REGISTRATION

Date: _____ D.O.B _____ Age:_____
Mr. ____ Mrs. ___ Miss _____Ms. _____ Dr._____
Last Name: _____
First Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Home Number: _____
Work/Cell Number:_____
E-Mail: _____
Social Security Number: _____
Occupation: _____
Employer: _____
Marital Status: (circle one) S M W D
Spouse: _____
Number of Children: _____
Referred By:_____
Previous Chiropractor:_____

ON A SCALE OF 1-10 WHAT IS YOUR CURRENT PAIN LEVEL:_____

WHAT DOES THIS CONDITION INTERFERE WITH?
(please circle)

Work Sleep Daily Activities

WHAT DO YOU DAILY ACTIVTIES MOSTLY CONSIST OF? (please circle)

Sitting Standing Bending Lifting Stretching

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION?

_____

INDICATE THE TYPE OF CARE YOU DESIRE?

____Acute Care (pain relief)
____Corrective Care (stabilize spinal structure)

PLEASE EXPLAIN THE REASON FOR THIS VISIT:_____

_____

_____

DO YOU HAVE COMPLAINTS IN ANY OF THE FOLLOWING AREAS:

___ Shoulders R/L ___ Knees R/L ____ Scapula R/L
___ Elbows R/L ___ Ankles R/L ____ Feet R/L
___ TMJ R/L ___ Hips R/L ____ Wrists R/L
___ Rib Pain R/L ___ Collar Bone R/L

THE PAIN IS : (circle all that apply)

SHARP DULL SHOOTING NUMBNESS

CONSTANT INTERMITTENT OCCASSIONAL

WHAT AGGRAVATES YOUR CONDITION?

_____

_____

WHAT ALLEVIATES YOUR CONDITION?

_____

_____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE?

_____

_____

MEDICAL HISTORY

NAME OF FAMILY PHYSICIAN

_____

IF YOU HAVE BEEN TREATED FOR A MEDICAL CONDITION IN THE LAST YEAR & HAVE <u>EVER</u> BEEN HOSPITALIZED PLEASE LIST THE CIRCUMSTANCES AND DATES:

_____

_____

PLEASE LIST ANY PRESCRIPTION/ NON-PRESCRIPTION MEDICATIONS YOUR TAKING_____

____

_____

INDICATE (X) IF YOU SUFFER FROM ANY OF THE FOLLOWING:

____Allergy	____Digestive Disorder
____Backaches	____Kidney Problems
____Arthritis	____High BP/Low BP
____Numbness	____Spinal Curvature
____Sciatica	____Anemia
____Stroke	_____Sinus Problems
____Colds	____Dizziness
____Diabetes	____Nervousness
____Cancer	____Irregular Menstrual Cycle
____Drug/Alcohol	____Urinary/Prostate

PLEASE READ CAREFULLY

It is important to the both of us that you - the patient – fully understand what Chiropractic IS and what it is NOT.

CHIROPRACTIC IS A PHILOSOPHY, SCIENCE, AND AN ART. Chiropractic is the PHILOSOPHY of things natural. We recognize that in all living things is an inborn or "intake" wisdom, which is responsible for the creation of Life, for sustaining Life and for the healing and recuperation of living cells. Chiropractic is the SCIENCE of locating and analyzing spinal misalignments (subluxations), which interfere with normal nerve transmission, thereby interfering with normal Life Expression and body function. Chiropractic is the ART of correcting these subluxations by adjustments for the removal of nerve interference, so that the body can achieve more normal Life Expression. CHIROPRACTIC IS NOT MEDICINE. It is NOT the diagnosis and treatment of diseases or symptoms. Chiropractors do NOT treat, heal or cure their patients. The practice of a Chiropractor is NOT dependent on medical techniques such as diagnostic tests or medical examinations. Chiropractic is NOT meant to replace emergency medical or first aid procedures.

I have read & understand the above statement & recognize that all the attached records have been taken for the informative & analytical purposes only & NOT for the purposes of diagnosing, treating, curing, or healing any existing or implied disease or diseased condition. I do hereby certify that all of my statements are true & accurate & complete. I understand & agree that health & accident insurance policies are an arrangement between an insurance carrier & me. I clearly understand what I am financially responsible for & I hereby guarantee payment for all services rendered. Although fees for services are due & expected at the time services are rendered. If I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time that has been arranged for with office personnel. I also agree to pay a finance charge of 1.5% per month on any balance due over 90 days, as well as all collection, court costs, attorney fees & interest fees accrued with the collection of this account. A collection fee representing 1/3 of the outstanding balance will be added if the account is referred for collection to an outside company or attorney.

