CHIROPRACTIC
PATIENT INFORMATION

Last Name _____ First Name _____ MI____

Date of Birth _____ Sex: M / F Parent's Name (under 18)_____

Address_____

City_____ State _____ ZIP_____

Ph#: _____ Cell Ph#: _____

Primary Care Physician's Name & Phone Number

_____

E-mail (For Appt. Reminders)_____

How did you hear about Mass Sport & Spine? _____

PATIENT WORK INFORMATION

Employer's Name _____

Employer's Address_____

City _____ State _____ Zip code_____

Occupation_____

●●●I AM RESPONSIBLE TO KNOW MY INSURANCE BENEFIT●●●

****Please Initial Here:_____***

AUTHORIZATION TO PAY MASS SPORT & SPINE
Assignment of Benefits

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MASS SPORT & SPINE AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE MASS SPORT & SPINE TO RELEASE ANY INFORMATION TO PROCESS THIS CLAIM.

SIGNED: _____DATE: _____

PRIMARY INSURANCE

Without this information we cannot bill your insurance correctly.

Insurance Carrier_____

Member ID #_____Group #_____

Subscriber Name_____ **Subscriber Date of Birth**_____

Subscriber's relationship to the patient _____

SECONDARY INSURANCE

Insurance Carrier_____

Member ID #_____Group #_____

Subscriber Name_____ Subscriber Date of Birth_____

Subscriber's relationship to the patient _____

ONLY -If you're here because of an auto accident or workers comp incident***

AUTO INSURANCE

Name of insured _____ Claim # _____

Auto Insurance Company Name _____

Address _____

City _____ State _____ Zip _____

Adjustor's Name _____ Phone #_____

WORKER'S COMPENSATION

Employer's Name (at time of injury) _____

Address_____

City_____State_____Zip_____

Occupation_____

W/C Insurance Company Name _____Claim # _____

Address _____

City _____ State _____ Zip _____

Adjustor's Name _____Phone #_____

ATTORNEY INFORMATION

Name _____ Phone #_____

IMPORTANT COMPANY POLICIES:

We strive to provide you with the best-personalized care available. To make this possible we adhere to a set of very important polices. Please read them carefully and indicate your agreement by signing at the bottom.

Please give 24-hour advance notice:

If you wish to change or cancel an appointment we require a minimum of 24-hour advance notice. Anything less than that will result in a $25.00 fee applied to your account.

Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

No Shows:

We understand things happen. If you are unable to keep your appointment please call and let us know. Simply not showing up will result in the loss of all scheduled future appointments. New appointments will be allowed on a "first-come, first-serve basis". **ALL NO SHOWS WILL BE CHARGED A FEE OF $50.00.**

Late Policy: 20 minutes

Being late by more than 20 minutes will require you to reschedule. If we allow a patient in for treatment later than 20 minutes from their appointed time, it will overlap and compromise the care of another patient. We do not allow this. Please call and reschedule for another day.

I have carefully read and agree to all of the above polices. In the event such policies are broken, I agree to the consequences set forth.

Please sign that you have read these policies:

Signed:_____Date:_____

HISTORY OF
PRESENT ILLNESS:

For what condition or symptoms are you being seen for at this time?

_____

_____

When did this condition begin? Did it begin suddenly or gradually?

_____

Has this problem occurred in the past? _____

Have you seen anyone else or been treated at all for this condition?

_____

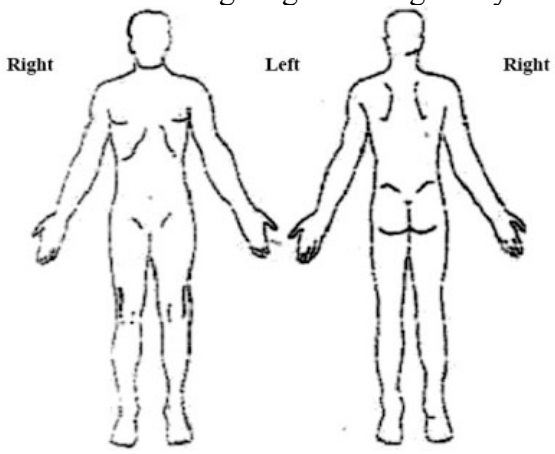
Have you ever been to a chiropractor before? _____

On a scale of 0-10, 0 being no pain and 10 being the worst pain, how would you rate your symptoms at their best? _____, at their worst? _____, and currently? _____

