JERSEY CITY CHIROPRACTIC & ACUPUNCTURE

944 Westside Avenue, Jersey City, NJ 07306
Tel: 201-432-3693 Fax: 201-432-3896

New Patient Information

Full Name: _____ Date: _____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: ___/___/___ Age: _____ Gender: ☐ Female ☐ Male Social Security #: _____

Home Phone: _____ Cell: _____ Email Address: _____

I am (circle) Single / Married / Divorced / Widowed / Separated

Occupation: _____ Employer: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

☐ Insurance_____ Primary account holder: _____ Birth Date: ___/___/___

☐ Out-of-pocket

How did you hear about us?

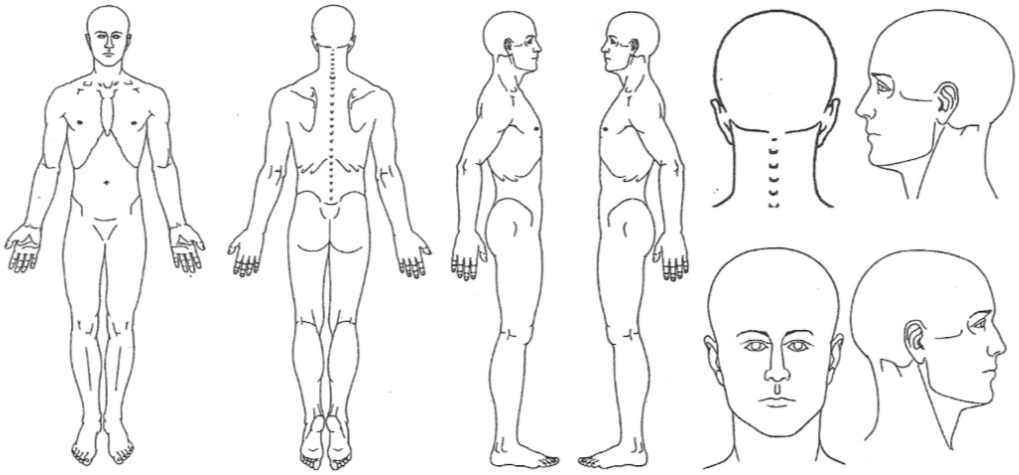
□ Google/Website □ Public Event □ Referred by _____

Reason for today's visit:

Describe the reason(s) for your visit today: _____

_____

Mark any area(s) of discomfort with the following key: ***A =Ache, Dull S = Sharp N =Numbness/Tingling T=Throbbing***



FRONT BACK RIGHT LEFT

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How did this start?_____ Have you experienced this before? □ Yes □ No

When did this start?_____ Are your symptoms getting □ Better □ Worse □ No change

What makes your symptoms feel BETTER:_____

What makes your symptoms feel WORSE:_____

On a scale of 0-10 (*0=no pain, 10=the worst pain you have ever had*) How would you rate your pain RIGHT NOW? _____

How often do experience your symptoms? □ *Constantly* □ *Frequently* □ *Occasionally* □ *Intermittently*

Do your symptoms interfere with any of the following? □ *Work* □ *Sleep* □ *Daily Activities (bathing, dressing, cooking, driving)*

Have you seen another healthcare provider or tried other types of treatment?_____

Have you seen a chiropractor before? □ Yes □ No Have you seen an acupuncturist before? □ Yes □ No

Do you have any of the following?
□ Unexplained recent weight LOSS
□ Recent fever/chills/nausea/vomiting
□ Numbness or tingling in the inner thighs or groin area
□ History of Cancer
□ Weakness in the legs (falling down, inability to stand)
□ Bowel or bladder dysfunction (loss of control or retention)

Do you have HEADACHES? Do you also have…
□ Dizziness
□ Double Vision
□ Difficulty Speaking
□ Difficulty Walking
□ Difficulty Swallowing
□ Nausea
□ Visual Disturbances
□ Facial Numbness
□ Drop Attacks/Fainting

Health Questionnaire:

Height: _____ Weight: _____

Medical Conditions: *list any health conditions you may have and how long you have had them*

Medications: *list all prescription or non-prescription medications, vitamins, or herbs you take, list dosage*

Surgeries or hospitalization: *list any surgeries or hospitalizations and the date of each*

Family History: *list all major diseases (CANCER, DIABETES, HEART DISEASE) and the relation of the individual to you*

Allergies:_____

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Social History:

Do you smoke currently? □ Yes □ No Did you smoke in the past? □ Yes □ No _____packs per day for _____years
Do you drink alcoholic beverages? □ Yes □ No Did you drink in the past? □ Yes □ No

Primary Care Medical Doctor:

Name: _____ Date last seen: _____
May we update them on your condition? □ Yes □ No

Additional Information for WOMEN:

Are you pregnant or nursing? □ Yes,_____weeks □ No # of pregnancies_____ # of children_____

Review of systems: For the conditions below please mark if you experience any of the following:

1 if you CURRENTLY HAVE these symptoms
2 if you PREVIOUSLY HAD these symptoms

MUSCULO-SKELETAL
_____ Neck Pain
_____ Shoulder Pain
_____ Elbow/Arm Pain
_____ Wrist/Hand Pain
_____ Back Pain
_____ Hip/Upper Leg Pain
_____ Knee Pain/Lower Leg Pain
_____ Ankle/Foot Pain
_____ Joint Swelling/Stiffness
_____ Weak Muscles
_____ Difficulty Walking

