HAINESPORT CHIROPRACTIC
2717 MARNE HIGHWAY
HAINESPORT, NEW JERSEY 08036
PHONE :(609) 267-5550 FAX (609) 267-3535

Today's Date: _____

Name_____ DOB: _____ Gender: M ☐ F ☐

Address_____

City _____ State _____ Zip Code _____

Cell Phone_____ Email _____

Occupation_____ Employer _____

Emergency Contact _____ Relation_____ Phone _____

Health Insurance:_____ Member ID: _____

Subscriber Name:_____ Subscriber DOB: _____

Height: _____ Feet:Inch Weight:_____ lbs

Why are you seeking chiropractic care:

_____

When / how did this start? _____

Does this interfere with your (circle) Sleep Work Daily Activities

On a scale from 1-10, 1 being no pain, rate your pain today? _____

What makes it better? _____ What makes it worse? _____

Describe your condition: (circle)

-Constant -Comes & Goes -Local -Radiating

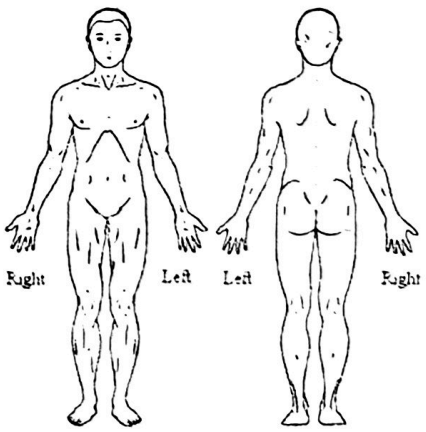
-Numb/Tingling -Stabbing/Sharp -Burning -Ache -Stiff

Do you have difficulty: (circle)

Sitting Standing Bending Forward/Backwards Twisting

Lifting Walking Reaching overhead Other_____

Mark where you are experiencing symptoms



Is this related to work or auto accidents? Y ☐ N ☐

Are you in litigation for any accidents? (Auto, Worker's Comp, etc) Y ☐ N ☐

Is there anything else the Doctor or Staff should know?

_____

_____

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Family History

Y N Diabetes
Y N High Blood Pressure
Y N Heart Disease
Y N Musculoskeletal Disease
Y N Cancer: _____
Y N Stroke/aneurysm
Y N Osteoporosis
Y N Other: _____

Current General History

Y N Unexplained Wt Change, Inc or Dec.
Y N Allergies: _____
Y N Bleeding/Bruising
Y N HIV
Y N Cancer: _____
Y N Insomnia
Y N Other: _____

Endocrine History

Y N Thyroid Condition: Hyper/Hypo
Y N Diabetes
Y N Other: _____

Eye/Ear/Nose/Throat

Y N Eye or Ear Pain
Y N Other Visual Conditions
Y N Change in vision/hearing/taste
Y N Ringing in Ears
Y N Dizziness
Y N Difficulty Chewing/Swallowing

Gastrointestinal System

Y N Anorexia/Bulimia
Y N Constipation/Diarrhea
Y N Nausea/Vomiting
Y N Abdominal Pain/Swelling
Y N Gallbladder Disease
Y N Liver/Pancreatic Disease:_____

Urinary System

Y N Urinary Urgency/Pain
Y N Difficulty holding/expelling
Y N Kidney Disease/Stone/Pain
Y N Prostate Issues
Y N Pelvic Pain

Cardiovascular System

Y N Heart Medications: _____
Y N Past heart or vascular disease
Y N Chest discomfort/pain
Y N Palpitations
Y N Edema
Y N High blood pressure
Y N Blood clot/aneurysm/DVT
Y N Sudden calf pain with walking
Y N Other: _____

Skin/Hair/Nails

Y N Skin Cancer
Y N Rashes/itching/lesions
Y N Psoriasis

Neurological System

Y N Headaches
Y N Seizures/epilepsy
Y N Vertigo
Y N Loss of sensation
Y N Head Trauma
Y N Multiple Sclerosis
Y N Vertebral Disc Condition
Y N Anxiety/Bipolar/Depression

Musculoskeletal System

Y N Osteoporosis/Fibromyalgia
Y N Arthritis: _____
Y N Scoliosis
Y N Joint pain/stiffness/swelling
Y N Muscle cramp/soreness/pain
Y N Neck pain
Y N Upper/Mid back pain
Y N Low back pain
Y N Shoulder/arm/hand pain
Y N Leg/knee/foot pain
Y N Fractures/dislocation/sprains
Y N TMJ issues

Pulmonary System

Y N Asthma/Shortness of Breath
Y N Apnea
Y N Pneumonia
Y N Cigarette Smoking
Y N Respiratory Infections
Y N Other: _____

Implants/Orthotics

Y N Cardiac/Pacemakers
Y N Joint replacement/Pins/plates/screws

Diet/Exercise

Y N Consume caffeine
Y N Consume alcohol

HAINESPORT CHIROPRACTIC

Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There will most likely be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. The adjunctive procedures depend upon your specific circumstance and may include but are not limited to: cold laser, exercises and other physical modalities.

It is important that you understand, as with all health care approaches, **results are not guaranteed, and there is no promise to cure**. As with all types of health care interventions, there are some risks to care, including, but not limited to: **muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains**.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, surgery, **or no care at all**. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____

Date: _____

Witness Name: _____ Signature: _____

Date: _____

Authorization to Release Information

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments.

Authorization to Release Information

I hereby authorize ***Hainesport Chiropractic*** to: (1) release any information necessary to insurance carriers regarding my care; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of one year. This order will remain in effect until revoked by me in writing.

I have requested medical services from ***Hainesport Chiropractic*** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____
Patient Name

_____ _____ _____
Patient/Responsible Party Signature Insurance ID # Date

_____ _____
Witness Date

Hainesport Chiropractic

HIPAA NOTICE OF PRIVACY PRACTICES

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

This notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related care services

Use and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of our office, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example: On occasion, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnosis or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for your chiropractic treatment may require that your relevant protected health information be disclosed to the health plan carrier.

Worker's Compensation

If applicable, we may disclose your protected health information as necessary to comply with state Workers' Compensation Laws.

Emergencies

We may disclose your protected health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency.

Healthcare Operations

We may disclose, as needed, your protected health information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to other health care workers that may be observing in our office. In addition, we will use a sign in sheet at the front desk where you will be asked to sign your FIRST name and time of your arrival in our office. As a courtesy to our patients it is our policy to call your preferred phone number to remind you of your appointment. If you are not available, we leave a reminder message on your voice mail or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment. We will send reminder cards to motivate patients to take care of their well being by scheduling an appointment. Thank you cards are also sent for patient referrals. At times, patient care, conditions, insurance, changes of insurance, verification and network information will be discussed within hearing distance of others.

We may use or disclose our protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Changes to this Notice of Privacy Information

Our office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, our office is by law required to comply with this notice, and maintain the privacy of your health information. If you have any questions about any part of this notice, or if you want more information about your privacy

Complaints

Complaints about our privacy rights or how our office has handled your protected health information should be directed to the privacy officer at (609) 267-5550. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights 26 Federal Plaza New York, NY 10278.

You may revoke this authorization at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name