Capaldi Chiropractic

Dr. Kiara M. Capaldi, DC

PATIENT INTRODUCTION FORM

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____

Marital Status: M ___ S ___ D ___ W ___ Primary Care Doctor: _____

Occupation: _____ How were you referred to our office? _____

Have you had chiropractic care before? _____ Where? _____

INSURANCE:

Primary Insurance: _____

ID Number: _____ Group Number: _____

Insured Name (IF NOT THAN PATIENT): _____ Date of Birth: _____

Secondary Insurance: _____

ID Number: _____ Group Number: _____

Insured Name (IF NOT PATIENT): _____ Date of Birth: _____

IS INJURY WORKERS COMPENSATION: Yes _____ No _____ **Date of Injury** _____

Insurance Carrier: _____ Phone #: _____

Claim Number: _____ Adjustor: _____

IS INJURY RELATED TO AN AUTOMOBILE ACCIDENT: Yes _____ No _____ **Date of Accident** _____

Attorney Name: _____ Phone #: _____

I authorize Capaldi Chiropractic to release any and all medical information to my health insurance, workmen's compensation carrier and/or attorney in order for my services to be paid. I understand that I will be fully responsible for any services not paid in full by insurance or my attorney in the case of a motor vehicle accident. I understand that if I suspend, terminate or transfer my care and treatment all outstanding services will be paid in full before my medical records are released or transferred.

_____ _____

PATIENT'S SIGNATURE (PARENT/GUARDIAN IF MINOR) EMAIL

DATE: _____

HIPPA CONSENT/AUTHORIZATION

Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires our office to obtain a written patient consent before disclosing Protected Health Information (PHI). We respect the privacy of your health care information. Below is a list of circumstances in which we have to use or disclose your health information.

- We may have to disclose your health information to other healthcare providers or hospitals for assessment, diagnosis or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for payment of services. (ie: Insurance Co., Attorney, Third Party Liability)
- We may need to use your health information within our practice for quality control or other operations purposes.

Dr. Kiara Capaldi and her staff are authorized to use my name, address, phone number and clinical records to contact me via telephone or mail for the purpose of:

- Mailing you a "Thank You" letter for referring a patient with an enclosed gift certificate. Your name may be listed on our office newsletter.
- Mailing you a missed appointment card.
- Telephoning you at home or on your cell phone to remind you of an appointment. *A message may be left on the answering machine or with the person answering the phone.*
- Telephoning you at work if we need to reschedule an appointment due to inclement weather or office emergency.

You may restrict, refuse or revoke your authorization to us at any time, however revocation must be in writing and mailed to the office of Dr. Kiara Capaldi. If you do not give us authorization it will not affect the treatment we provide or insurance reimbursement.

This notice is effective as of December 1, 2015. This authorization will expire seven years after the date on which you last received services from us.

I authorize your to use or disclose my health information in the manner described above. I acknowledge that I have read the Notice of Privacy Practices and agree to it's terms. I understand that have the right to obtain a copy of the Notice of Privacy Practices upon request and recognize that there is a copy of said practices accessible at all times in the waiting room.

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. Necessary forms will be completed to file for insurance carrier payments.

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 the assignment is to be considered as valid as the original.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits, Personal Injury Protection (PIP), and Medical Payments coverage (MEDPAY), private insurance and any other health/medical plan, to issue payment check (s) to Capaldi Chiropractic for chiropractic services rendered to me and/or my dependents regardless of my insurance benefits, if any, ***I understand that I am responsible for any amount not covered by insurance.***

Printed Patient Name

Witness Signature

Patient Signature

Date

CAPALDI CHIROPRACTIC
PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ☐None ☐Light ☐Moderate ☐Strenuous

What is your height and weight? ____feet ____inches ____lbs.

