

- **** Preferred Chiropractic Doctor (PCD) Members:** This is a discount program only available to patients **not** using health insurance. As a member of PCD, you will receive special member fees as indicated by the fee schedule above. The cost to become a PCD member is only $37 per year for an individual and his or her family. As a PCD member, you can pay for your care at the time of each visit, or to speed up your appointments, weekly, monthly and yearly. Corrective Adjustment Plans (CAPs) are available as well.

With PCD, you will **not** get receipts to submit to your insurance company. You can, however, be given a receipt for tax purposes or a medical savings account (MSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance diagnosis given with these receipts.

If you acquire insurance for a special situation such as an auto accident or a worker's compensation injury and choose to utilize that coverage, you will be charged our regular office fees until such claim is settled. We will help you get reimbursed quickly on these claims. Once the claim is complete, you can begin to pay PCD fees again.

To become a PCD member, simply fill out the application and pay your membership fee. We will gladly send it in for you. If you complete the application and make payment in our office today, your membership and discounts will be effective immediately. Ask our Chiropractic Team for a registration form.

I have read and I understand the above policies. **I have initialed the one that applies to me.**

_____ _____

(Printed Name of Patient) **(Date)**

_____ _____

(Signature of Patient or Parent or Guardian) **(Printed Name of Parent or Guardian)**

01-2021

Assignment of Benefits from Health Insurance Carrier

I hereby assign payment directly to this office for professional services rendered and I shall personally be responsible for any unpaid balance to the doctor. _____ (initials)

I hereby authorize the release of any medical or other information necessary to process insurance claims. I authorize and direct payment of benefits otherwise payable to me to go to Dr. Jordan Plasker. I understand that obtaining eligibility for benefits is not a guarantee of payment. _____ (initials)

I understand that my co-payment and/or co-insurance is/are an estimated calculation and is/are ultimately determined by my insurance company and that the quote given to me is not a guarantee of my total financial responsibility. _____ (initials)

I understand that I am financially responsible for any co-payments, deductibles, co-insurance and **any procedures not covered by my insurance**. I understand that I agreed to my treatment plan and I am responsible for any procedures deemed medically unnecessary by my insurance company, unless I am enrolled in a Corrective Adjustment Plan (CAP). _____ (initials)

I understand that I am responsible for obtaining referrals and if insurance denies payment for not having one I am fully responsible for payment of all fees. If payment is sent to me by my insurance company the full amount will be remitted to Dr. Plasker. Failure to do so will result in full responsibility of the balance. _____ (initials)

Any over payments will be refunded and any underpayments will be billed to me after being processed by my insurance company. I understand that the subscriber of my insurance is the party ultimately responsible for my account. _____ (initials)

_____ _____

(Printed Name of Patient) **(Date)**

_____ _____

(Signature of Patient or Parent or Guardian) **(Printed Name of Parent or Guardian)**

I understand that a balance may be owed depending on how the claim is processed by my insurance. I hereby authorize payment to my credit card listed below.

Please circle --- AMEX, VISA, MC, Discover, Debit Card

Card # _____ Expiration _____

Name on Card _____ CVC _____

_____

(Signature of Patient or Parent or Guardian)

INSURANCE POLICIES AND GUIDELINES FAQs

We itemize all of our procedures. The reason for this is to let the insurance company personnel know exactly what was done on each visit, what was not done and why. In reporting to insurance companies, we are responsible to them to accurately inform them of your condition, status, any complications, exacerbations, unusual circumstances, etc., that would affect your recovery. We are also responsible for letting them know how long we anticipate your care will be, and at what frequency. All this involves a tremendous amount of staff and professional time and expense. However, we do this as a service to you; it lessens the burden of having to communicate with the insurance company, it lessens the responsibility and threat that insurance will no longer cover care, and it makes care a far easier process. All we ask is your cooperation. Our usual procedures and their costs are listed separately and a copy will be provided.

Because we itemize and document every procedure in accordance with insurance protocol rather than just describe what is being done as an "office visit", the charges can vary from to $50 to $318 per visit for the actual adjustment, plus charges for any special procedures performed. For various reasons, we know that there are a lot of charges that won't be paid, such as maximum dollar amount limits per visit, procedures that the policy does not cover, etc. We expect to receive denials on claims, as it is the nature of the insurance industry. However, we are still going to bill for everything we do, whether we get paid or not, so that we can adequately communicate with these companies.

Our experience shows that an insurance company that receives billing that describes your visit as an "adjustment" does not understand what is being done and why. Some have taken the position that billing sent in this way implies that you are haphazardly receiving adjustments without any diagnostic criteria to objectively determine if an adjustment is even needed on that visit. Insurance companies are not familiar with the principles of Chiropractic, and they look on this practice of reporting the same way they would if an M.D. were to just randomly give out shots or pills to every patient without FIRST determining whether or not the patient actually needed anything done that visit. It just isn't good practice.

