Patient Information

Date:_____ Social Security #_____ Patient Account #_____

Full Name_____

Address_____ City_____

State_____ Zip_____ Home Phone_____Work Phone_____

Circle One: Male Female Family Physician_____

Patient's Relationship to Insured_____ Insureds Date of Birth_____

Patients Date of Birth _____/_____/_____ Age_____ Marital Status: S M D W

Occupation_____ Employer_____

Referred By_____

Reason for Visit_____

Symptoms
Frequently/ Occasionally/ Intermittently

Quality
Sharp/ Shooting/ Burning/Throbbing/ Tingling/ Soreness/ Weakness/ Numbness

Intensity
0 1 2 3 4 5 6 7 8 9 10

Do any of you or your blood relatives have a history of any of the following?

Arthritis:	Self ☐ Relative ☐	Please list all current Medications
Cancer:	Self ☐ Relative ☐	_____
Depression:	Self ☐ Relative ☐	_____
Diabetes:	Self ☐ Relative ☐	Known Drug or Food Allergies
Heart Problems:	Self ☐ Relative ☐	_____
High Blood Pressure:	Self ☐ Relative ☐	Previous Hospitalizations
Lupus:	Self ☐ Relative ☐	_____

Describe Symptoms_____

Females Only: Are you pregnant or is there any possibility you may be: Yes ☐ No ☐

I, the undersigned, a patient in this office hereby authorize the Doctor (and whomever he may designate as his assistant(s) to administer treatment as necessary.) I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature_____ Date_____

Since we use an automated system for appointment reminders, please select the method you prefer to be reminded of your appointments.

