Patient Health Assessment: Personal Information

Chiropractic Care of Bedminster
Nick Mavrostomos, D.C.
1430 U.S. Hwy 206 North, Suite 260
Bedminster, NJ 07921
(908) 234-2317

General Information

Patient Name: Last First Date:

Primary Care Physician's Name: _____

Primary Care Physician's town / telephone #: _____

Patient Sex: M F Marital Status: Married, Divorced, Single

Date of Birth: Social Security #:

Race: Preferred Language:

Patient Address: _____ City/State _____ Zip Code

Home Phone: _____ WorkPhone:_____

Cell Phone: _____ E -Mail: _____

Referred to our office by:_____

Patient Employer/Patient Occupation: _____

Emergency Contact and Phone Number: _____

Are you the Primary person insured? If not please fill this out

Subscriber Name: _____ SubscriberDateofBirth:_____

Relation to Patient: _____ Subscriber Employer: _____

Complaint History **Chiropractic Care of Bedminster, P.C. 1430 U.S. Hwy 206 N Suite 260 Bedminster, NJ 07921**

Name_____

1. Describe your current complaint: _____

What were you doing when you got hurt?_____ Date of Onset:_____

THIS IS IMPORTANT PLEASE BE SPECIFIC AND COMPLETE

2. How would you describe pain?

Sharp	Soreness	Throbbing	Tingling	Dull	Stiffness
Spasm	Burning	Ache	Weakness	Numbness	Shooting

3. How would you rate the intensity of your pain today? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10

(no pain) (moderate pain) (terrible/unbearable pain)

4. How often is the pain present?

Constant (81-100%) Frequent (51-80%) Occasional (26-50%) Intermittent (25% or less)

5. Since your problem began, is the pain:

Getting Worse Getting Better Staying the Same

6. How did your problem begin?

An auto accident Work related accident Other type of accident

Gradual Sudden No specific reason

Explain:

7. What makes your problem better?

Nothing Walking Standing Sitting Moving around/exercise Lying down Inactivity

8. What makes your problem worse?

Nothing Walking Standing Sitting Moving around/exercise Lying down Inactivity

9. Are you currently taking medications? **Yes** **No**

If yes, please describe

10. Were you previously treated for an earlier occurrence of this same condition? Yes No

If yes, by whom? MD Chiropractor Physical therapist Other

What were the approximate dates, type of treatment and the results?

11. What is your physical activity at work?

Student

Mostly sitting Light manual labor Moderate manual labor Heavy manual labor

12. Do you exercise?

No regular exercise	1-2 times a week	3-4 times a week	5-7 times a week
Cardiovascular	Stretching	Weight Machine	Free Weights
Sports		(type)	

13. What is your present general stress level?

No stress Minimal stress Moderate stress Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities? Circle one

No effect	Have some limited physical restrictions, but can function
Need some assistance with daily activities	Cannot work
Cannot function without assistance	Totally disabled

