SIGNATURE HEALTH & WELLNESS

CONFIDENTIAL PATIENT HISTORY

Name:_____ Social Security #: _____

Address:_____City:_____State:_____Zip:_____

Home Telephone #:_____ Work Telephone #:_____

Age: _____Birthdate: _____ # of Children: _____

Marital Status: M-S-W-D *(please circle)* Occupation: _____

Emergency Name: _____Emergency Telephone #: _____

Referred By: _____

HEALTH INFORMATION:

Do you have: **Pain Stiffness Tightness Discomfort Tension Stress Postural Concerns** *(please circle)*

What regions: _____

List **ANY** other problems or concerns: _____

How long have you been this way? _____ Have you had this or similar conditions in the past?____

What activities aggravate your condition?_____

Is this condition getting worse? **YES-NO-CONSTANT-COMES AND GOES** *(please circle)*

Is this condition interfering with your: **WORK-SLEEP-DAILY-ROUTINE-OTHER** *(please circle)*

Other doctors who treated these conditions? _____

List **ANY** surgical procedures and year performed: _____

Date of Last Physical Examination: _____

Drugs you take now (please check): _Pain Killers _ Muscle Relaxers _ Pep Pills _Tranquilizers _Insulin _

Age of Mattress:__ __Comfortable __Uncomfortable Are you wearing: __Heel Lifts __Sole Lifts __Inner Soles

Have you been in an auto accident? __Past Year __Past 5 Yrs __Over 5 Yrs __Never

Have you had any other personal injury or accident? _Past Year __Past 5 Yrs __Over 5 Yrs __None

Have you **EVER** suffered from: __Dizziness __Backache __Heart Trouble __Diabetes __ Arthritis

__Headaches __Asthma __Neuritis __Digestive Issues __Nervousness __Sinus Trouble __Neck Pain

INFORMED CONSENT FOR CARE

When a patient seeks preventative health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science of art which concerns itself with relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health provider.

All questions regarding the doctors' objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

PRINT NAME SIGNATURE DATE

Consent to evaluate and adjust a minor child:

I, _____being the parent or legal guardian of_____
Have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE: (FEMALES)

This is to certify that to the best of my knowledge I am **NOT** pregnant and the above doctor and his/her associates have my permission to perform an X-Ray evaluation. I have been advised that X-Ray can be hazardous to an unborn child.

Signature:_____ **Date:**_____

I understand & agree that health & accident policies are an arrangement between an insurance carrier & myself. Furthermore, I understand that this Health & Wellness Office will prepare any necessary reports & forms to assist me in making collection from the insurance company & that any amount authorized to be paid directly to this Health & Wellness office, will be credited to my account upon receipt. However, I clearly understand & agree that all services rendered me are charged directly to me & that I am personally responsible for payment. I also understand that I suspend or terminate my care & treatment; any fees for professional services rendered me will be immediately due & payable.

Patient's Signature: _____ **Date:** _____

Gaurdian's Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS

I hereby instruct & direct my insurance company to pay the following provider direct payment for services rendered:

SIGNATURE HEALTH & WELLNESS CENTER
410 Route 46 East
Fairfield, NJ 07004

If policy provisions prohibit direct payment to physician, I hereby request payment for services rendered per current policy provisions. Payment is for the profession or medical expense benefits allowable, & otherwise payable to me under my current insurance policy as payment toward charges for profession services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS INSURANCE POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Assignment of Rights and Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated:_____ _____

Signature of Policy Holder

Patient Signature:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

SIGNATURE HEALTH & WELLNESS CENTER

I,_____HAVE READ A COPY OF Signature HEALTH & WELLNESS CENTER'S notice of patient privacy practices.

_____ _____

Signature of Patient or
Parent of legal Guardian

Date

Patient Consent for use and disclosure Of protected Health Information

Chiropractic & Wellness Center at Signature Health

I hereby give my consent for Chiropractic & Wellness Center at Signature Health. PC to use and disclose protected health information (PHI) about me to carry out treatment. Payment and healthcare operations (TPO)

Chiropractic & Wellness Center at Signature Health Notice of privacy practice a more complete description of such uses and disclosure.

I have the right to review the notice of Privacy Practices prior to signing this consent Chiropractic & Wellness Center at Signature Health, reserves the right to revise its notice of Privacy at any time. A revised notice of privacy practice may be obtained by forwarding a written request Gold's Chiropractic and Wellness Center at 471 Courtlandt Street Belleville NJ 07109.

With this consent, Chiropractic & Wellness Center may call or mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in the carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical laboratory results among others.

With this consent, Chiropractic & Wellness Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in the carrying out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consent in writing expect to the extent that the practice has already made disclosure in reliance upon prior consent. If I do not sign this consent, or later revoke it, Chiropractic & wellness Center at Signature Health may decline to provide treatment to me. For security purposes all common areas are being recorded by video.

_____

Signature of Patient Legal Guardian

_____

Patient's Signature

_____

Print Name of Patient or Legal Guardian