- Text message (cell) _____
- Email _____
- Voicemail (home phone) _____

Coordination of Benefits

Main Policy

Insurance Company: _____ Policy Holder: _____

Health Plan: _____ Effective Date: _____

Birthdate: _____ SSN: _____

Through Employer? _____ Medicare or Medicaid? _____

Employer Name: _____ Insurance Company: _____

Coverage Type(s): ☐ Medical ☐ Vision ☐ Dental ☐ Other: _____

Family Members Covered: _____

Secondary Policy 1

Insurance Company: _____ Policy Holder: _____

Health Plan: _____ Effective Date: _____

Birthdate: _____ SSN: _____

Through Employer? _____ Medicare or Medicaid? _____

Employer Name: _____ Insurance Company: _____

Coverage Type(s): ☐ Medical ☐ Vision ☐ Dental ☐ Other: _____

Family Members Covered: _____

Secondary Policy 2

Insurance Company: _____ Policy Holder: _____

Health Plan: _____ Effective Date: _____

Birthdate: _____ SSN: _____

Through Employer? _____ Medicare or Medicaid? _____

Employer Name: _____ Insurance Company: _____

Coverage Type(s): ☐ Medical ☐ Vision ☐ Dental ☐ Other: _____

Family Members Covered: _____

Signature _____

Date _____

Patient's Rating of Pain

Date _____

Patient Name

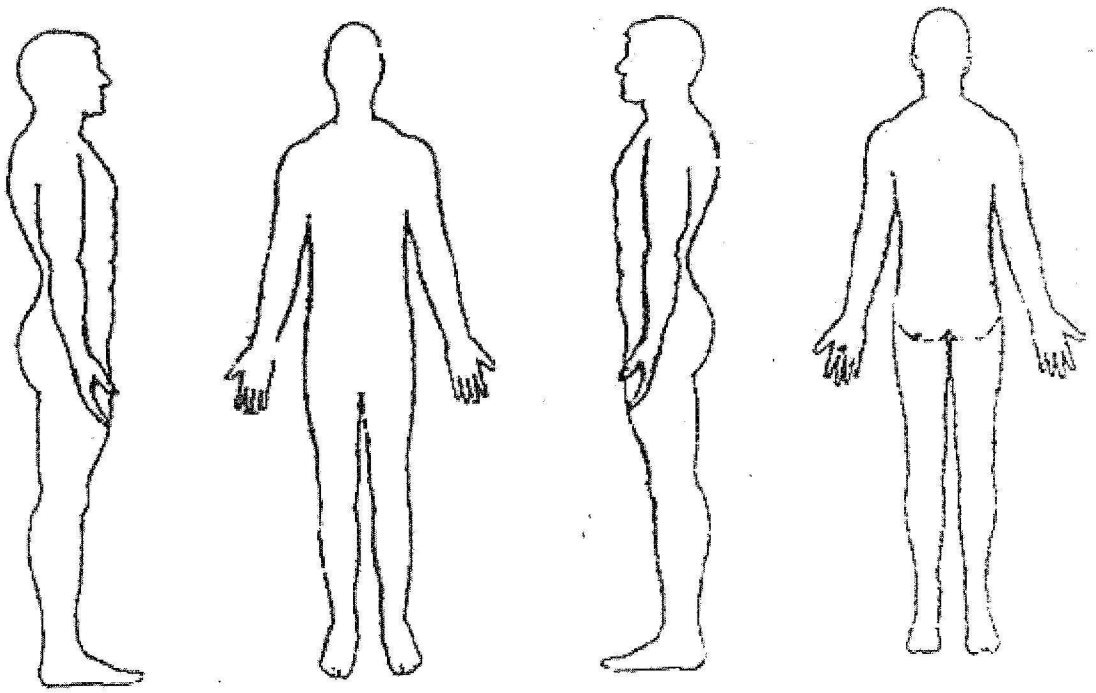
Patient # _____

Subjective Pain Level: On a scale of 1-10 place an X in your current pain level.

Normal	**Low Pain**	**Moderate Pain**	**Intense Pain**	**Emergency**
( ) 0	( ) 1	( ) 4	( ) 7	( ) 10
	( ) 2	( ) 5	( ) 8	
	( ) 3	( ) 6	( ) 9	

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress areas of radiation. Include all affected areas.

Pain Symbols			
Numbness	= = = = = = = = =	Pins & Needles	+ + + + + + + + +
Burning	X X X X X X	Stabbing	/ / / / / /



Health 1st
Consent for Purposes of Treatment, Payment and Healthcare Options

I,_____ [Name of Individual] consent to Health 1st ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition; the provisions of health care to me, or the past, present, or future payment for the provision of health care services to me, and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right or review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Health 1st of Plainfield
FINANCIAL POLICY

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and this chiropractic clinic. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible. Payment for all services are required at time of service and we will provide you with the necessary forms to allow you to file your own insurance claims. This will allow the clinic to concentrate on the patient's health and maintain reasonable health care costs.

We are not certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. The patient's percentage is usually 20% to 30% of covered costs, after the deductible has been met. Our average office fee ranges from $30.00 to $80.00.

"ON THE JOB" INJURY

Worker's Compensation pays in full for Chiropractic care. Upon being released from care, a 3-month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance forms as soon as possible. If an attorney is handling your case, please notify the insurance department right away. Although you are ultimately responsible for our bill, our office will wait for settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the first visit. For your convenience, payment may be arranged at the first visit of each week. We are happy to accept your check, MasterCard, Visa or Discover. If you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually send directly to our office in payment of the services that Medicare will cover. For Chiropractors this includes only manual manipulations of the spine. Medicare pays 80% of the allowable fee once the deductible has been met and the patient will be required to pay the remaining 20%. The patient is also responsible for payment in full of all non-covered service. Our office will complete the necessary forms and file them with the Medicare provided at no charge.

ANCILLARY PRODUCTS

Vitamins, Orthotics, braces, ice packs, and orthopedic pillows are to be paid in full at the time of ordering. The cost of these products can be obtained at the front desk.

FAILURE TO GIVE APPROPRIATE NOTICE

A 24 hour notice is required for all changes in scheduling appointments. All missed appointment without a 24 hour notice will be a $25.00 non-refundable charge to the patient (not covered by insurance.) We reserve the right to reschedule any patient 10 minutes late for an appointment.

NOTICE

If patient care is suspended or terminated, any fees for services are due in full immediately. Patient agrees that they will pay all collection costs, attorney fees and court costs incurred by the doctor in the collection of all sums due.

Patient's Name _____

Patient Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of April 1, 2003, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

> Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
> Payment: We may use and disclose your health information to obtain payment for services we provide to you.
> Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

Our chiropractic practice will seek to obtain Consent from you permitting us to use or disclose your health information for these activities. You should be aware that our chiropractic practice does not require obtaining, or confirming the existence of a Consent, prior to:

> a) Emergency treatment;
> b) Treatment, when such treatment is required by law; or
> c) Treatment of patients when communication barriers prevent obtaining Consent.

You should also be aware that you have the right to revoke that Consent at any time by providing the practice with written notice.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____ , [Patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices Health 1st, which describes the Practice's policies and procedures regarding use and disclosure of any of my Protected Health Information created, received or maintained by the practice.

_____ _____

Date Signature

_____

Print Name

FOR OFFICE USE ONLY
IF NOTICE NOT PROVIDED TO PATIENT

The practice has made a good-faith effort to obtain an acknowledgement of _____ [patient name] receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons:

_____ Patient Unavailable
_____ Patient Physically Unable
_____ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner:

_____ Personally
_____ Mail
_____ Phone
_____ Follow Up
_____ Other _____

_____ _____

Date Signature of Chiropractor of Heath 1st