**Liebman Wellness Center 100 W. Old Marlton Pk. Marlton, NJ 08053**

## REQUIRED PATIENT INFORMATION FOR INSURANCE BILLING

**(PATIENT)**

**LAST NAME: _____FIRST:_____ MI: _____DOB:_____/_____/_____ SEX: M _____F_____**

**STREET: _____APT #:_____CITY: _____ST:_____ZIP:_____**

**SS# _____H. PHONE: _____/_____WK PHONE: _____/_____ CELL PHONE: _____/_____**

**MARRIED: ___ SINGLE: ___ DIV: ___ OTHER: ___ SPOUSE'S NAME_____SPOUSE'S WK PH #_____/_____**

**SPOUSE'S CELL PH # _____/_____ EMAIL ADDRESS: _____REFERRED TO THIS OFFICE BY: _____**

**_____ EMERGENCY CONTACT NOT LIVING WITH YOU: _____PH #: _____/_____**

## PRIMARY INSURANCE INFORMATION

**(INSURED)**

**(IF PRIMARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARENT OR OTHER INFORMATION OF PRIMARY INSURED BELOW)**

**INSURED NAME: _____DOB: _____/_____/_____SS# _____ SEX: M_____F_____**

**INSURANCE CO: _____ID#_____ GROUP #_____**

**PATIENT'S RELATIONSHIP TO INSURED_____**

(Please include the social security number and date of birth of the primary insured for your insurance to be billed.)

## SECONDARY INSURANCE INFORMATION

**(INSURED)**

**(IF SECONDARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARENT OR OTHER INFORMATION OF SECONDARY INSURED BELOW)**

**INSURED NAME: _____DOB: _____/_____/_____SS# _____ SEX: M_____F_____**

**INSURANCE CO: _____ ID#_____ GROUP #_____**

**PATIENT'S RELATIONSHIP TO INSURED_____**

## PAYMENT POLICIES

**You are responsible for anything your insurance does not cover. All Co-Pays are due and payable at each visit. These fees may apply, please initial the following boxes:**

- ☐ **$5 FEE FOR CO-PAYS NOT PAID AT TIME OF SERVICE.**
- ☐ **$75 NO SHOW FEE FOR ANY MISSED APPOINTMENT THAT WAS NOT CANCELLED OR RESCHEDULED 1 FULL BUSINESS DAY PRIOR TO THE APPOINTMENT. PLEASE BE CONSIDERATE AND CALL AT LEAST 1 BUSINESS DAY BEFORE YOUR APPOINTMENT IF YOU CANNOT COME IN.**
- ☐ **$35 NSF CHARGE FOR ANY RETURNED CHECK FROM THE BANK**

**If you are a private pay patient without insurance, all charges are due at the time of visit. We do not send statement to private pay patients.**

## PRESCRIPTION POLICY

**Please do not wait until your last pill to call for a refill. There is a 48 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be denied. Assignment of benefits are payable to the doctors.**

**PLEASE SIGN AND DATE THIS DOCUMENT SHOWING THAT YOU HAVE READ AND UNDERSTAND OUR POLICIES.**

**SIGNATURE _____DATE: _____**

**Revised 10-28-20**

Patient Name: _____ D.O.B._____ Date: _____

**Email address:** _____ SS#: _____

**INTAKE ASSESSMENT FORM**

This questionnaire must be completed prior to your appointment with Revive Life Treatment Centers.

Your careful answers will help us to understand your pain problem and design the best treatment program for you. It is understandable that you might be concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential, and no outsider is permitted to see your case record without your written permission.

**Sex:** Female Male or Other **Language:** _____**Race:** _____
**Ethnicity:** _____ Hispanic or Latino ____ Not Hispanic or Latino

**Current Address:** __ _____

**City:** _____ **State:** _____ **Zip:** _____

**Telephone: Home:** _____ **Mobile:** _____

**FAMILY MD:**_____

**Address:** _____

**Phone #:** _____ **Fax #:** _____

**Preferred Pharmacy:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Telephone:** _____

_____ Patient gives consent to retrieve prescription history when request is triggered

_____ Patient does not give consent retrieve prescription history when request is triggered

**Patient Signature:** _____ Date: _____

LIEBMAN
Wellness Center

Patient Name: _____ D.O.B._____ Date: _____

## Chief Complaint

What is bothering you?

_____

_____

_____

_____

_____

_____

_____

Are there any symptoms associated with your pain (check all that apply)?

- ☐ Numbness
- ☐ Weakness
- ☐ Urinary Incontinence
- ☐ Incontinence of bowel
- ☐ Tenderness of affected area
- ☐ Pain with only a light touch
- ☐ Cool, pale skin
- ☐ Swelling
- ☐ Redness
- ☐ Tingling
- ☐ Sleeplessness

Other (describe): _____

_____

_____

_____

_____

Patient Signature

LIEBMAN
Wellness Center

Patient Name: _____ D.O.B._____ Date: _____

# Past Medical History

## Allergies

Do you have any allergies? (please list) _____

_____

_____

_____

_____

## Current Medications

What medications are you currently taking? (please list)

| Medication | Strength or Dosage | How Often do Take this Medication | Why do you take this Medication | Who Prescribed This Medication |
|---|---|---|---|---|
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Patient Signature


Patient Name: _____ D.O.B._____ Date: _____

# Past Medical History (cont'd)

## Past Surgical History

Please List

| Date | Type of Operation | Complications (describe) |
|---|---|---|
| | | |
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_____

Patient Signature