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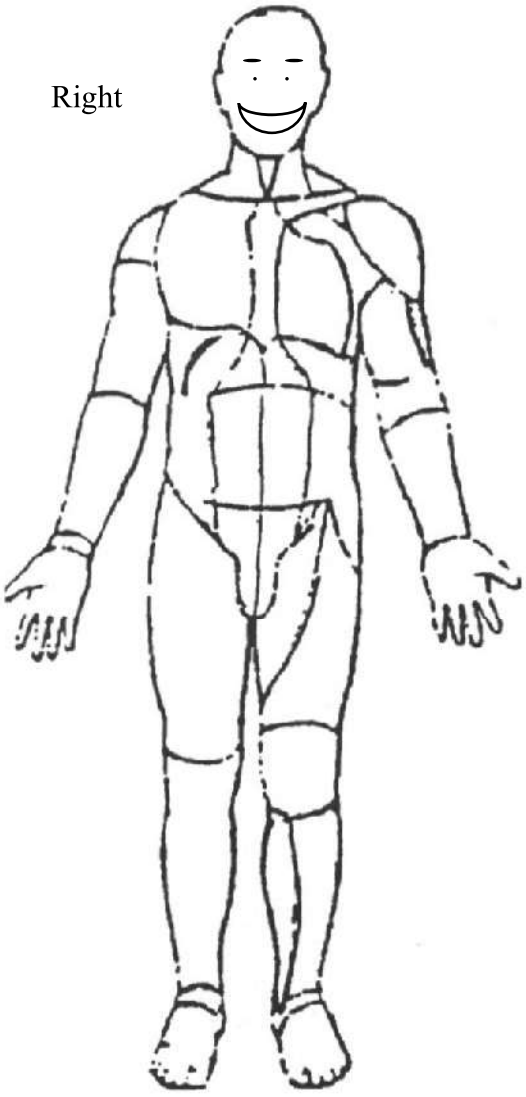
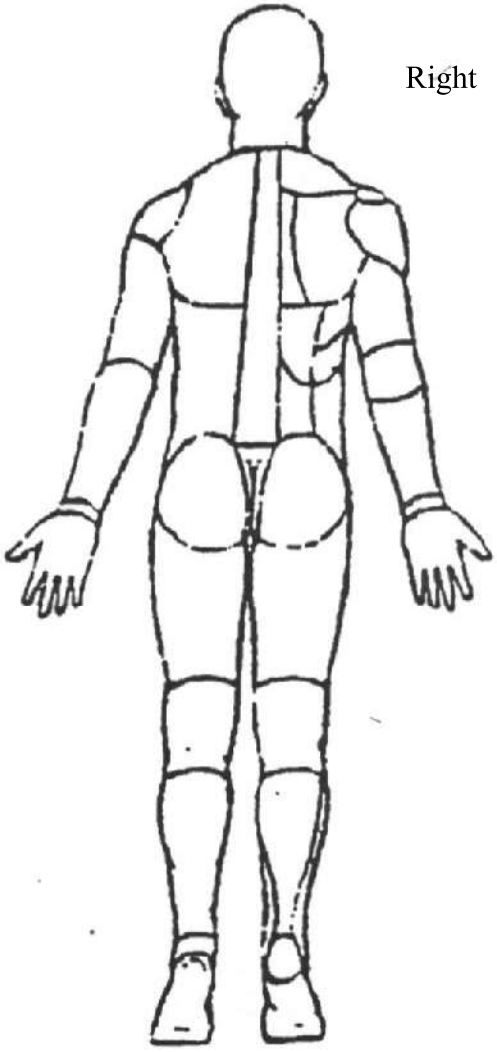
Please shade in figures below where you have pain or other symptoms

Right



Right



Past or Present Symptoms, Conditions or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present
Neck pain	___	___
Sciatic pain	___	___
Shoulder pain	___	___
Arm/elbow pain	___	___
Hand pain	___	___
Upper back pain	___	___
Lower back pain	___	___
Pain in upper leg or hip	___	___
Pain in lower leg or knee	___	___
Pain in ankle or foot	___	___
Jaw pain	___	___
Swelling/stiffness of joints	___	___
Headaches	___	___
Dizziness	___	___
Fainting spells	___	___
Convulsions	___	___
General prolonged fatigue	___	___
Condition of uterus/ovaries	___	___

Symptom	Past	Present
High Blood Pressure	___	___
Heart condition	___	___
Respiratory condition	___	___
Digestive problems	___	___
Kidney/Bladder	___	___
Menstrual problems	___	___
Breast soreness/lump	___	___
Sinus conditions	___	___
Prostate condition	___	___
Cancer	___	___
Stroke	___	___
Excessive weight loss/gain	___	___
Skin condition	___	___
Arthritis	___	___
Diabetes	___	___
Allergies/Asthma	___	___

Allergies:_____
_____

Comments:
_____
_____
_____
_____
_____

Tobacco use: ____Never ____Past ____Present
Alcohol use: ____Never ____Past ____Present ____Occasional ____Moderate _____Heavy
Caffeine use: ____Never ____Past ____Present ____Occasional ____Moderate _____Heavy
Pregnancy: ____Never ____Past ____Present
Surgical Procedure(s): Please list with dates _____
_____
_____
_____
_____

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Fax (908) 234-0975

Nick Mavrostomos, D.C.