NOTICE: **I hereby authorize you or any credit reporting agency employed by you to investigate the references herein listed or any of the information stated above & secure a report of my credit from Trans Union Credit Information Company to determine my qualifications for a credit account.**

NOTICE TO PATIENT: **Do not sign this credit agreement before you read it or if it contains any blank spaces. You are entitled to a completely filled in copy of this credit agreement. You may at any time pay any part of all of your indebtness under this agreement.**

SIGNATURE OP RESPONSIBLE PARTY:

_____

DATE_____

Insurance Information & Disclaimer

PRIMARY INSURANCE

Name of Insured_____

Relationship to patient _____

Insured's birthdate_____

Soc. Sec. #_____

Employer_____

Date Employed_____

INSURANCE COMPANY:_____

Group #_____

I.D. #_____

ADDITIONAL INSURANCE

Name of Insured_____

Relationship to patient_____

Insured's birthdate_____

Soc. Sec. #_____

Employer_____

Date Employed_____

INSURANCE COMPANY:_____

Group#_____

I.D.#_____

- I authorize use of this form on **all** my insurance submissions.
- I authorize release of information to my **Insurance Companies.**
- I understand that **I am responsible** for my bill.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

Name (Please Print)_____ **Medicare#**(if applicable)_____

Signature_____ **Date**_____

FOR OFFICE USE ONLY:

Effective date_____ Deductible_____ Deductible Met_____

Paid at % _____ Max Payout_____

Number of visits _____per year/ per 60 day period / medical necessity

Co-Insurance_____ Co-pay_____ Out of Pocket_____

Pre-cert/Referral needed_____ ACN needed_____

Covered Benefits:	Evaluation & Exams	Yes	No
	X-rays	Yes	No
	Modalities	Yes	No

Mailing Address for claims: _____

_____

_____

Date: _____ Time:_____ Name of Customer Service Rep_____

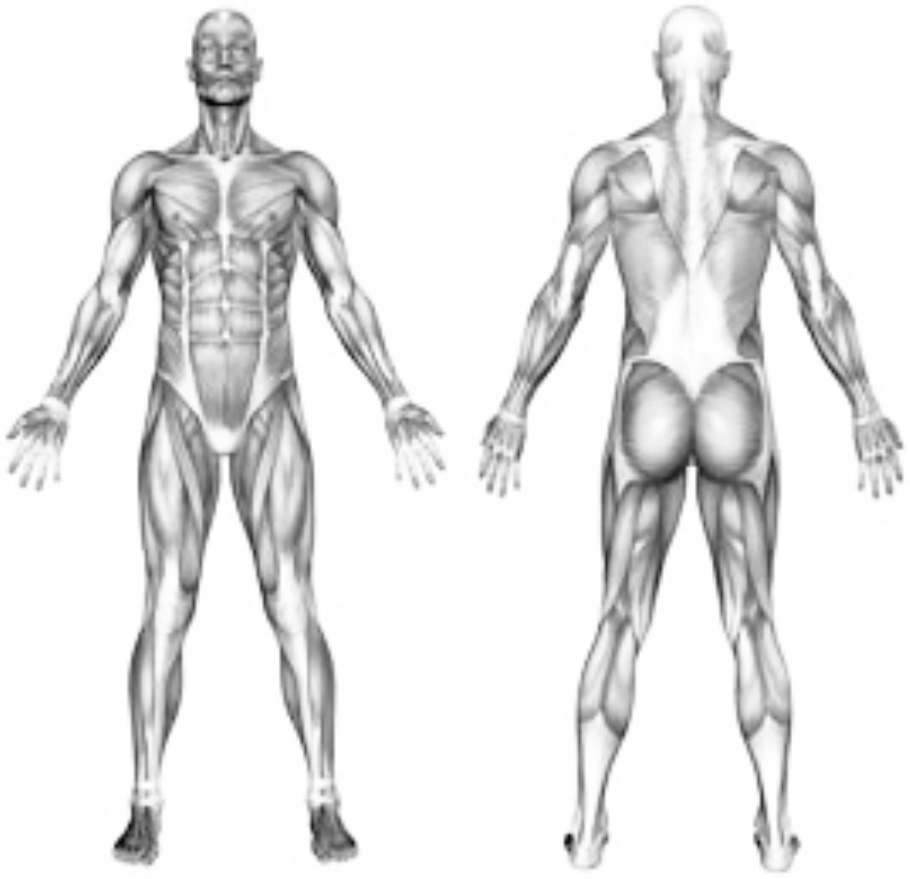
C.A _____

PRINT NAME: _____ DATE:_____

Please **circle** the following sensation you are experiencing today.

PAIN TINGLING STIFFNESS WEAKNESS

Please **circle** **all areas** on this diagram that apply to your condition today.



