**Welcome to our office!**

**Dr. Richard Carlson**

**Rachel Miller PT, DPT**

**Dr. Nicholas Tagliaferro**

6106 Black Horse Pike, Unit A3

Egg Harbor Township, NJ 08234

(609) 415-2821

**CONFIDENTIAL PATIENT CASE HISTORY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_ Best Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this related to: Auto Accident Yes No; Work Injury Yes No; Slip & Fall Injury Yes No

How did you hear of our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:**

List any surgical operations and year performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently or have you ever suffered from:

Pacemaker Heart trouble Diabetes Take blood thinners

Are you currently on prescription medications? Yes No If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAIN DRAWING:** Please mark the figures below with the letters that best describe the sensation or pain you are feeling.

A = Ache B = Burn R = Radiating Pain D = Dull Pain

N = Numbness S = Stabbing P = Pins & Needles O = Other



**PLEASE INDICATE HOW YOU WOULD RATE YOUR PAIN**

**(LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)**

**FINANCIAL RESPONSIBILITY**

All services rendered are charge directly to you, the patient. You then are ultimately responsible for all payments regardless of whether or not this office accepts insurance assignment

I understand if I default in paying my portion due, I will be responsible for any and all collection fees, legal cost and attorney fees. I understand that my “cash fee” is a time of service discount. If I do not pay at the time of service the charges of convert to the regular insurance fee schedule.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

**I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND FULLY ACCEPT ALL OF ITS TERMS.**

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TERMS OF ACCEPTANCE**

The goal of chiropractic is to relieve pain by restoring function to the human body. Through correcting joint restrictions, muscle imbalances, and faulty movement patters we are working to help you live a happy and healthier life.

Through the use of joint manipulation, Post Isometric Relaxation, Active Release Technique, Graston, and functional rehabilitation we are working to improve the quality your joints, muscles, and movements.

Regardless of what disease or condition is called, the chiropractor does not offer to heal or treat it. Nor does the chiropractor offer advice regarding the treatment of disease. The only goal is to allow the body to do its job. The chiropractor promises no cure from and offers no treatment of disease.

**I have read the above, understand it fully, and undertake chiropractic care and physical therapy on this basis.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**HIPAA Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996(HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices described how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (HCO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information**

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

**TREATMENT:** We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**PAYMENT:** Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**HEALTHCARE OPERATIONS:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use your image and/or name on social media for promotional purposes. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health Issues required by law: Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings; Law Enforcement, Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity, Military Activity and National Security; Workers’ Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when requited by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

**OTHER PERMITED AND REQUIRED USES AND DISCLOSURES** will be made only with your consent, authorization or opportunity to object unless required by law.

**YOU MAY REVOKE THIS AUTHORIZATION** at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS**

The following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you will have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

**We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.**

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

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Signed Dated

FOR OFFICE USE ONLY

Patient Refused to Sign

Patient Unable to Sign for the following reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_