GALLOWAY - EGG HARBOR TOWNSHIP - ATLANTIC CITY - HAMMONTON

CONFIDENTIAL PATIENT CASE HISTORY

Name: _____ Sex:____ Marital Status:____ Race:____ DOB:_____

Address:_____ City:_____

State: ____ Zip Code:_____ Home Phone:_____ Cell Phone:_____

Social Security #:_____ Email Address:_____

Occupation:_____ Company Name:_____

Family Doctor:_____ Phone:_____ Last Physical: _____

PRESENT CONDITION:

Is this related to: Auto Accident ☐ Yes ☐ No; Work Injury ☐ Yes ☐ No; Slip & Fall Injury ☐ Yes ☐ No

What is your main complain? _____

Other Complaints? _____

What makes it worse? _____

What makes it better? _____

How long have you had this condition? _____ Similar condition in the past? _____

Other Doctors treated for this condition?_____

Related testing: ☐ X-ray ☐ MRI ☐ CT Scan ☐ EMG/NCV(nerve test) ☐ Other_____

If yes, please list all test completed and where they were done: _____

Do you currently or have you ever suffered from:

☐ Dizziness ☐ Backaches ☐ Heart trouble ☐ Diabetes ☐ Arthritis ☐ Headaches

☐ Asthma ☐ Neuritis ☐ Sinus Problems ☐ Nervousness ☐ Neck Pain ☐ Stroke

☐ Nausea ☐ Osteoporosis ☐ Reflux/heartburn ☐ Parkinson's ☐ Digestive Disorders

☐ Cancer ☐ Pacemaker ☐ Other _____

Are you currently on prescription medications? □ Yes □ No If yes, please list: _____

_____

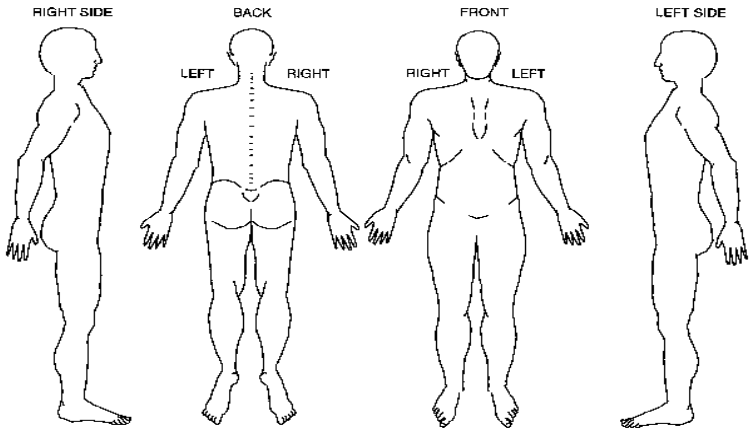
Do you have any drug allergies? □ Yes □ No If yes, please list: _____

_____

Do you smoke cigarettes? □ Yes □ No If yes, how many a day and how often? _____

PAIN DRAWING: Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with an arrow (↑, ↓, ←, →) to indicate the pain.

A = Ache	B = Burn	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	O = Other



PAST HISTORY/TRAUMA

Have you had previous Chiropractic Care? □ Yes □ No

Where: _____ Last Seen: _____

Have you ever had any injuries or auto accidents? □ Yes □ No If yes, when and describe? _____

_____

List any surgical operations and year performed: _____

_____

Prior □ X-ray □ MRI □ CT Scan □ EMG/NCV (nerve test) □ Other_____

We believe a clear definition of our office policy will allow both patient and the doctor to concentrate on the big issues – REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENTS

1. We honor all appointments at the scheduled time.
2. Multiple appointments will be given for your convenience in order to incorporate these appointments into your daily routine.
3. It is the frequency of visits that count and not the days, therefore, if you are unable to keep a scheduled appointment, please CALL IMMEDIATELY to reschedule your visit. It is your obligations to make up a missed appointment within the same week of any cancellation.

Signature: _____

HEALTH INSURANCE AND FINANCIAL RESPONSIBILITY:

If no insurance, write **"none."**

Primary Insurance Name: _____ Phone #: _____

ID # _____ Group # _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Is a referral required? ☐ Yes ☐ No If yes, did you bring it with you today? ☐ Yes ☐ No

Secondary Insurance Name: _____ Phone #: _____

ID # _____ Group # _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Is a referral required? ☐ Yes ☐ No If yes, did you bring it with you today? ☐ Yes ☐ No

All services rendered are charge directly to you, the patient. You then are ultimately responsible for all payments regardless of whether or not this office accepts insurance assignment

1. PATIENTS WITHOUT INSURANCE – All payments are expected at the time services are rendered, unless prior financial arrangements have been established. Patient balances may not exceed $150.00 at any time.
2. PATIENTS WITH INSURANCE – Deductible and all copayments are expected at the time services are rendered. Patient balance may not exceed $150.00 at any time.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions concerning your health care or our policy, please let us know. We welcome your referrals and look forward to an excellent doctor-patient relationship what works for our mutual benefit.

I understand if I default in paying my portion due, I will be responsible for any and all collection fees, legal cost and attorney fees.

I DO NOT HAVE ANY ADDITIONAL INSURANCE COVERAGE OTHER THAT WHAT I HAVE PROVIDED ABOVE. IT IS MY RESPONSIBILITY TO PROVIDE THIS OFFICE WITH ANY CHANGES OR UPDATES WHEN IT COMES TO MY MEDICAL COVERAGE. IF I DO NOT PROVIDE THE PROPER INFORMATION REGARDING MY COVERAGE, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANYTHING NOT COVERED BY MY INSURANCE COMPANY.

I understand and agree that the health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to pay directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND FULLY ACCEPT ALL OF ITS TERMS.

Patient's Signature: _____ Guardian's Sig: _____ Date: _____

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

PATIENT INFORMATION

Patient Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

I hereby authorize:

Atlantic County Family Spine & Rehab
506 South New York Road
Galloway, NJ 08205

REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to: Atlantic County Family Spine and Rehab Street Address: 506 South New York Road City: Galloway State: New Jersey Zip Code: 08205

Please indicate the information or types of information to be disclosed, including dates if necessary:

_____

_____

Specify dates (or date ranges) if applicable: _____

_____

This request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation should be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or on the following date: _____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information of genetics.

_____ _____

Signature of Patient or Authorized Representative Date:

ATLANTIC COUNTY FAMILY SPINE AND REHABILITATION CENTER, LLC

506 South New York Road, Galloway, NJ 08205 (609) 748-0222 Fax: (609) 748-0270

HIPAA Notice of Privacy Practices

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

The Health Insurance Portability and Accountability Act of 1996(HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse Protected Health Information (PHI).

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

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, 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, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health Issues required by law: Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings; Law Enforcement, Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity, Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when requited by the

Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

OTHER PERMITED AND REQUIRED USES AND DISCLOSURES will be made only with your consent, authorization or opportunity to object unless required by law.

YOU MAY REVOKE THIS AUTHORIZATION at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you will have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

_____ _____

Signed Dated

FOR OFFICE USE ONLY

☐ Patient Refused to Sign

☐ Patient Unable to Sign for the following reason _____