Please list all medications/vitamins/supplements that you are currently taking:

_____

Please fill in the following diagram using the symbols to indicate where your pain is:



Aching: AAA
Burning: ///
Numbness: ^^^
Pins & Needles: ###
Stabbing: xxx
Throbbing: ooo

Please indicate the following activities that may affect your condition:

	Better	Worse	No Change
Bending Forward:	[ ]	[ ]	[ ]
Bending Backwards:	[ ]	[ ]	[ ]
Sitting:	[ ]	[ ]	[ ]
Standing:	[ ]	[ ]	[ ]
Walking:	[ ]	[ ]	[ ]
Coughing/Sneezing/Bowel Movements:	[ ]	[ ]	[ ]
During Physical Activity:	[ ]	[ ]	[ ]
After Physical Activity:	[ ]	[ ]	[ ]

Lying on Back:

[ ] [ ] [ ]

Lying on Stomach:	[ ]	[ ]	[ ]
Driving:	[ ]	[ ]	[ ]
Lifting:	[ ]	[ ]	[ ]

Have you had x-rays done for this condition? If yes, when? _____

PAST MEDICAL HISTORY:

Please indicate all past surgeries: _____

_____

Do you have a history of Falls? _____ If Yes, when was your last fall?_____

Please indicate whether you or a family member has had the following conditions:

Cancer _____
Heart Disease _____
Arthritis/Gout _____
High Blood Pressure _____
Bleeding Tendency _____
Diabetes _____
Stroke _____
Kidney or Bladder Problem _____
Respiratory Disease _____
Pneumonia/emphysema _____
Asthma _____
Hernia _____
Thyroid Disease _____
Other _____
_____

Are you pregnant or is there any chance you may be pregnant? _____
Do you have any surgical implant/Pacemaker? _____

MASS SPORT & SPINE NOTICE OF INFORMATION OF PRACTICES

UNDERSTANDING YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:
-Request a restriction on certain uses and disclosures of your information (45CFR164,522)
-Obtain a paper copy of the notice of information upon request
-Inspect and obtain a copy of your health record (d5 CFR164,524)
-Request and amend your health record (45 CFR 164,528)
-Obtain an accounting of disclosures of your heath information (45 CFR 164,528)
-Request communications of your health information by alternative means or alternative locations
- Revoke your authorization to use or disclose heath information except to the extent that actions has already been taken

OUR RESPONSIBILTY:.

We are required to:
-Maintain privacy of your health information
-Provide you with a notice as to our legal duties and privacy practices with respect to your information
-Abide by the terms of this notice
-Accommodate reasonable requests you may have to communicate health information by alternative means or locations. We reserve the right to change our practices and to make the changes effective for all protected health care information we maintain. If our information practices change we will notify you the next time you come in to our office for treatment.

If you have any questions and would like additional information, you may contact Health and Human Services. If you believe your privacy rights have been violated you can file a complaint with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

Examples of Disclosures for treatment, Payment and Health Operations

We will use and disclose your health information for treatment for example: information obtained by us will be recorded in your record and used to determine the course of treatment that should work beast for you. Members of your healthcare team will then record the actions they took and their observations. In that way your physicians and other providers will know how you are responding to treatment. Copies of these records as well as other reports will be provided to others providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For ex., a bill may be sent to you or a third-party payer. The information on or accompanying the bill may

include information that identifies you, as well as your diagnosis, procedure sand supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with worker's compensation or other similar programs established by law.

We will use and disclose your health information for regular health operations. For example, members of our staff may use the information in your health record to phone you regarding confirmation of appointments or to notify patient of missed appointments. Logistics may dictate the portions of treatments are conducted in an open gym atmosphere where disclosures may be overheard. Every reasonable precaution is taken to limit these events.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform their job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information or assist in the notifying a family member, personal representative or another person responsible for your care, of your location, and general condition.

Family Communication: After careful judgment, we may disclose to a family member or other person you designate health information relevant in that person's involvement in your care or payment related to your care, of your location and general condition.

Funeral Directors & Organ Procurement Organizations We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
Public Health As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement and Correctional Institution We may disclose health information for law enforcement purposes required by law should you be an inmate of a correctional institution; we may disclose to the institution or agents thereof health information necessary for your heath and the health and safety of other individuals.
Federal Law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.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& Spine