Some companies pay 100%, some pay 90%, some pay 80%, some pay 50%, some pay for x-rays but not examinations, some pay for examinations and not x-rays, some pay only for an adjustment, some pay everything BUT the adjustments. MEDICARE pays about $40 per visit for 12 visits per year, demanding that x-rays be taken but not paying for them nor the examinations the patient MUST have, and the list goes on and on. We only state this so that you are aware of the practices that exist within the insurance industry.

For patients who choose NOT to participate in our Corrective Adjustment Plan (**CAP)** program, we want you to know that what you are at LEAST responsible for is your DEDUCTIBLE and a dollar amount toward your patient portion that your policy says you must pay (co-payment or co-insurance). If you have a special financial situation that makes this difficult or impossible for you, you have only to speak to one of our staff and arrangements will be made so you can receive the care you need at a fee you can afford. We cannot, however, read minds…you must tell us. Then we can help you!

If you do participate in our **CAP** program, any charges that your insurance company does not cover will NOT be billed to you. We ABSORB those costs because we must continue to report them in a manner that shows them what is being done; whether we are paid for it or not. We accept all patients, regardless of financial ability to pay!! This policy allows us to care for all people based on THE PATIENT'S NEEDS.

ANY INSURANCE-RELATED CORRESPONDENCE THAT YOU RECEIVE MUST BE BROUGHT TO US SO THAT WE MAY HAVE A COPY OF IT FOR OUR RECORDS. Often the patient receives information that is vital to processing a claim that never finds its way to the doctor's office, such as the Explanation of Benefits (the stub attached to the check), a scheduled independent examination, a scheduled hearing, etc. We ask that you please help by bringing all documentation to us.

Please understand it is our purpose to obtain as much coverage toward your care that your insurance company provides you. In this way, we can help ALL people, not just those who can afford it. By following the above policies, this is made possible.

Please sign your name below, indicating that you have read the above and understand it. Thank you.

_____ _____

Printed Name of Patient **Date**

_____ _____

Signature of Patient or Parent or Guardian **Printed Name of Parent or Guardian**

Please Retain For Future Reference

Chiropractic Active Life Plan Explanation Sheet

Chiropractic Active Life Plans are designed to help you and your family reach optimum health ***now***, and over the course of your lifetime. Too many people wait until their health fails before they make it a priority, and they pay a heavy price for this "if it ain't broke don't fix it" attitude.

One of the fastest growing segments of our population today is centenarians. These are people who are 100 years old. Currently there are 70,000 people over the age of 100. With the baby boom generation maturing over the next 50 years, the U.S. Census Bureau expects the number of centenarians to climb to over 4.2 million by the year 2050.

The chances of you reaching this milestone are increasing every day. The question is, "what will your health be like when you get there?" Do you think the health choices you make today will impact the quality of life in your future? Of course they will.

One of the most common comments heard from seniors is, "If I knew I was going to live this long, I would have taken better care of myself." We are getting this advance notice that our parents and grandparents didn't receive. What will you do with this information?

Chiropractic Active Life Plans will help you achieve the quality of life you deserve!

Three types of Chiropractic Active Life Plans You and Your Family Can Enjoy

- **Corrective Adjustment Plans (CAP):**

Corrective Adjustment Plans are designed for you if you are currently experiencing pain, sickness, dis-ease, spinal subluxation degeneration, or health problems of any kind. The CAP Plan is designed to help you feel healthy again as quickly as possible and to stabilize your spine.

This occurs with frequent chiropractic adjustments, usually three times per week, over a short period of time lasting 2 weeks to 6 months. Dynamic exams are performed every 12 visits to determine how your body is healing and your spine is correcting and stabilizing.

Once your spine is stabilized, your adjustment frequency will graduate to one time per week for the balance of a year. As your Corrective Adjustment Plan winds down, our chiropractic team will discuss your Wellness Adjustment Plan with you so you can continue to remain healthy and active over the course of your life.

- **Wellness Adjustment Plans (WAP)**

If you have already completed your Corrective Adjustment Plan with our office or another chiropractor, or you are extraordinarily healthy and have no spinal subluxation degeneration, you can go right onto a WAP to help you achieve and maintain optimum health.

WAPs consist of weekly or monthly adjustments (depending on the condition of your spine and your long-term health goals). The more active you are, and the more active and healthy you want to be over the course of your life, the more you will value and appreciate your WAP.

- **Family Adjustment Plans (FAP)**

The more you spend time in our office, the more you will see generations of families on Chiropractic Active Life Plans, enjoying the benefits of the chiropractic lifestyle. As you learn about the benefits of chiropractic care, you too will want your entire family participating in chiropractic care.

Our FAPs are designed to make family care affordable so that everyone can enjoy the good health, activity, and peak performance that chiropractic care provides.

At your **Chiropractic Report of Findings**, we will discuss with you which Chiropractic Active Life Plan you are eligible for so that you can reach all your health objectives.

Congratulations on participating in chiropractic care, with your family! We look forward to helping you achieve all your health goals over the course of your lifetime.