Lower Bucks
Total Health and
Wellness Center, P.C.

NEW CHIROPRACTIC PATIENT INTAKE FORM

Name_____**Date**_____

Address_____**City**_____**State**_____**Zip**_____

Telephone_____**Email Address**_____

Age_____ **Birthdate**___/____/_____ **Gender** M/F **Marital Status** M S D W

Referred By (*If Applicable*)_____

Occupation_____ **Employer**_____

Years Employed_____**Work Phone**_____**Ext**_____

Is your condition due to a motor vehicle or work related accident? YES / NO _____
If Yes, have you filed a claim with your auto insurance or worker's compensation? YES / NO

Attorney's Name (*if applicable*)_____**Telephone**_____

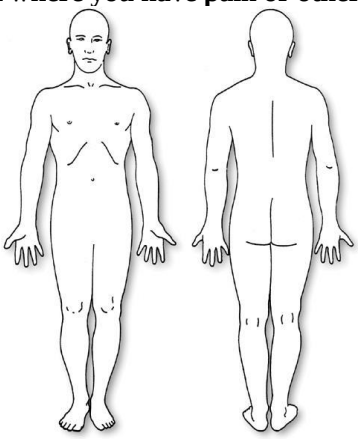
Emergency Contact_____**Telephone**_____

Date your problem began _____/_____/_____

Please describe how your problem began

_____
_____
_____
_____

Mark an X where you have pain or other symptoms



How bad is your pain? 0 1 2 3 4 5 6 7 8 9 10
No Pain Excruciating Pain

Describe your pain/symptoms (circle all that apply) Sharp/Stabbing Throbbing Achy Dull Soreness Weakness Numbness Tingling Burning Shooting Other _____

How often are your symptoms present? Constantly / Frequently / Occasionally

Since your problem began, your condition is improving / has not changed / is getting worse

What makes the problem better? (circle all that apply) Nothing Lying Down Walking Standing Sitting Movement Inactivity/Rest Other _____

What makes the problem worse? (circle all that apply) Nothing Lying Down Walking Standing Sitting Movement Inactivity/Rest Other _____

Can you perform your daily activities? Yes / Yes, but only with help / No

Have you seen another health care professional or had any treatment for this problem prior to your coming to our office today? YES / NO
If YES, please list what type of treatment below

_____
_____
_____

Have you had any X-rays, MRI or other tests for this condition? YES / NO
If YES, please list what tests and when below

_____
_____
_____

Are you presently taking any medications (including birth control)? YES / NO
If YES, please list the medications you are taking below

_____
_____
_____

Do you have any known allergies (including seasonal allergies)? YES / NO
If YES, please list them below

_____
_____
_____

Have you had any recent or previous hospitalizations or surgical procedures? YES / NO
If YES, please list dates and procedures below

_____
_____
_____

Health History

Please mark an X next to any symptoms you are presently experiencing as well as any symptoms listed below that you have had in the past. Knowledge of these conditions may influence the type of treatment you receive at our office.

Present	Past	Condition
____	____	Neck Pain
____	____	Shoulder Pain (R/L)
____	____	Upper Arm/Elbow Pain (R/L)
____	____	Hand/Wrist Pain (R/L)
____	____	Upper Back Pain
____	____	Lower Back Pain
____	____	Hip/Upper Leg Pain (R/L)
____	____	Knee Pain (R/L)
____	____	Lower Leg Pain (R/L)
____	____	Ankle/Foot Pain (R/L)
____	____	Jaw Pain
____	____	Fainting
____	____	Epilepsy/Convulsions
____	____	Visual Disturbances
____	____	Headaches
____	____	Tinnitus (Ringing in Ears)
____	____	Rapid Heart Rate
____	____	Loss of Appetite
____	____	Anorexia
____	____	Asthma
____	____	Abnormal Weight Gain/Loss
____	____	Diabetes
____	____	Excessive Thirst
____	____	Frequent Urination
____	____	Chronic Cough
____	____	Chronic Sinusitis
____	____	General Fatigue
____	____	Irregular Menstrual Cycle
____	____	Irregular Menstrual Flow
____	____	PMS
____	____	Loss of Bladder Control
____	____	Abdominal Pain
____	____	Constipation
____	____	Irregular Bowel Habits
____	____	Difficulty Swallowing
____	____	Heartburn/Indigestion

Present	Past	Condition
____	____	Depression
____	____	Aortic Aneurysm
____	____	High Cholesterol
____	____	Hypertension
____	____	Chest Pain
____	____	Heart Attack (Date)_____
____	____	Stroke (Date)_____
____	____	Cancer_____
____	____	Blood Disorder_____
____	____	Lung Disorder_____
____	____	Arthritis
____	____	Rheumatoid Arthritis
____	____	Ulcer(s)
____	____	Prostate Problems
____	____	Liver/Gallbladder Problems
____	____	Hepatitis
____	____	Kidney Disorders (stones, etc)
____	____	Bladder Infection
____	____	HIV/AIDS

Family History

____ Cancer ____ Diabetes
____ Hypertension ____ Arthritis
____ Heart Problems ____ Lung Problems
____ Headaches ____ Back Problems

Do you have a permanent Disability Rating?

