Patient Demographic Form

Name(성함):_____

Date Of Birth(생년월일):_____

Today's Date(날짜):_____/_____/_____ Age(나이):_____ Sex(성별): M / F

Right or Left Handed(오른손/왼손 잡이): R / L

Address(주소):_____ City(도시):_____

State(주):_____ Zip(우편번호):_____

Telephone #(전화번호):_____

Email Address: (이메일):_____

Primary Insurance(1차 건강보험):_____

Card Holder Name(가입자 성함):_____

Secondary Insurance(2차 건강보험):_____

Card Holder Name(가입자 성함):_____

Emergency Contact Name(응급전화 이름):_____

Relationship to Patient(관계):_____

Phone #(전화번호):_____

Primary Care Doctor's Name(주치의 이름):_____

How did you hear about us? (저희를 어떻게 알고 찾아오셨나요?):

_____

Signature(사인):_____

BALANCE & DIZZINESS CENTER
17 Brinkerhoff Terrace Suite 201, Palisades Park NJ 07650
201 947-4777

Dizziness, Balance & Falls Prevention Questionnaire

(어지럼증/낙상(넘어짐) 예방 자가진단서)

Patient Name(이름):_____ Date(날짜):_____

Patient Date of Birth(Mon/Day/Yr)(월/일/년):_____/_____/_____

1.) Circle what best applies (해당되는 질병에 동그라미를 쳐주세요)

[ ] Dizziness (어지럼증) [ ] Balance (중심) [ ] Both (둘다)

Section A

Dizziness questions: (If you are NOT DIZZY SKIP this section) Mark all that apply:
(어지럼증 질문: (어지럽지 않으면 이 부분은 넘어가주세요) 해당사항을 정확히 기재해주세요)

2.) Duration of dizziness episodes:
(어지럼증 지속시간)

[ ] Seconds(초)
[ ] Minutes(분)
[ ] Hours (시)

3.) When did symptoms first begin?
(증상은 언제 처음 느껴졌나요?)

[ ] Days ago (며칠 전)
[ ] Weeks ago (몇주 전)
[ ] Months ago (몇달 전)
[ ] Years ago (몇년 전)

4.) My dizziness is…
(어지럼증 현상은…)

[ ] Constant (끊임없이 지속된다)
[ ] Periodical (간헐적이다)

5.) My dizziness is best described as…
(어지럼증 증상 형태)

[ ] I feel like I am spinning/moving
(내 몸이 빙빙 도는 느낌이 듭니다)
[ ] I see the world around me spinning/moving
(내 주위가 빙빙 돕니다)
[ ] Lightheadedness/ “swimming” sensation
(현기증/붕 떠있는 느낌)

6.) My last dizziness episode was…
(가장 최근에 느꼈던 어지럼증은…)

[ ] Today (오늘)
[ ] Days ago (며칠 전)
[ ] Weeks ago (몇주 전)
[ ] Months ago (몇달 전)

7.) Symptoms present with…
(어지럼증과 함께 오는 증상…)

[ ] Nausea (구역질)
[ ] Vomiting (구토)

8.)These positions make me dizzy
(이 자세를 취하면 어지럼증이 옵니다)

[ ] Sitting (앉을때)
[ ] Lying in bed (침대에 누울때)
[ ] Standing (서있을때)
[ ] Getting up (일어설때)
[ ] Turning (돌때)
[ ] Bending (굽혔다 필때)

MEDICAL HISTORY – Mark all that apply:

(병력기록 -해당사항을 정확히 기재해주세요)

[ ] Headaches (두통)
[ ] Heart Murmur (심잡음)
[ ] Congenital Heart Defect (선청성 심장질환)
[ ] Stomach Pains (복부 통증)
[ ] Migraines (편두통)
[ ] Motion Sensitivity (멀미)
[ ] Sensitivity to light (빛에 민감)
[ ] Sensitivity to sound (소리에 민감)
[ ] Sensitivity to smell (냄새에 민감)
[ ] Facial Numbness (안면 마비)
[ ] Breathing Difficulty (숨쉬기 힘듬)
[ ] Double Vision (이중 시력)
[ ] Blurred Vision (흐린 시야)
[ ] Cataracts(백내장)
[ ] Macular degeneration (시력 감퇴)
[ ] Glaucoma (녹내장)
[ ] Visual floaters/ spots (비문증)
[ ] Low vision (저시력)
[ ] Shingles (대상 포진)
[ ] Cold sores / fever blisters (단순포진)