NERVOUS
_____ Numbness/Tingling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Convulsions/Seizures
_____ Confusion

GASTRO-INTESTINAL
_____ Excessive Hunger or Thirst
_____ Nausea/Vomiting
_____ Diarrhea
_____ Constipation
_____ Black or Bloody Stool
_____ Hemorrhoids/Rectal Bleeding
_____ Gallbladder Infection or Stones
_____ Abdominal Pain
_____Abdominal Bloating
_____ Ulcers

GENITO-URINARY
_____ Bladder or Kidney Infection or Stones
_____ Pain or Difficulty with Urination
_____ Scanty or Infrequent Urination
_____ Frequent Urination
_____ Discoloration of Urine or Blood in Urine
_____ Loss of Bladder Control
_____ Retention of Urine

CARDIO-VASCULAR/RESPIRATORY
_____ Chest Pain
_____ Rapid Heart Beat or Palpitations
_____ High/Low Blood Pressure
_____ Difficulty Breathing or Shortness of Breath
_____ Persistent Cough
_____ Coughing up Blood
_____ Swelling in legs
_____ Bleeding or Circulation Disorders

EYE, EAR, NOSE, THROAT
_____ Vision Changes
_____ Ringing in Ears or Tinnitus
_____ Hearing Loss
_____ Frequent Nosebleeds
_____ Sinus Congestion
_____ Difficulty Speaking or Swallowing

OTHER
_____ Unexpected Weight Gain/Loss
_____ General Fatigue
_____ Allergies
_____ Insomnia
_____ Acne or Skin Conditions
_____ Hormonal Imbalances
_____ Anxiety or Depression

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OFFICE POLICIES:

Please **initial** each paragraph indicating your agreement, then sign and date at the bottom of the page.

_____ **Form completion:** By signing below, I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ **Consent for Examination:** By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests, and procedures for the above minor.

_____ **Authorization for Contact:** By signing below, I authorize Jersey City Chiropractic & Acupuncture (JCCA) to use my name, address, telephone number, and/or email address to contact me regarding appointments, newsletters, products, and events. The use of this information is intended to make my experience with JCCA more efficient, productive, and to further enhance my access to quality health care. If I choose not to authorize this information use, my decision will have no adverse effect on my care or my relationship with the staff at Jersey City Chiropractic & Acupuncture. My authorization may be revoked at anytime via writing.

_____ **Financial Policy:** By signing below, I understand the financial policy, and that I am financially responsible for all unpaid balances for my care.

- **Regarding ALL insurance:** We accept insurance, however not all plans have chiropractic or acupuncture coverage. We will verify your insurance and let you know your coverage. If you do have coverage, we will bill your insurance carrier. If you have questions regarding your coverage, we strongly suggest you contact your insurance carrier. Payment of deductibles, non-covered services, co-payments, or co-insurance is expected at time of service. If your insurance carrier fails to pay for services within ninety days, you are responsible for payment and any outstanding balances.

- **Regarding Medicare:** Medicare pays for a limited portion of chiropractic services and limits the number of reimbursable treatments. Reimbursable care is limited to spinal manipulation and does not include initial exam, manual therapies, physiotherapy modalities, or supplements that may be recommended during care. Medicare does not cover acupuncture. Payment for non-reimbursable care is your responsibility.

- **Regarding Personal Injury, Worker's Compensation, or Litigation:** If an attorney is involved, you are required to sign a Physician's Lien that will be forwarded to the attorney for signature. If we do not receive the signed lien from the attorney within 14 days, the fee for all services rendered is your responsibility.

- **For those without insurance:** We accept cash, checks, and credit/debit cards. Payment is expected at time of service.

_____ **Assignment of Benefits & Release:** By signing below, I authorize Jersey City Chiropractic & Acupuncture (JCCA) to release medical records required by my insurance company(s). I authorize my insurance company to pay benefits directly to JCCA and I agree that a reproduced copy of this authorization will be as valid as the original. I agree that I will be responsible for any collection agency or attorney fees incurred.

Printed Name: _____

Signature: _____ Date _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and your accessibility. Please review it carefully.

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You have the right to:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory.
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes. In the case of fundraising: we may contact you, but you can tell us not to contact you again. Sale of your information

Our Uses and Disclosures: We typically use or share your health information in the following ways.

- **Treat you:** We can use your health information and share it with other professionals who are treating you.
- **Run our office:** We can use/share your health information to run our office, improve your care, and contact you if necessary.
- **Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities.
- **Help with public health and safety issues**: Preventing disease, Helping with product recalls, reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety

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- **Do research:** We can use or share your information for health research.
- **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Jersey City Chiropractic & Acupuncture Privacy Official: Please contact our privacy officer if you have any questions, comments, or concerns. Dominique Bariso drbariso@gmail.com 201-432-3693. This notice is effective as of March 10, 2016.

ACKNOWLEDGEMENT OF RECEIPT

By my signature below I acknowledge that I received a copy of the Notice of Privacy Practices for Jersey City Chiropractic & Acupuncture.

_____ _____ _____

Print Name Signature Date

If completed by a personal representative, please print and sign your name below.

_____ _____ _____

Print Name & Relationship to Patient Signature Date

FOR OFFICE USE ONLY: I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Patient refused to sign □ Communication barriers □ Other: _____

_____ _____ _____

EMPLOYEE Name Signature Date