Full payment is due for all office visits on the day of the visit. Our office participates with numerous HMO/PPO CARRIERS. If you are a member of one of these plans you are responsible for obtaining either a written referral authorization number prior to your visit or your visit will be on an out of network fee schedule until one is obtained. If you have a deductible, you will be billed when we get the Explanation of Benefits from your plan. Your balance is due within one (1) month of the notice from the insurer.

All co-payments must be made at the time of service. This is to be paid when you sign in. This facilitates your check out when leaving the office. If you do not pay your deductible or co-payment we are required to tell the insurer of your refusal. This may result in cancellation of your insurance coverage.

Management of personal medical insurance coverage is ultimately the patient's responsibility. Our staff is available to assist you, but not responsible for knowledge of each patient's individual plan requirements. Please refer to your health plan member services of benefit handbook to verify coverage and confirm eligibility.

Insurance companies do not pay for maintenance care. A patient is considered to be receiving maintenance care when he/she has reached maximum medical improvement and is still receiving treatment. If the treating chiropractor or your insurance company determine that your care has reached maintenance status you will be responsible for services rendered at prevailing office rates.

It should be understood that some fees may not be reimbursed fully or that at some point your insurance company may cease payment of services. You will be financially responsible for any balances due as a result of such action by your insurance company.

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct my insurance company to make out the check to the office and mail it as follows: 1430 U.S. Hwy 206 North, Suite 260, Bedminster, New Jersey 07921, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Verification of benefits by our office does not guarantee payment by your health insurance company for services or durable medical equipment, please always be aware your contractual agreement.

*Patients Signature:*_____*Date:*

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HEALTH in the HILLS
healthinthehills.org

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practice provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance portability and Accountability Act of 1966) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____
_____

_____ _____ _____
(Print Patient Name) (Patient Sign) (Date)

Initials:_____

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HEALTH in the HILLS
healthinthehills.org

Authorization for Release of Medical Records

First Name:_____ Last Name:_____ DOB:_____

I hereby authorize **Chiropractic Care of Bedminster** and it's associated to release or request from other Doctors or Hospitals, any and all information which they possess or require relating to my examinations and illness, which may be part of the medical record, including psychiatric/psychological, alcohol, drug abuse, AIDS, ARC, or HIV related diagnosis, treatments and rehabilitation for the following period:

_____

_____

_____

_____

PHYSICIAN, HOSPITAL, AGENCY

Full Name:_____

Address:_____

City, State, Zip: _____

Information is being released or requested for the following reasons (circle answer):

A) To a Physician for continued medical care
B) Insurance
C) Attorney
D) Other: _____

Signature of patient or other legal representative: **Witness Signature:**

_____ _____

Date: _____ **Date: _____**

Initials: _____

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HEALTH in the HILLS
healthinthehills.org

Dear Patient,

RE: Medical Form Fee Notice

Policy: Policy regarding the processing of medical forms.

We strive to provide you with the highest quality of care and service. Part of our commitment to your well-being includes maintaining accurate medical records and providing various forms and documents as needed for your personal or professional requirements.

We have implemented a nominal fee of $15.00 for the processing and provision of medical forms, including but not limited to:

Medical Records Requests
Disability Claim Forms
School or Camp Health Forms
FMLA (Family Medical Leave Act)

This fee is designed to cover administration costs associated with the retrieval, preparation, and delivery of these forms. Please note that this fee is not covered by insurance and is the responsibility of the patient or the requesting party.

Payment for the form fee can be made in the following ways:

In person at our front desk during your visit or form pick-up

Thank you for understanding.

_____ _____

Signature Date

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healthinthehills.org

1430 Hwy 206 North Suite 260
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Due to an increase in patients arriving significantly late and cancelling without prior notice, a new office policy is in effect. If you arrive 15 minutes past your appointment time and cannot be seen without the disruption of other patients or if you do not cancel within 24 hours prior to your appointment, a twenty-five ($25) no show fee will be placed on your account.

Thank you,
Nick Mavrostomos, D.C, CKTP

Name: _____ Date: _____

Signature: _____