[ ] Heart Attack (심장마비)
[ ] Mitral Valve Prolapse (승모판 탈출증)
[ ] Chest Pains (가슴 통증)
[ ] Anemia (빈혈증)
[ ] Stroke (뇌졸증)
[ ] High blood pressure (고혈압)
[ ] Low blood pressure (저혈압)
[ ] Orthostatic hypertension (기립성 고혈압)
[ ] COPD (만성 폐쇄성 폐질환)
[ ] Diabetes (당뇨)
[ ] Leukemia (백혈병)
[ ] Thyroid problems (갑상선)
[ ] Kidney problems (콩팥)
[ ] Liver problems (간)
[ ] Stress (스트레스)
[ ] Anxiety (불안증)
[ ] Panic attacks (공황장애)
[ ] Depression (우울증)
[ ] Seizures (발작)
[ ] Chemotherapy (화학요법)

[ ] Loss of consciousness (기절)

[ ] Arthritis / Rheumatism (관절염/류마티스)

[ ] Neck Pain (목 통증)

[ ] Back Pain (허리 통증)

[ ] Asthma (천식)

[ ] Venereal Disease (성병)

[ ] Emphysema (폐기종)

[ ] Artificial Joints/Bones (인공 관절/뼈)

[ ] Serious Head injury or been knocked unconscious (머리 부상/외부 충격으로 인한 기절)

[ ] Tinnitus (이명/귀울림)

[ ] Hearing Loss (청력감퇴)

[ ] Falls (넘어짐)

[ ] Staggered Gait (비틀비틀 걸음)

Please list any major surgeries you had, (수술기록을 기재해 주세요)

_____

_____

Please list any medications you are taking, (복용하고 계시는 약을 기재해주세요.)

_____

_____

_____

Prior relevant medical evaluations, diagnostic testing, and treatment:

(과거 의료진단 기록, 진단 테스트, 치료 기록:)

Have you seen other healthcare providers for you current condition? (지금 가지고 있는 증상 때문에 치료나 검진을 받으신적이 있나요?) [ ] yes(네) [ ] no(아니요)

If yes, who(만약 받으셨다면 어디서 받으셨나요?): [ ]Primary care doctor(주치의)
[ ]ENT/HNS doctor(이비인후과) [ ]Neurologist(신경외과) [ ]Cardiologist(심장내과)
[ ]Emergency room doctor(응급실) [ ]other(기타) : _____

Additional Information (추가 정보)

Is there anything else you would like to make sure to tell your physician about?
(의사에게 따로 알려야하는 사항을 적어주세요)

_____

_____

_____

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DIAGNOSTIC ULTRASOUND PLUS, INC.

Notice of Privacy Practices Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood your *Notice of Privacy Practices Consent Form* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices Consent Form.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

INSURANCE AUTHORIZATION, FINANCIAL POLICY AND AGREEMENT

We are committed to providing you with the best possible care. If you have insurance, we will gladly accept assignment of benefits and file all insurance claims, provided verification of your insurance policy(s) allows assigned benefits and coverage for the services rendered.

I hereby authorize payment directly from my insurance carrier to the rehabilitation agency for the benefits due to me in my pending claim. I further authorize the release of any medical information required by my insurance carrier.

I, the undersigned, understand that the rehabilitation agency will bill my insurance carrier for the services rendered upon verification of coverage from my insurance company. I also understand that should my insurance company fail to make complete payment for services rendered, I am responsible for complete payment of physical therapy services, including any and all deductibles, coinsurance amounts. I am responsible for payments that are denied for lack of medical necessity as determined by your health insurance payer. The charges incurred are not subject to any fee schedule or reductions unless the rehabilitation agency is a contracted managed care provider for my insurance carrier. I also understand that if my treatment is due to an injury which results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand the payments of the fee are not contingent upon a settlement of litigations; however, I hereby instruct my attorney to pay the rehab agency in full, directly from the proceeds from any settlement or judgment rendered on my behalf.

EXPLANATION OF MEDICARE BENEFITS

Accepting the assignment means that the provider of services agrees to accept the "allowable" charges as determined by Medicare as full payment. However, you much remember Medicare generally pays 80% of the allowable charges. Therefore, you are still responsible for the 20% balance. In addition to the 20% you are responsible for any amounts applied toward your annual Part B deductible and any non-covered charges.

SUPPLEMENTAL COVERAGE/CO-PAYMENT

A rehab agency representative has explained to me that under the Medicare guidelines, I will be responsible for 20% of the allowable charge. The rehab agency has agreed to accept assignment of the benefits on this portion of the charges; I also understand that should the supplemental insurance company fail to pay for these charges with a "reasonable length of time", or send payment directly to me, I will become responsible for payment in full.

The above Patient Financial Policy and Agreement has been read and/or explained to me:

Patient's Signature:_____

Date:_____