YES/NO

Location_____
Rating Percentage_____
Date Rating Was Received _____

Please Check All That Apply to You

____	____	Tobacco
____	____	Alcohol
____	____	Drug/Alcohol Dependence
____	____	Coffe/Tea/Caffinated Soft Drinks

Cups/Cans Per Day_____

Height____'____ **Weight**_____

I certify that the information I have provided is complete and accurate to the best of my knowledge. I agree to notify this office immediately of any changes in my health condition.

Patient's Signature _____**Date** _____

Parent/Guardian **MUST** sign for all patients under 18 years of age

INSURANCE INFORMATION

Patient Name_____**Date**_____

Insurance Carrier_____

Insurance ID#_____**Group** #_____

ATTENTION MEDICARE PATIENTS

Please notify us if your Social Security Number is different from your Medicare ID number

Subscriber's Name_____

Subscriber's Date of Birth_____

Subscriber's Employer_____

Relation to Subscriber SELF SPOUSE DEPENDENT

I understand and agree that I am responsible for payment of any services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable.

Patients with group or individual insurances are responsible for any unpaid balance in the event that their insurance does not cover chiropractic care or is terminated while they are under care at this office.

I fully accept responsibility and release Lower Bucks Total Health and Wellness Center, P.C. and its doctors from any and all liability in the unlikely event that a problem occurs from my treatment. By signing below, I affirm that the provided information above is correct and that I consent to chiropractic care at this office.

_____

Patient's Name (print)

_____

Patient's Signature **Date**

Parent/Guardian **MUST** sign for all patients under 18 years of age

Lower Bucks
Total Health and
Wellness Center, P.C.

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.

Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health information to other health care professionals within our practice for the purpose of treatment, verifying insurance benefits, payment and/or health care operations.

example

On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Lower Bucks Total Health and Wellness Center, P.C.

It is our policy to provide a substitute health care provider, authorized by Lower Bucks Total Health and Wellness Center, P.C. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to sickness, vacation or an emergency situation.

Payment

We may disclose your health information to your insurance provider for the purposes of payment or health care operations.

example

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Lower Bucks Total Health and Wellness Center, P.C. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy to you, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition and codes which describe the health care services rendered."

Workers' Compensation

We may disclose your health information as necessary to comply with State Worker's Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Appointment Reminders

As a courtesy to our patients, we may send you appointment reminders in the forms of phone calls, text messages or emails. If we call and you are not there or you do not answer, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed in any of these reminder formats other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Fundraising and Marketing

It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc throughout the year. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, dates and times and request your participation in such events. It is not our policy to disclose any personal health information about your condition for the purpose of Lower Bucks Total Health and Wellness Center, P.C. sponsored fundraising events."

Change of Ownership

In the event that Lower Bucks Total Health and Wellness Center, P.C. is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Lower Bucks Total Health and Wellness Center, P.C. is not required to agree to your requested restriction(s).

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information

- You have a right to request that Lower Bucks Total Health and Wellness Center, P.C. amend your protected health information. Please be advised, however, that Lower Bucks Total Health and Wellness Center, P.C. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Lower Bucks Total Health and Wellness Center, P.C.

- You have the right to request a paper copy of this Notice of Privacy Practices at any time.

Changes to This Notice of Privacy Practices

Lower Bucks Total Health and Wellness Center, P.C. reserves the right to amend this Notice of Privacy Practices at any time in the future and will make provisions effective for all information that it maintains. Until such amendment is made, Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to comply with this notice.

Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice, or if you want more information about your privacy rights, please call Charles Flood, D.C. at 215-788-3608. If Charles Flood, D.C. is not available, you may make an appointment for a personal conference in person or by phone within 2 working days.

Complaints

Complaints about your privacy rights or how Lower Bucks Total Health and Wellness Center, P.C. has handled your health information should be directed to Charles Flood, D.C. at 215-788-3608. If Charles Flood, D.C. is not available, you may make an appointment for a personal conference in person or by phone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS
Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of

__11__/__1__/__14__

I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide Lower Bucks Total Health and Wellness Center, P.C. with my authorization and consent to use and my disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient's Name (print)

_____

Patient's Signature **Date**

Parent/Guardian **MUST** sign for all patients under 18 years of age

_____

Authorized Facility Signature **Date**