Confidential Patient Case History

Please print. Thank you!

NAME_____DATE_____DOB_____AGE_____SEX_____
ADDRESS_____CITY_____STATE_____ZIP_____
HOME #_____WORK#_____CELL #_____SS#_____
MARITAL STATUS_____SPOUSE_____NO. CHILDREN_____OCCUPATION_____
FAMILY DOCTOR &LOCATION_____REFERRED BY_____

Insurance Information

Primary Insurance: Name of Company_____Name of Insured_____
Address of Insured (if different) _____DOB of Insured (if different)_____
SS# of Insured_____ _____Relation to you_____
Secondary Insurance: Name of Company_____Name of Insured_____
Address of Insured (if different) _____DOB of Insured (if different)_____
SS# of Insured_____ _____Relation to you_____

What is your major complaint? _____
How long have you had this condition_____Have you had this or similar conditions in the past?_____

VAS pain scale Please circle how you feel today

←-least—1———2———3———4———5———6———7———8———9———10—worse→

What activities aggravate your conditions?_____
Is the condition getting worse? Y N How long has it been since you really felt good?_____
Is this condition interfering with: ☐ work ☐ sleep ☐ daily routine Age of Mattress_____
List previous diagnoses & treatments you have received for present condition_____
Please list any previous: Surgeries _____
Hospitalizations_____
Illnesses_____
Traumas (including motor vehicle accidents)_____
Allergies (food or drug)_____
FAMILY PAST AND PRESENT HEALTH PROBLEMS
Mother_____
Father_____

HAVE YOU EVER:	HABITS:	Heavy	Moderate	Light	None
Been knocked unconscious? Yes ☐ No ☐	Exercise	☐	☐	☐	☐
Been treated for a spine or nerve disorder? Yes ☐ No ☐	Alcohol	☐	☐	☐	☐
Had a fractured bone? Yes ☐ No ☐	Coffee	☐	☐	☐	☐
	Tobacco	☐	☐	☐	☐

DATE OF LAST (in months) **Review of Systems**
Blood Test_____ Urine Test_____
Physical Examination_____ Spine X-Ray_____
Chest X-Ray_____ MRI/CAT Scan_____

Please check if any of the following pertain to you:

General		**Muscle & Joint**		**Gastro-Intestinal**		**Eyes, Ears, Nose & Throat**	
Allergy	☐	Arthritis	☐	Colitis	☐	Asthma	☐
Chills	☐	Foot trouble	☐	Constipation	☐	Colds	☐
Convulsions	☐	Hernia	☐	Diarrhea	☐	Earache	☐
Fainting	☐	Low back pain	☐	Distension of abdomen	☐	Enlarged thyroid	☐
Fatigue	☐	Neck Pain or stiffness	☐	Gall bladder trouble	☐	Eye pain	☐
Headache	☐	Pain or numbness	☐	Liver trouble	☐	Sinus problems	☐
Nervousness	☐	Painful tailbone	☐	Nausea	☐		
Depression	☐	Poor posture	☐	Pain over stomach	☐	**Genito-Urinary**	
Neuralgia	☐	Sciatica	☐			Blood in urine	☐
Numbness	☐	Spinal curvature	☐	**For Women Only:**		Frequent urination	☐
		Swollen joints	☐	Painful Menstruation	☐	Kidney infection or stones	☐

ARE YOU HIV/AIDS POSITIVE? YES ☐ NO ☐ ARE YOU PREGNANT? YES ☐ NO ☐

Have you ever had previous chiropractic care? _____If yes, date of last care & doctor_____
IN CASE OF EMERGENCY (Name of relative or close friend not living in your home):
NAME_____PHONE_____
ADDRESS_____

WEST PARK CHIROPRACTIC CENTER

PAYMENT AGREEMENT

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic care at our office, and you may choose the plan which best suits your needs. Please read carefully, and choose the plan that you prefer. This information will enable us to better serve you and help us to avoid misunderstandings in the future. Our main concern is your health and well being, and we will do our best to help you.

PLAN # 1 – INSURANCE: If you have insurance, which covers Chiropractic care, we will bill your insurance company directly. *You will be responsible to pay any deductible or copay as required by your insurance company.* Please bring in either a completed insurance claim form or your insurance card, on or before your second visit. Until we have either the completed form or a copy of your insurance card, and we can therefore verify your insurance coverage, you will be required to pay for your care in full. If we do not receive this information within 2 days of your first visit, we will provide you with the forms so that you may bill insurance directly. In the event that an insurance check for your care should be mailed to you, you are expected to bring the check to our office. If you would like to submit your own claims, please let us know.

