Comprehensive Chiropractic & Rehab™

Name: _____ **Date of birth**: _____/_____/_____ **SSN**: _____

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

Home Phone: _____ **Cell**: _____ **Email**: _____

Gender: ☐ Male ☐ Female **Work Status:** ☐ Full ☐ Part ☐ Unemployed ☐ Retired **Student Status**: ☐ Full ☐ Part

Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partnership ☐ Widowed

OPTIONAL: Preferred Language:_____ ☐ Decline ☐ Blank

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White ☐ Decline ☐ Blank

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline ☐ Blank

Emergency Contact: _____ **Phone #**: _____ **Relation**: _____

Current Primary Care Physician/Practice: _____

MEDICAL HISTORY: Please indicate whether you have had or currently have any of the following:

☐ Heart Disease	☐ Chronic Lung Disease	☐ Diabetes	☐ Cancer	☐ Arthritis
☐ High Blood Pressure	☐ Hepatitis	☐ Asthma	☐ Stomach Problems	☐ Kidney Issues
☐ Muscular-skeletal	☐ Neurological/Seizures	☐ Psychological/Psychiatric Disorders		☐ Anemia

Are you currently pregnant? ☐ Yes ☐ No If yes, how far along are you? _____ Trimester _____ # of weeks

History of previous injuries, surgeries, hospitalizations, or motor vehicle accidents: _____

_____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

Have you had any spinal x-rays or MRIs in the past 5 years? ☐ Yes ☐ No When_____ Where _____
Previous chiropractic treatment? ☐ Yes ☐ No If yes, last date of treatment _____ By whom: _____

Do you do any of the following on a regular, daily basis: Exercise? ☐ Yes ☐ No _____ hours per week
Drink? ☐ Yes ☐ No _____ drinks per week **Smoke?** ☐ Yes ☐ No _____ # of years _____ # packs per day

Do you wear any of the following? Heal Lifts: ☐ Yes ☐ No Arch Supports: ☐ Yes ☐ No Prescription Orthotics: ☐ Yes ☐ No

How were you referred? ☐ Drive By/Walk-in ☐ Internet ☐ Health Insurance ☐ Referred by _____

What types of services are you interested in? ☐ Chiropractic Evaluation ☐ Adjustment ☐ Needleless Acupuncture
☐ Massage Therapy ☐ Cupping ☐ Personal Training ☐ Nutritional Counseling ☐ Durable Medical Equipment ☐ Custom Orthotics
☐ Alternative/Holistic Options ☐ Nutra Metrix Products ☐ Other_____

Motor Vehicle Accident Patient's Only

Date of Accident: _____ ***ER visit: ☐Yes ☐No Where:*** _____ ***Tests Performed: ☐Yes ☐No***

Did you hired an attorney: ☐Yes ☐No _____

Patient Signature: _____ Date: _____/_____/_____

Parent or Legal Guardian: Name: _____ Signature: _____

Doctor's Signature: _____ Date: _____/_____/_____

OFFICE USE:

Payer Type: ☐ Self-Pay ☐ Commercial Insurance ☐ Medicare ☐ Medicaid ☐ VACCN ☐ Auto ☐ LOP ☐ Workers Comp ☐ PI - Injury

Comprehensive Chiropractic & Rehab™

GENERAL AND FINANCIAL POLICY

By signing below, you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office staff of any address or telephone number changes.
- Your account is to be kept current. All self-pay or insurance copayments, co-insurance and deductibles will be collected at the time of service payable by cash, check, Visa, MasterCard, Discover, or American Express.
- If you do not have your payment (s), your appointment may be rescheduled.
- If you are unable to keep a scheduled appointment, please notify us 24 hours before your appointment so that we may offer that time to another patient. **There is a $40.00 charge for missing a scheduled appointment time, or giving less than 24 hours' notice, this includes massage appointments.**
- A return check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.
- There a $45.00 charge for the completion of paperwork (ex: disability, FMLA, etc)
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

IF YOU HAVE HEALTH INSURANCE COVERAGE: As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. **We must emphasize that as medical providers at Comprehensive Chiropractic and Rehab, our relationship is with you, not your insurance company.** Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of injury.

By signing below, you confirm you understand that:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service (s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- You are responsible for requesting a referral from your Primary Care doctor if your insurance policy requires one.
- If you are a **MEDICARE PATIENT,** please be advised that Medicare and Medicare Advantage Plans **only cover** Spinal Adjustments in a Chiropractor's office. All services outside of the Spinal Adjustment in our office will be your financial responsibility. As a patient, you are responsible for payment of the yearly Medicare deductible.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

I understand that services rendered by a licensed massage therapist in our office, are NOT reimbursed by insurances and that the office does not provide or fill out forms for insurance purposes. I agree I will be solely responsible for payment of these services at the time the service is provided.

By signing below, you have read and understand the above Financial Policy and agree to meet all financial obligations for services performed at Comprehensive Chiropractic and Rehab, Inc.

CONSENT TO TREATMENT: I hereby authorize and give consent for Dr Wai Wen "Michael" Cheng, and all associate staff to examine and treat me, this includes services that are covered by my health insurance policy and those that are not covered, it is my decision as a patient if I want to have those services performed at an out of pocket expense.

_____	X _____	_____
Printed Patient's Name	**Signature of Patient/Legal Guardian**	**Date**

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for Dr Wai Wen "Michael" Cheng, and all associate staff to examine and treat my child appropriately, this includes services that are covered by my health insurance policy and those that are not covered, and if needed, treat my minor child _____ (child's name).