For each of the conditions listed below, place a check in the PAST column if you had the condition in the past. If you presently have a condition listed below, place a check in the PRESENT column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pain	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Tobacco Use
						☐	☐	Alcohol Use
☐	☐	Shoulder Pain	☐	☐	Kidney Stones			
☐	☐	Elbow/Upper arm Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Systemic Lupus
			☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Hip/Upper leg Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Knee/Lower Leg Pain				☐	☐	HIV/AIDS
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Loss/Gain			
			☐	☐	Loss of Appetite			
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	**Females Only**		
			☐	☐	Ulcer	☐	☐	Birth Control Pills
☐	☐	Joint Swelling/Stiffness	☐	☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Liver Disorders	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis	☐	☐	Gall Bladder Disorders			
☐	☐	General Fatigue	☐	☐	Cancer	**Other Health Issues**		
☐	☐	Muscular Incoordination	☐	☐	Tumor	☐	☐	_____
☐	☐	Visual Disturbance	☐	☐	Asthma	☐	☐	_____
☐	☐	Dizziness	☐	☐	Chronic Sinusitis	☐	☐	_____

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Other_____

List all prescriptions and over-the-counter medications and nutritional/herbal supplements you are taking:

_____

_____

List any prior surgeries with their dates:

_____

SIGNATURE: _____ **DATE:** _____

NOTES: _____

_____

Graston Technique Questionnaire and Informed Consent

Please answer the following questions. Read the statements concerning Graston Technique and sign below. If you have any questions, please speak with your clinician.

1.	Do you bruise easily?	Yes	No
2.	Do you bleed for a long period of time after you cut yourself?	Yes	No
3.	Are you taking blood thinners or anticoagulants?	Yes	No
4.	Do you take aspirin on a regular basis?	Yes	No
5.	Do you take cortisone on a regular basis?	Yes	No
6.	Have you ever had inflamed veins or blood clots?	Yes	No
7.	Do you have surgical implants in your body?	Yes	No
8.	Do you have diabetes or kidney disease?	Yes	No
9.	Do you currently have any infections?	Yes	No
10.	Do you have uncontrolled high blood pressure	Yes	No

Graston Technique (GT) is an instrument assisted variation of traditional cross fiber or transverse friction massage. The GI instruments consist of six stainless steel tools of various sizes and contours. FT is a form of treatment used to "break up" of "soften" scar tissue, thus allowing for the return of normal function in the area being treated.

Graston Technique may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin
3. Superficial tissue bruising.
4. Post treatment soreness.

Graston Technique is designed to minimize discomfort: however the above reactions are normal and in some instances unavoidable.

Graston Technique has several basic components. Your clinician will determine the protocol for you.

1. Warm up the treatment area.
2. Graston Technique Instrument Assisted Soft-Tissue Manipulation.
3. High repetition, low load exercise.
4. One to three 30-second stretches.
5. Low repetition , high weight exercise
6. Ice therapy
7. Stretching / rehabilitation exercise.

All components of Graston Technique have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Print your name: _____ Date: _____

Signature: _____

CAPALDI CHIROPRACTIC

Informed Consent

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of joints with the doctor's hands. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated. Although spinal adjustments are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fracture/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chances as being struck by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Treatment Results: I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

Payment Agreement:
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Kiara M. Capaldi will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are to be 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 to me will be immediately due and payable. A monthly finance charge of 1.5 % will be added to any unpaid balance after 30 days.

Cancellation Policy:
As a courtesy to other clients, we request cancellation of an appointment at least 24 hours prior to the appointment time. Failure to cancel your appointment 24 hours prior will result in a $35 clinic fee.

I have read, or have had read to me, the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely to consent to treatment.

To attest to my consent to these procedures I hereby affix my signature to this authorization for treatment.

