New Patient Exam

Advanced Chiropractic Center
Dr. Giuseppe Romano, D.C.

Today Date: _____

PATIENT INFORMTION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail: _____

Sex: ☐ Male ☐ Female

Height: ____ Ft ____In Weight: ____lbs

Marital Status: _____

Social Security #: _____

Date Of Birth: _____

Occupation: _____

Employer/School: _____

Notify In Case of Emergency: _____

Phone #:_____

Relationship To Patient: _____

Whom May We Thank For Referring You?: _____

_____

INSURANCE INFORMATION

Insurance Carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____

Policy #: _____

Effective Date: _____

Policyholder's Name: _____

Relationship to Patient: _____

ACCIDENT INFORMTION

Is Condition Due To An Accident? : ☐ Yes ☐ No

Type Of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Date Of Accident: _____

To Whom Have You Reported This Accident?

☐ Auto Insurance ☐ Worker Compensation

☐ Employer ☐ Other: _____

ATTORNEY INFORMTION (if applicable)

Attorney Name: _____

Address: _____

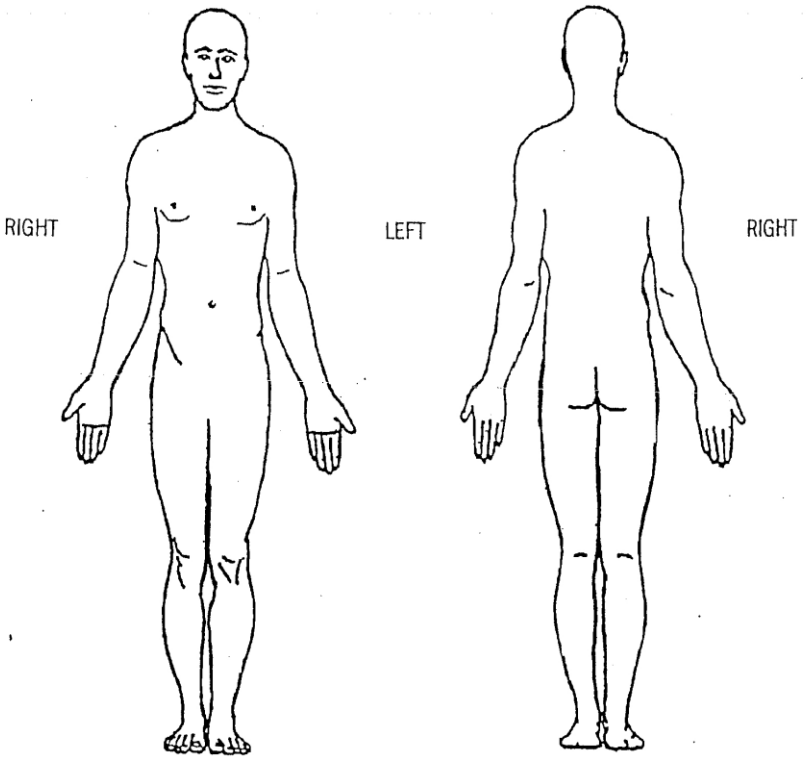
City: _____ State: _____ Zip: _____

Telephone #: _____

Name: _____ Date of Birth: _____

Age: _____ ☐ Right Handed ☐ Left Handed

/// STABBING XXX BURNING *** TINGLING OOO NUMBNESS +++ ACHING



Pain Level 0 1 2 3 4 5 6 7 8 9 10

NONE MOD SEVERE

1. Reason For Visit: _____
2. Date Of Onset Of Symptoms Or Injury: ____/____/____
3. Associated Signs And Symptoms: _____
   _____
4. Please Describe Your Pain: ☐ Aching ☐ Burning ☐ Dull ☐ Numbness ☐ Sharp ☐ Stabbing ☐ Tingling
5. Any Recent Injuries/Surgeries: _____
   _____
6. Have You Seen Any Doctors For This Conditions?: ☐ Yes ☐ No

7. Is Your Pain: □ Constant □ Intermittent
8. A: What Make Your Pain Worse?: _____
   B: What Make The Pain Better?: _____
9. A: What Treatment Have You Had For This Condition?:
   □ Medications □ Surgery □ Physical Therapy □Other: _____
   B: Name and Address of other doctor(s) who have treated you for your condition: _____
   _____
10. Are Your Symptom: □ Better □ Worst □ The Same Since Onset
11. Had any other Neck, Back, or Joint Injuries In The Past: □ Yes □ No Describe: _____
    _____
12. Previous Health History: _____
    _____
13. Previous Surgeries: _____
    _____
14. Allergies: _____
    _____
15. Medications: _____
    _____
16. Family History:_____
    _____
17. Social History: Do You Use Alcohol?: □ Yes □ No How Much? _____
    Do You Use Tobacco? □ Yes □ No How Much? _____
    Do You Use Recreational Drugs? □ Yes □ No If So Explain? _____
    Occupation: _____ □ Full Time □ Part Time
    □Unemployed Date Last Worked: ____/____/____
18. Place A Mark To Indicate If You Have Any Of The Following:

