Coniglio Chiropractic Wellness CENTER

PATIENT INFORMATION

Name:_____ Today's Date:_____
Address:_____City:_____State:_____ Zip:_____
Email:_____Phone#_____Cell Provider:_____
Birthdate_____ Age:_____ Sex: ☐Male ☐Female ☐Other
Status;☐Minor ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
Employer:_____Occupation:_____ How Long?_____
Employer's Address:_____City:_____State:_____ Zip:_____
Who may we thank for referring you?_____
In case of emergency notify:_____ Phone#_____ Relation:_____

INSURANCE INFORMATION

Insured's Name:_____ Relation:_____ Birthdate:_____

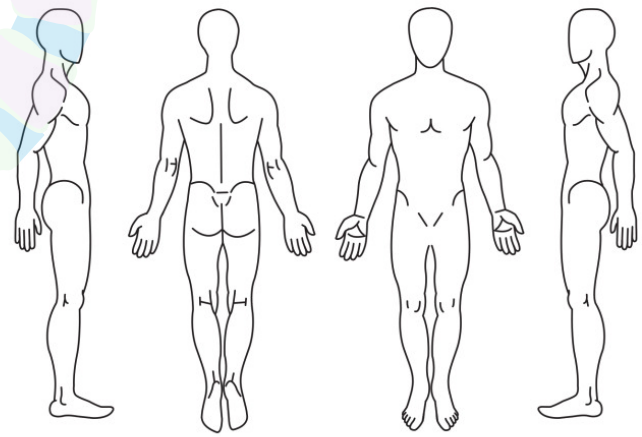
Company's Name:_____

Address:_____City:_____State:_____ Zip:_____
Insured's ID#_____ Group #(plan, local or policy)_____

REASON FOR VISIT

Reason for today's visit:_____
Have you been seen by a chiropractor? ☐ Yes ☐ No Clinic or Dr's name:_____
Are you in pain: ☐Yes ☐No Rate you pain on a scale from 1-10:_____
Did injury occur at: ☐ Work ☐ Sport/Play ☐ Auto Accident ☐ Routine/Household activity
When and where did injury/condition occur?_____
Explain what happened:_____
Is your condition getting worse?☐ Yes ☐ No ☐ Constant ☐ Come and goes
Is your condition interfering with your: ☐Work ☐ Sleep or ☐ Daily routine?
If so, how:_____
Has this or something similar happened in the past?
☐Yes ☐ No Explain:_____
_____
_____

Using the adjacent body charts, please circle all affected areas:



HEALTH HISTORY

Are you taking any medications? ☐ Yes ☐ No List of medication you are taking_____

_____

Do you have or ever had:

Y N Heart Attack/ Stroke	**Y N** Heart Surg/pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Detect
Y N Mitral valve Prolapse	**Y N** HIV+/AIDS/ARC	**Y N** Hepatitis	**Y N** Artificial Valves
Y N Shingles	**Y N** High/low blood pressure	**Y N** Ulcers/ Colitis	**Y N** Difficulty Breathing
Y N Alcohol/Drug Abuse	**Y N** Cancer	**Y N** Venereal Disease	**Y N** Psychiatric Problems
Y N Fainting/Seizures	**Y N** Chemotherapy	**Y N** Sinus Problems	**Y N** Lower Back Problems
Y N Frequent Neck Pain	**Y N** Severe/Headaches	**Y N** Glaucoma	**Y N** Rheumatic Fever
Y N Emphysema/Asthma	**Y N** Anemia/ Diabetes	**Y N** Kidney Problems	**Y N** Tuberculosis
Y N Arthritis	**Y N** Artificial Bones/Joints/Implants		

Please List any other serious medical condition(s) not listed above:_____

_____

_____

List any past serious accidents with dates:_____

Please list anything that you may be allergic to:_____

Family health history:_____

Do you take any Supplements or Vitamins? ☐ Yes ☐ No Do you exercise? ☐ Yes ☐ No _____Hrs per week

Do you Smoke? ☐ Yes ☐ No How much?_____ How long?_____

Are you wearing: ☐ Shoe lifts ☐ Inner soles ☐ Arch supports Are you dieting? ☐ Yes ☐ No Since:_____

For Woman: Are you taking birth Control ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If so, how long?_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (insurance co.) and assign directly to Coniglio Chiropractic, LLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please Print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date *Relationship to Patient*

Coniglio Chiropractic LLC Office Policy

Coniglio Chiropractic L.L.C. is pleased to accept your insurance assignment, as soon as the responsible party verifies your exact coverage. We will file forms to assist you in every way we can. It must be fully understood that the contract is between you and your insurance company. You are fully responsible for any amount that is not paid by your insurance.

1. You are required to sign an "Authorization to Pay Physician" form and any other assignment documents required by your insurance company on your first visit.
2. Our office does not guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your insurance claim is denied, you are responsible for the full amount.
3. Our office will ***NOT*** enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. If circumstance warrants, your insurance assignment may be withdrawn.
4. I agree to pay any collection and/or attorney fees that may arise as a result of any unpaid balance being forwarded to a collection agency and/or attorney to cause payment.
5. All returned checks are subject to a $25 service fee and a late payment fee.
6. Missed appointment policy: A missed appointment fee of $100 for your first visit, occurs without 24 hours notice of cancellation. For any scheduled visit thereafter a $60 missed appointment fee will be assessed without advanced notification of cancellation.
7. For your health this is a Smoke-Free property.
8. Your credit card will be held securely on electronic file for any balance due, which includes any missed appointment fees.
9. I hereby give Coniglio Chiropractic Center LLC the permission to use and/or publish photographs of me for promotional purposes
10. I have read and understand the above office policy and agree to its terms.

_____ _____

SIGNATURE OF PATIENT/GUARDINAN DATE

Coniglio Chiropractic L.L.C.

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustments and other professional procedures, including various modes of physio-therapy, acupuncture and diagnostic services, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or any other licensed professionals who now or in the future treat me while employed by, working or associated with, or serving as backup for the doctor named below, including those working at the office.

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use their hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which they feel at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

This office includes nutritional recommendations in the treatment of patients. The goal of nutrition is to support the body to improve its overall health and not to treat a specific disease or symptom. All medication changes must be made by my medical physician. I understand nutritional supplements have been proven to be extremely safe when taken as directed. There is always a chance for an adverse reaction from any product. If I feel I am having a reaction to a product, I will stop using the product until I can discuss the matter. The products are sold retail and there is a NO refund policy.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, and treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have had the opportunity to discuss with the doctor and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks of treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Professional Care. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices 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 the 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 1996) 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 practice 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 discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Emergency Contact: _____

Phone Number: _____