Patient's Signature	Date
Doctor's Signature	Date

Name_____ **Date of Birth**_____

Present complaint:_____

_____

_____

_____

When did the problem begin_____

Did your problem begin:

Immediately after a specific incident____ After multiple incidents____ Gradually developed over time___

No specific reason noted ____

Briefly describe how your problem began:_____

_____

_____

What makes your problem BETTER:

Lying down___ Sitting___ Standing___ Walking___ Movement/exercise___ Inactivity___ Nothing___

Other_____

What makes your problem WORSE:

Lying down___ Sitting___ Standing___ Walking___ Movement/exercise___ Inactivity___ Nothing___

Other_____

Please describe the character of your current pain:

Sharp/stabbing___ Sharp/Dull___ Gripping/Constricting___ throbbing/gnawing___ Aches___ Dull___

Soreness___ Weakness___ Numbness___ Shooting___ Burning___ Tingling___

How often are the complaints present?

Constant(76-100%)___ Frequent(51-75%)___ Occasional(26-50%)___ Intermittent(25% or less)___

Since your problem began, the pain has: increased___ decreased___ not changed___

How would you grade your overall stress level?

No stress____ minimal stress____ moderate stress____ greatly stressed___

Physical activity at work?

Sitting more than 50% of workday___ Light manual labor___ moderate manual labor___ heavy manual labor___

General physical activity:

No regular exercise program___ light exercise program___ strenuous exercise program___

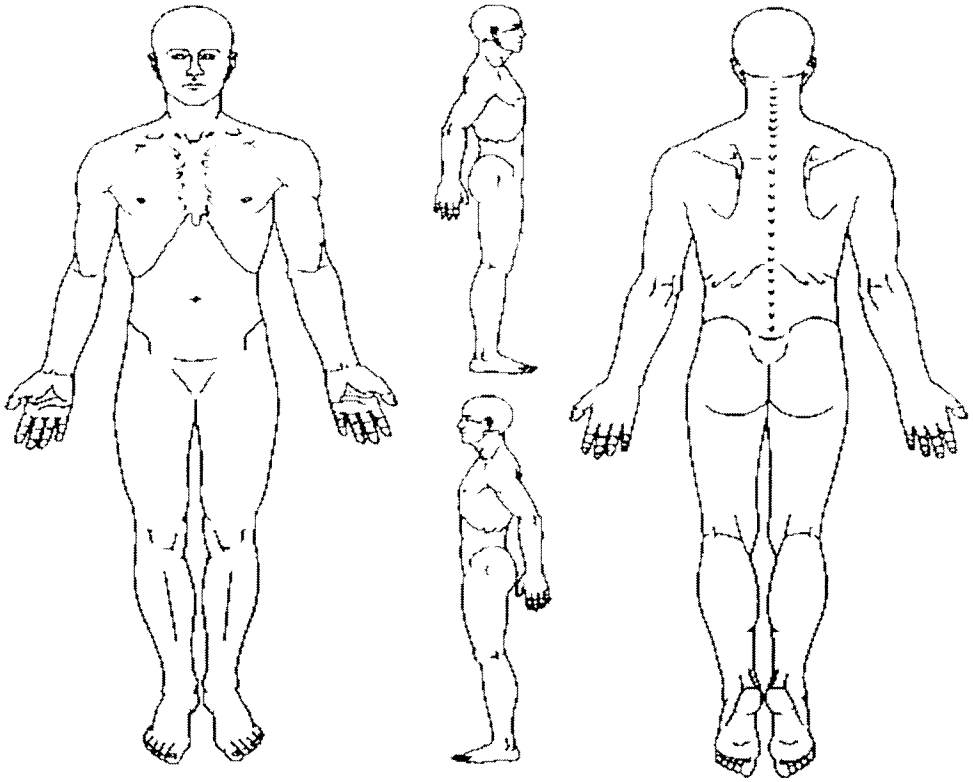
What treatment have you received for this present condition?

No treatment(professional or self treatment)___ medication(s) (L and OTC)_____

Physical therapy___ chiropractic___ injections___ surgery___ other:_____

Were you previously treated for this same condition before? No___ Yes___

If yes: MD___ Therapist___ Chiropractor___ Other:_____



Please rate your pain level at **this time**:

0 5 10

No pain Worst Pain

Patient's Signature:_____ Date:_____