OPTIMUM HEALTH THROUGH CHIROPRACTIC CARE

Patient Information

Thank you for choosing our practice for your chiropractice needs. Please complete this form in ink. If you have any questions or concerns, do not hesistate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS/HIC/Patient ID# _____

First Middle Initital Last

Address_____ City _____ State ____ Zip _____

Sex: ☐ Female ☐ Male Birthdate _____ E-mail _____

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Do you prefer to recieve calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Seperated ☐ Divorced ☐ Partnered for ___ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State ____ Zip _____

Spouse or Parent's Name_____ Employer _____ Work Phone (___)_____

Whom may we thank for referring us? _____

Person to contact in case of emergency _____ Phone (___)_____

Responsible Party

Name of person responsible for this account _____

Relationship to patient _____ Phone (____)_____

Address _____ City_____ State_____ Zip_____

Name of employer _____ Work Phone (_____)_____

Insurance Information

Name of insured _____ Relationship to Patient _____

Birthdate_____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone (____)_____

Address _____ City_____ State_____ Zip_____

Insurance Co. _____ Phone (___)_____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit?_____

DO YOU HAVE ADDITIONAL INSURANCE ☐ NO ☐ YES IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to Patient _____

CONFIDENTIAL

Birthdate_____ Social Security # _____ Date Employed _____
Name of Employer _____ Work Phone (____)_____
Address _____ City_____ State_____ Zip_____
Insurance Co. _____ Phone (___)_____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit?_____

Symptoms

Reason for visit _____ When did you first notice the symptoms _____
Is this condition getting progressively worse? _____
Where specifically is the problem(s) located? _____
Which activites are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other
Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
Rate the severity of your pain. (1,mild pain or discomfort, to 10, severe pain) 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
What treatment have you already recieved for your condition?
☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other_____
Name and address of other doctor(s) who have treated you for your condition:
_____

Health History

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Bulimia	☐ Goiter	☐ Migraines Headaches	☐ Prosthesis	☐ Typhoid Fever
☐ Alcoholism	☐ Cancer	☐ Gout	☐ Miscarriage	☐ Prostate Problems	☐ Ulcers
☐ Allergy Shots	☐ Cataracts	☐ Heart Disease	☐ Mononucleosis	☐ Rheumatoid Arthtitis	☐ Vaginal Infections
☐ Anemia	☐ Chemical Dependency	☐ Hepatitis	☐ Multiple Sclerosis	☐ Rheumatic Fever	☐ Venereal Disease
☐ Anorexia	☐ Chicken Pox	☐ Hemia	☐ Mumps	☐ Scarlet Fever	☐ Whooping Cough
☐ Appendicits	☐ Depression	☐ Herniated Disc	☐ Osteoporosis	☐ Stroke	☐ Other _____
☐ Arthritis	☐ Diabetes	☐ Herpes	☐ Pacemaker	☐ Suicide Attempt	_____
☐ Asthma	☐ Emphysema	☐ High Cholsesterol	☐ Parkinson's Disease	☐ Thyroid Problems	_____
☐ Bleeding Disorders	☐ Epilepsy	☐ Kidney Disease	☐ Pinched Nerve	☐ Tonsilitis	_____
☐ Breast Lump	☐ Fractures	☐ Liver Disease	☐ Pnuemonia	☐ Tuberculosis	
☐ Bronchitis	☐ Glaucoma	☐ Measles	☐ Polio	☐ Tumors/Growths	

Date of last exams _____
(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No
List any type of surgeries which you have had and the dates in which they occured:
_____
Please list any medications you are currently taking: _____
Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? (ex. sitting, standing, light labor, heavy labor, computer)

_____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any?) _____

Do you smoke? ☐ No ☐ Yes ☐ How much per day? _____

How much liquor do you consumer on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependant(s) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my signature on all insurance submissions.

The above-named doctor may use health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative | Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient

ASSIGNMENT AND INSTRUCTTIONS FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Garden State Chiropractic Center, L.L.C.
711 Tennent Road
Manalapan, New Jersey 07726

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

See Above Address

The profressional or medical expense benfits allowable, and otherwise payable to me under my current insruance policy as payment toward the total charges for professional services rendered.
THIS IS A DIRECT ASSIGMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned asignee, and I have agreed to pay, in a current manner, any balance of said profressional services charges over and above this insurance payment. I understand the above doctor has a financial interest in any diagnostic testing.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any Insurance Company, adjuster, or attorney involved in this case.

Dated this _____ day of _____ 20_____

_____ Signature of policyholder

_____ Signature of claimant, if other than policyholder

_____

By signing above, the co-payment/deductible of my Chiropractic Treatment would be a financial hardship on me

GARDEN STATE CHIROPRACTIC, L.L.C.

DR. WAYNE F. KREIGER
DR. NICHOLAS C. KREIGER
DR. JANET MANZONI

711 Tennent Road
Manalapan, NJ 07726
Telephone: (732) 972 - 1080
Fax: (732) 972 - 0866

Patient Name: _____ Date:_____

Patient Date of Birth: _____

Preffered Language: __ Dutch __ English __ French Canadian __ German __ Greek __ Italian
__ Japanese __ Portugese __ Russian __ Spanish

Race: __ American Indian or Alaskin Native __ Asian __ Black or African American
__ Native Hawaiin or Pacific Islander __ White

Smoking status for 13 years and up: __ Current everyday smoker __ Current some-days smoker
__ Former Smoker __ Never smoked
__ Current smoker, status unknown __ unknown

Ethnicity: __ Hispanic or Latino __ Not Hispanic or Latino

Allergies to any medications and corresponding reactions (please list, if any): _____

_____

_____

List all medications you are currently taking and corresponding dosages if known: _____

_____

_____

Patient Siganture: _____ Date: _____

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S NOTICE OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Patient's Notice of Privacy Rights, provided on my behalf and in accordance with the law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice:

_____

Affirmed,

_____
Patient Name

_____
Date

Patient's Notice of Privacy Rights

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on hte use and release of health records, establish appropriate safeguards that health care providers and others must achievr to protect the privacy of Personal Health Information and to hold violators accountable with appropriate penalties for violation of a patient's right to privacy.

AS A PATIENT OF THIS PRACTICE:
1. You are entitles to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.

2. You are entitled to see your medical records

3. You are entitled to receive a copy of your medical records (forms are available upn request). As per allowance by HIPAA the charge will be _____ per page.

4. You are entitled to make an amendment to your patient health information within those records (forms are available upon request).

5. While the doctor has a right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records (forms are available upon request). If the doctor disagrees, he shall supply you with written notification of such disagreement.

6. The doctor has a righ to rebuttal to the patient's disagreement. But any time a file is sent out of the office. a copy of the rebuttal must be included in the file.

7. You have the right to specify how access to your health information is restricted and from whom.

8. You have the right to indicate the method, phone numbers, and addresses to which telephonic and written communications to you shall be sent.

9. All covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPAA privacy rule and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable Business Associate Agreements whenever applicable with those parties. This means those

parties are bound to maintain the same privacy and security of your information, as are we.

10. No personal health information shall be given out to any entity not related to your treatment and billing of medical services rendered, without your written authoritzation, except as covered under applicable law. you have a right to receive upon request an accounting of any disclosure of personal health information not made for treatment, reimbursement or administrative pruposes as described above, or otherwise excepted by law.

11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.

12. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf) so as to maintain the intent of HIPAA in establishing that standard.

13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.

14. You have the right to contac the Department of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint, toll free: 1-877-696-6775 or E-Mail: www.hhs/gov/ocr