Comprehensive Chiropractic & Rehab™

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

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

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

Preferred method for appt reminders: ☐ EMAIL ☐ TEXT, if text messages, who is your service provider? _____

Gender Identity: ☐ Male ☐ Female **Work Status:** ☐ Full ☐ Part ☐ Retired **Student Status**: ☐ Full ☐ Part ☐ N/A

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

OPTIONAL QUESTIONS: 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

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

_____

Family History of illness: _____

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, includes activities: _____
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 ☐ Business Referral _____ ☐ Referred by _____

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

Reason for today's visit: _____

Patient Signature: _____ Date: _____/_____/_____

Doctor Signature: _____ Date: _____/_____/_____

OFFICE USE:

Payer Type: ☐ Self-Pay ☐ Private Health Insurance ☐ Medicare ☐ Auto ☐ Workers Comp ☐ Personal Injury ☐ LOP

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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.

_____	_____	_____
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

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:
_____

Date:
_____

If not signed, reason why acknowledgement was not obtained:
_____

_____

_____

Comprehensive Chiropractic & Rehab™

MOTOR VEHICLE ACCIDENT QUESTIONAIRE

Name: _____ Date of Accident: _____

Intersection: _____ **City**: _____ **State**: _____

Weather conditions: _____ **Police/EMT**: ☐ YES ☐ NO

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

Role during the accident: ☐ DRIVER ☐ PASSENGER (☐ FRONTSEAT ☐ BACKSEAT) ☐ PEDESTRAIN

What type of vehicle were you driving or a passenger in? _____

What type of vehicle was the car involved? _____

After the accident, where you: ☐ CONSCIOUS ☐ DAZED ☐ UNCONSCIOUS

Were you shocked or surprised when the accident occurred? ☐ Yes ☐ No

How fast was the vehicle you were in going: _____mph **Other vehicle: _____mph**

What happened: _____

_____

_____

Current Complaints: _____

_____

_____

Rating of your pain: _____

At the time of the accident, how were you facing? ☐ STRAIGH AHEAD ☐ RIGHT ☐ LEFT ☐ DOWN ☐ UP

Did the airbags deploy? ☐ YES ☐ NO

Where was the impact on the car? ☐ FRONT ☐ REAR ☐ LEFT SIDE ☐ RIGHT SIDE

Were your brakes applied? ☐ YES ☐ NO

Were you shoved at the time of impact? ☐ YES ☐ NO **If yes**, ☐ FORWARD ☐ BACKWARD ☐ SIDEWAYS

What part of your body hit the interior of the vehicle? _____

What part of the vehicle did your body hit? _____

Did you embrace for the impact? ☐ YES ☐ NO

How much damage was there to your vehicle? _____

Is your vehicle totaled? ☐ YES ☐ NO

Right after the accident, what did you feel or experience? _____

Have you had treatment since the accident? ☐ YES ☐ NO **If yes, with who?** _____

What medications are you currently on? _____

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

***For additional medical information, including history, diagnosis, surgeries, please see the New Patient Intake form.**

Doctor's Signature: _____ **Date:** _____