About billing: Payment is expected at the time of your first visit and we ask that you pay your deductible and co-payments at the front desk as you are treated. We will mail a quarterly statement (Jan./Apr./June/Sept.) of your account detailing charges, payments and adjustments. A final bill will be mailed once you have completed treatment and all expected insurance payments have been received.

PLAN # 2 – CASH: Fees are paid to us at the time services are rendered, unless special arrangements have been made in advance. Please speak with your doctor about any financial concerns you may have.

PLAN # 3 – INDUSTRIAL: You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

PLAN # 4 – AUTO INJURY: Please supply us with a copy of the accident report, your car insurance declarations page (explanation of benefits), and your health insurance information. Once we have verified insurance coverage, we will submit billing directly to your insurance company. In the event that the check should come to you, you are expected to bring it in to our office.

I understand and qualify for Plan # ____ requirements. I agree to the terms described herein.

Printed Name: _____

Signature: _____

Insurance Assignment Policy Statement

You have selected "Insurance Assignment" as the method of choice to take care of your financial obligation with this office. It is important that you realize that in this office we offer the option of "Insurance Assignment" strictly as a courtesy to our patients, and as such our patients must understand and agree to the following:

1. That you are considered a cash patient until you bring in completed insurance forms and this office qualifies and accepts your coverage.
2. That you are ultimately responsible for full payment of any and all services rendered.
3. That you must pay all deductibles in full.
4. That co-insurance must be paid at the time of service or at the end of each and every week.
5. That if your carrier has not paid a claim within 60 days of submission, you are responsible to take an active role in the recovery of your claim and that after 90 days you will be responsible for payment in full on any outstanding balance.
6. That in the event you discontinue your program of care prior to the Doctor's consent, you are responsible for payment in full of any outstanding balance and the courtesy of insurance assignment is immediately discontinued.

This insurance assignment policy must be followed and we ask that you sign this form as an acknowledgement that our policy was explained to you, that you understand and accept full responsibility.

Signature:_____ **Date:**_____ **Witness**____

West Park Chiropractic Center, L.L.C.

LEADERS IN ALTERNATIVE HEALTHCARE

Dr. David J. Fisher
Dr. Glenn A. Grieco

Letter of Consent for Treatment

I, _____, consent to be treated by West Park Chiropractic Center, L.L.C. I hereby authorize Dr. David J. Fisher, Dr. Glenn A. Grieco, and any covering licensed New Jersey chiropractor to perform chiropractic manipulations and/or adjunctive therapy upon me, the patient. I fully understand that I will be given a comprehensive physical, neurologic, and orthopedic examination prior to any treatment. Before said treatment is performed, the attending doctor will render a primary diagnosis and explain other treatment options available including and not limited to not treating at all, physical therapy, orthopedic care, and pain management. In addition, the attending doctor will go over contraindications to spinal manipulations and any potential risks. Please be advised that all forms of treatment come with some degree of risk. Please be advised that cervical manipulation has been linked to stroke and the incidence has been shown to be 1 in 1 million. The doctor is trained to look for contraindications and will treat accordingly to the most current safe guidelines and protocols. As the patient, I fully understand the potential risks to spinal manipulations and consent to be treated by West Park Chiropractic Center, L.L.C.

_____
Patient Signature

_____
Date

780 WEST PARK AVENUE OAKHURST, NJ 07755 (732) 517-1090 FAX (732) 517-1096

HIPAA Compliance

NOTICE OF PRIVACY PRACTICES

West Park Chiropractic Center, LLC (Practice), in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (Privacy Rule) and applicable state law, is committed to maintaining the privacy of your protected health information (PHI). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be disclosed to third parties. This Notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSURE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization may use and disclose your PHI for the purpose of:

(a) **Treatment**- To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care.

(b) **Payment**- To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care.

(c) **Health Care Operations**- To operate in accordance with applicable law and insurance requirements and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI.

(d) **Advice of Appointment and Services**- The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

(e) **Directory/ Sign- In Log**- The Practice maintains a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

(f) **Family/ Friends**- The Practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(i) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(ii) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

The Practice may also use and disclose your PHI, without your consent or authorization in the following instances:

a) De-identified Information, b) Business Associate, c) Personal Representative, d) Emergency Situations, e) Public Health Activities, f) Abuse, Neglect or Domestic Violence, g) Health Oversight Activities, h) Judicial and Administrative Proceeding, i) Law Enforcement Purposes, j) Avert a Threat to Health or Safety, k) Workers' Compensation, l) National Security and Intelligence Activities, m) Military and Veterans

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

You have the right to:

(a) Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a

written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclose, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information". You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by federal law (including Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request, but you will have to right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by federal law (including Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your requests before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer.

(h) Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) May be required by State law to maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation

(f) Will not retaliate against you for filing a complaint.

This notice is in effect as of 4/15/03.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____

Patient Name

_____

Date