□ Are You Pregnant?	□ Hypertension	□ Pain when Urinating	□ Seizures
□Chills	□ Palpitations	□ Increase Urination	□ Tremors
□ Fevers	□ Cough	□ Urinary Retention	□ Depression
□ Headache	□ Shortness of Breath	□ Hay Fever	□ Suicide
□ Weight Loss	□ Wheezing	□ Joint Pain	□ Excessive Thirst
□ Blurry Vision	□ Abdominal Pain	□ Boils	□ Too Hot or Cold
□ Double Vision	□ Diarrhea	□ Swollen Glands	□ Too Tired or Sluggish
□ Ear Infection	□ Constipation	□ Itching	□ Blood Colts
□ Sore Throat	□ Nausea	□ Skin Rash	□ Ring In The Ears
□ Sinus Problems	□ Vomiting	□ Dizziness	□ Chest pain

   □ Other(s): _____
19. Diagnostic Studies:
    □ X-Ray (s) □ MRI(s) □ CT Scan(s) □ Lab(s) □Other(s) _____
    Where: _____

Please Initial Each Line & Sign Below:

_____ **PATIENT MEDICAL HISTORY FORM:** I have completed this form & carefully reviewed its contents. I attest to the accuracy & correctness of the information

_____ **OFFICE POLICIES:** Our office is a zero balance office. All services including co-payment must be paid for at the time of service at the time of service unless other arrangements have been made.

All missed appointments must be made up according to your care plan.

Please call 24 hours in advance if you need to reschedule your appointment.

_____ **ASSIGNNMENT OF BENEFIT/HIPPA GUIDELINES :** I certify that, I, and/or dependent(s) have insurance coverage with _____ and assigned directly to Advanced Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

The aboved-named facility may use my 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 or the benefits payable for related services

I am aware that Advanced Chiropractic Center will abide by the HIPAA regulations for the purpose of keeping my records confidential and only upon my written consent will my records be allowed to leave advanced Chiropractic Center.

_____ **FINANCIAL RESPONSIBILITY:** I have requested professional services from Advanced Chiropractic Center on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in the full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

_____ **ASSIGNMENT OF INSURANCE BENEFITS :** I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan

(or its administrator) to provide documentation starting such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check(s) to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to endure that my bills for profession services from Provider are paid in full.

_____ **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Provider to (1) release any information necessary to my health benefits plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

_____ **ERISA AUTHORIZATION :** I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claims, right or cause of action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. €2560.5031(b) (4) with respect to any healthcare expense incurred as a result of the services I received from Providers and the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. Furthermore, the Provider shall have every right and I hereby authorize the Provider to request a Summary Plan Description (SPD) on my behalf.

Patient or Guardian Signature: _____ Date: ____/_____/_____

Advanced Chiropractic Center of Woodbridge, INC
1030 St George Ave #202
Avenel, NJ 07001

ASSIGNMENT OF BENEFITS

PATIENT NAME: _____

- I IRREVOCABLY ASSIGN TO **A.C.C**. ALL OF MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY **A.C.C.**
- I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIM BY **A.C.C** TO BE RELEASED TO **A.C.C.**
- I IRREVOCABLY AUTHORIZE **A.C.C** TO FILE ACT ON MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.
- I IRREVOCABLY AUTHORIZE **A.C.C** TO OBTAIN COUNCIL AND ENTER LEGAL OR OTHER ACTIONS ON MY BEHALF AND/OR IN MY NAME, INCLUDING THE ARBITRATION/DISPUTE RESOLUTION PROCESS, TO COLLECT SUCH SUMS DUE IT SHOULD SUMS NOT BE PAID WITHIN THE LEGALLY PRESCRIBED TIME FRAME. IN THE EVENT THAT **A.C.C** ELECT TO BRING A LAWSUIT OR PETITION FOR ARBITRATION/DISPUTE RESOLUTIONS AGAINST THE INSURANCE CARRIER.
- I IRREVOCABLY ASSIGN MY RIGHTS TITLE, AND INTEREST UNDER THE MEDICAL EXPENSE BENEFITS AND/OR PIP SECTION OF ANY INSURANCE POLICY UNDER WHICH I AM ENTITLED TO PROCEED FOR BENEFITS, THIS ASSIGNMENT SHALL SUIT OR SUBMIT TO ARBITRATIONS/DISPUTE RESOLUTION THEIR CLAIM FOR ANY UNPAID BILLS FOR SERVICES RENDERED FROM INJURIES THAT I SUSTAINED IN THIS OR ANY ACCIDENT.
- IN THE EVENT THAT THIS ASSIGNMENT IS HELD INVALID FOR ANY REASON, I HEREBY AUTHORIZE **A.C.C** TO APPOINT AN ATTTORNEY OF ITS CHOICE TO REPRESENT ME DIRECTLY AGAINST ANY INSURER FROM WHICH I MAY COLLECT PIP BENEFITS AND TO BRING A CLAIM IN A FORUM OF ITS CHOICE. THIS APPOINTMENT IS INTENDED ON ENABLING THE ATTORNEY TO COLLECT BILLS OF **A.C.C.**

- **THE UNDERSIGNED PATIENT DOES HEREBY AGREE AND ACKNOWLEDGE THAT HE/SHE MAY RECEIVE BENEFIT CHECKS DIRECTLY FROM THE INSURANCE CARRIER FOR SERVICES RENDERED BY THE PROVIDER. THE UNDERSIGNED PATIENT HEREBY AGREES TO IMMEDIATELY FORWARD SAID CHECKS TO A.C.C UPON RECEIPT OF THE SAME.**
- A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE VALID AS THE ORIGINAL. THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION AND I UNDERSTAND ITS NATURE AND EFFECT.

_____ _____

PATIENT SIGNATURE DATE

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**
WITNESS:		
_____	_____	_____
Printed Name	**Signature**	**Date**