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)

Blood Test_____
Physical Examination_____
Chest X-Ray_____
Urine Test_____
Spine X-Ray_____
MRI/CAT Scan_____

Review of Systems

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_____

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 Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.