○ **NECK**

- ○ Shoulder L/R C5-C6
- ○ Elbow L/R C6-C7
- ○ Wrist L/R Hands C6-C8

○ **MID-BACK PAIN**

○ **RIBS & LOW BACK**

- ○ Hips L/R T12-L2-L3
- ○ Knee L/R L3-L4
- ○ Ankle L/R Toes L4-L5-S1

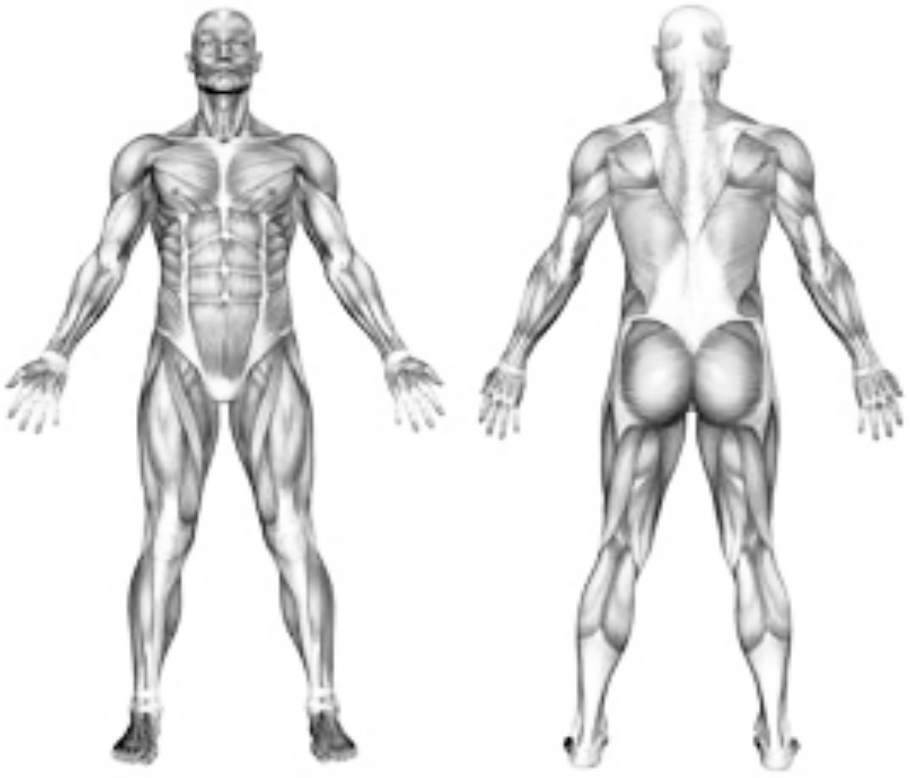
As required by your insurance company:, before, we can address any problems on your spine or any of your extremities, **you must fill out this form**.

Your Signature:_____

Dr.Louis A. Lorenzo --Family Chiropractic Center-- Parsippany, NJ 07054

Please **circle the areas** on this diagram where you feel or have felt the following sensations:
Please **specify Right or Left** side by marking the diagram accordingly.

Pins & Needles Numbness Tingling Burning Sharp/ Stabbing Pain Other



Indicate the severity of your symptoms by marking an "**X**" on the line:

How bad are your symptoms now?

_____

1 (None) 10 (Most Severe)

How bad have they been in the past?

_____

1 (None) 10 (Most Severe)

HIPPA Notice of Privacy Practices

Dr. Louis A. Lorenzo
Family Chiropractic Center
359 North Beverwyck Road
Parsippany, New Jersey 07054
Phone # 973-334-6868
Fax # 973-263-8892

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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 indentify you and that relates to your past, present or future physical or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

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 of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of physician's practice and another 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, you 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 your 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, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office, In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name indicate your physician. We may also call you by name in the waiting room when you physician is ready to see you. We may use or disclose your protected health information, as necessary, to contract you to remind of you your appointment.

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 as 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 required by the Secretary of Department of Health and Human Services to investigate or determine our compliances with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law.

You many 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 in the indicated in the authorization.

Your Rights
Following is a state 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 complied 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 protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. 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 of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If 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 you request for amendment, you have the right to fie 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 right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw a provided 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 contract of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have receives this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ Date:_____

Patient's Pregnancy Evaluation Form

Dear Patient, in order for us to fully evaluate you we are required to take X-ray of some part of your body. It has been predicted that an unborn child in its first trimester would be more sensitive to radiation than an adult. In order to insure that accidently, knowingly or otherwise, no Fetus (unborn child) be exposed to radiation from X-ray machines, we ask you provide us with the following information. We thank you for the information and this information is strictly confidential and is solely used for the purpose it is intended.

Date:_____

Name:_____

Date of Birth:_____

Date of the onset of last Menstrual Period:_____

Is there a change that you may be Pregnant?_____

To the best of my knowledge, I am not pregnant and by providing this application form Physician/Technologist has informed me of the effects of Radiation to the Unborn baby and me by signing below have consented to taking the X-ray of my body parts for further studies.

Signature:_____

Your Prescribed Visit Schedule:

1. _____ times per week for_____ weeks.
2. _____ times per week for _____ weeks
3. _____ times per week for _____ weeks
4. Re-evaluation at _____

Date you will attend Spinal Care Class: Wednesday _____ at 7:30PM

Provisions of Care:

A. Must keep/ visit appointment schedule. If schedule is not adhered to you will be released from care.
B. IF you have to miss a scheduled appointment, you must call the office at least 3 hours prior to reschedule. There is a $25 missed appointment fee.
C. You must ATTEND one Spinal Care Class within the first 2 months of care. We encourage you to bring a family member or friend!

I ACCEPT THESE PROVISIONS OF CARE:

Signature: _____ Date:_____

*This is for your records; the office will keep a copy in your file.