_____	_____	_____
Printed Name Legal Guardian	**Signature of Legal Guardian**	**Date**

REVISED: 6/11/2018; 9/9/2020; 10/18/2020

Comprehensive Chiropractic & Rehab™

NOTICE OF PRIVACY PRACTICES

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We use your Patient Health Information We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacies who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that me be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent.
Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any further uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using post cards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting are and in each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Suman Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Comprehensive Chiropractic and Rehab, Inc
Attn: Office Manager
1422 Easton Road
Abington, PA 19001
215-443-5626

Effective Date: April 14, 2003

I, _____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:X
_____

Date: _____

Acknowledgment from Parent or Guardian of a minor (under the age of 18)

Parent/Guardian's Name:
_____

Signature:X
_____

Date: _____

Comprehensive Chiropractic & Rehab™

Appointment Cancellation Policy

Your health and the health of all our clients matter to us. To ensure that all our clients are treated fairly and are able to receive treatment in a timely manner, Comprehensive Chiropractic and Rehab asks that you provide at least 24-hours' notice if you need to change, reschedule or cancel your appointment. If you change or reschedule your appointment without providing us with 24-hours advance notice or fail to keep your appointment (if you are a no-show) you will be charged a fee of $40. This fee must be paid before another appointment is scheduled.

Contact our office via phone or text at 215-443-5626 or via email at scheduling@drmikecheng.com

In the event of an emergency, please contact the office manager. They will make a final determination in regards to your situation.

Comprehensive Chiropractic and Rehab reserves the right to refuse services at anytime and without notice.

Massage Services policy additions

In addition to the above policy guidelines please make note of the following regarding massage appointments:

1. *Late Arrivals: All those arriving late for a scheduled massage appointment, understand that you may still be able to see the therapist, but your time will be shortened to accommodate those whose appointments follow yours. Depending on how late you arrive, the therapist will determine if there is enough time remaining to start treatment. Regardless of the length of the treatment given, you will be responsible for the "full" session. Out of respect and consideration to your therapist and other patients, please plan accordingly and be on time.*
2. *Packages: If you have purchased a massage package, all appointments that are considered a "no show" or are cancelled without the 24-hour notice will be charged the standard fee. Your account will have massage time deducted from the balance available on your package purchase instead of being billed a separate invoice.*

By checking the following boxes and signing below, I acknowledge the following:

____ *I have received and understand Comprehensive Chiropractic and Rehab's cancellation and rescheduling policy.*

____ *I agree that I will be responsible for paying a fee of $40 in the event that I fail to provide Comprehensive Chiropractic and Rehab with at least 24-hours' notice before changing or canceling my appointment.*

____ *I agree that I will notify the office if I am not able to attend a scheduled therapy rather than opting to just not come in and be considered a "no show."*

Patient's Name _____ *Date of Birth* _____

Patient's Signature _____ *Date*_____ ____ *Yes, please copy* ____ *No copy*

If patient is a minor and under the age of 18, signature is required by parent or legal guardian:

Parent/Legal Guardian's Name _____ *Signature* _____

Relationship to patient _____ *Date* _____ ____ *Yes, please copy* ____ *No copy*

Revised 7/28/2017, 5/18/2018, 11/26/2021, 8/28/2023; 12/15/2023

Comprehensive Chiropractic & Rehab™

WORKERS COMP INJURY QUESTIONAIRE

Name: _____ **Date of Injury**: _____ **Time:**_____

Place of Employment: _____ **City**: _____ **State**: _____

Working conditions at the time of injury: _____

Was the incident reported to your supervisor immediately ☐ YES ☐ NO **Name of Supervisor:**_____

Hospital ER Visit: ☐YES ☐NO **Where:** _____ **When**: ☐ IMMEDIATELY ☐ NEXT DAY

Position at time of injury: _____ ☐ Full-time ☐ Part-time ☐Temporary

What type of work do you do? _____ **Are you still employed by the same company now?** ☐YES ☐NO

After the injury occurred, how did you feel? _____

Did you finish the remainder of your shift: ☐ YES ☐NO ☐ HOURS WORKED TOTAL THAT DAY_____

Has this type of injury occurred before? ☐YES ☐NO If yes, when? _____

What type of response did your place of employment give when you informed them of the injury:

_____

Describe what happened: _____

_____

_____

Current Complaints: _____

_____

_____

Rating of your pain

On a scale of 1 to 10, with 1 being the least pain and 10 being the worst pain ever, tell us what was your pain rating was

at the time of injury _____ **and currently what is it** _____

At the time of the injury, did you fall? ☐ YES ☐ NO **Did you hit any part or area of your body** ☐ YES ☐ NO

Did anything stop or break your fall? ☐ YES ☐ NO **If yes, what did** _____

Did the injury occur on one side of your body more so then the other? ☐ LEFT SIDE ☐RIGHT SIDE ☐FRONT ☐BACK

Have you had treatment since the injury? ☐YES ☐NO **If yes, what kind of treatment and where?** _____

_____

What are the current medications that you are taking? Check if recently added since the injury or as a result of the injury?

☐ _____ ☐ _____ ☐ _____

☐ _____ ☐ _____ ☐ _____

Allergies? ☐YES ☐NO If yes, please list them _____

_____

Signature of person completing this form:_____ Relation to patient:_____ Date:_____

Chiropractor's signature after review completed:_____ Date:_____