Peltzman Chiropractic Associates

Registration Form

Please print clearly. Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Employer: _____ Occupation: _____ ☐ FT ☐ PT

Address: _____ City: _____ State: _____ Zip: _____

Are you under 25 and covered on your parent's insurance? ☐ Yes ☐ No

Are you a student and covered by your parent's insurance? ☐ Yes ☐ No

How did you hear about our office?

☐ Patient Referral: _____ ☐ Insurance

☐ Google ☐ Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Cell: _____ Work: _____

Primary Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Carrier: _____ ID/Policy: _____

Name of Primary Policy Holder: _____ Date of Birth: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Domestic Partner

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Is your current condition the result of work injury or auto accident? ☐ Yes ☐ No

What are your present symptoms?

_____

_____

Have you seen a chiropractor before? ☐ Yes ☐ No

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Confidential History Form

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. **Please print clearly.** Thank you.

Name: _____ Date: _____

CURRENT COMPLAINTS:

□ Headaches	□ Neck Pain	□ Arm Pain	□ Chest Pain
□ Mid-Back Pain	□ Hip Pain	□ Leg Pain	□ Arm/Hand Numbness
□ Buttock Pain	□ Low-Back Pain	□ Leg/Foot Numbness	

□ Other: _____

_____

ONSET (How did your pain start?):

□ Unknown □ Woke up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain:_____

_____

_____

_____

_____

PAST MEDICAL HISTORY (Please check each box if you have had the following problems.):

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma
□ Bypass	□ Cancer: where?			□ Diabetes
□ Dialysis	□ Diverticulosis	□ Emphysema	□ Hypertension	□ Headaches
□ Heart Attack	□ Heart Disease	□ Heart Failure	□ Hemophilia	□ Hemorrhoids
□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.	□ Leg Swelling
□ Liver Prob.	□ Murmur	□ Obesity	□ Pacemaker	□ Pass Out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea
□ Stroke	□ Surgeries:			□ Thyroid
□ Tuberculosis	□ Ulcer	□ Varicose Veins		
□ Other:				

_____

FAMILY MEDICAL HISTORY

Mother:	Age: _____	□ Living	□ Deceased
Father:	Age: _____	□ Living	□ Deceased
Siblings:	Age: _____	□ Living	□ Deceased
	Age: _____	□ Living	□ Deceased

Please check each box if any family member (mother, father or siblings) has had any of the following:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma
□ Bypass	□ Cancer: where?			□ Diabetes
□ Dialysis	□ Diverticulosis	□ Emphysema	□ Hypertension	□ Headaches
□ Heart Attack	□ Heart Disease	□ Heart Failure	□ Hemophilia	□ Hemorrhoids
□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.	□ Leg Swelling
□ Liver Prob.	□ Murmur	□ Obesity	□ Pacemaker	□ Pass Out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea
□ Stroke	□ Surgeries:			□ Thyroid
□ Tuberculosis	□ Ulcer	□ Varicose Veins		
□ Other:				

CURRENT MEDICATIONS: Please list all current medications below or provide us with a list of medications.

Name of Medicine	Strength	Dosage

List of known ALLERGIES:

_____

_____

_____

TOBACCO

Type: _____

Year begun:_____

Still smoking: □ Yes □ No

Year quit: _____

Packs per day: _____

ALCOHOL

Type: _____

How often: _____

How much: _____

How many years:_____

Exercise

□ None □ Light □ Moderate □ Heavy

Other:

_____

_____

_____

_____

REVIEW OF SYSTEMS: Do you (did you) have the following? (Check the appropriate boxes):

General: □ Weight gain □ Weight loss □ Fever □ Hair loss
□ Weakness □ Other: _____

Eyes: □ Eye strain □ Sensitivity to light □ Wear glasses or contact lenses

Ear, nose, throat: □ Sinusitis □ Ringing in ears □ Hearing loss □ Dizziness
□ Hoarseness □ Running nose □ Discharge or pain □ Difficulty breathing through nose
□ Painful teeth, gums or palate □ Pain or difficulty swallowing □ Growths in the mouth

Cardiovascular: □ Palpitations □ Chest pain □ Fainting □ Varicose veins
□ Dizziness □ Pain in the legs □ Cold feet/hands □ Difficulty climbing stairs
□ Shortness of breath

Respiratory: □ Spit up blood □ Shortness of breath while walking □ Asthma/wheezing
□ Cough with or without phlegm □ Other: _____

Gastrointestinal: □ Abdominal pain □ Nausea □ Vomiting □ Diarrhea
□ Hemorrhoids □ Change in shape or color of stool

Genitourinary: □ Discharge □ Frequent urination □ Pain □ Pain with urination

Musculoskeletal: □ Weakness □ Back pain □ Neck pain □ Leg pain
□ Arm Pain □ Shoulder pain □ Numbness □ Headaches
□ Other: _____

Skin: □ Jaundice □ Dry skin □ Growths □ Pigment change
□ Moles that have changed color, shape or bleed

Neurologic: □ Numbness □ Weakness □ Tremors □ Confusion
□ Memory loss □ Other: _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

I, _____, understand that as part of my healthcare, Peltzman Chiropractic Associates, LLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, 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 the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

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 following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Peltzman Chiropractic Associates, LLC, 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 organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Peltzman Chiropractic Associates, LLC, reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.506 of the Code of Federal Regulations. Should Peltzman Chiropractic Associates, LLC, change their notice, they will send a copy of any revised noticed to the address that I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____
Patient's Name

_____ _____
Patient's Signature **Date**

591 Route 34, Matawan, NJ 07747 • Tel: (732) 566-7658 • Fax: (732) 583-7847
www.PeltzmanChiropractic.com

Peltzman Chiropractic Associates

INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Fractures are rare occurrences and generally result from some underlying weakness of the bone that I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization and surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Drs. Jeffrey and/or Valerie Peltzman have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____	_____
Patient's Name	**Drs. Jeffrey or Valerie Peltzman**
_____	_____
Signature	**Signature**
Date: _____	**Date:** _____

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Office Policy Statement

Dear Patient

You have selected "**Insurance Assignment**" as the method of choice to take care of your financial obligation with this office. It is important that you realize that we offer the option of "**Insurance Assignment**" strictly as a courtesy to our actively treating patients who are following a recommended treatment schedule prescribed by the doctor, and as such, our patients must understand the terms and agree to the following policy:

1. You are considered a **cash patient** until you bring in all of your insurance information, including a referral from your primary care physician (if necessary) and we have a copy of your insurance card and have qualified, as well as accepted, your insurance coverage as partial or full payment. If you have a second insurance, it is your responsibility to submit claims to your second insurance carrier. **It is the patient's responsibility to know their insurance coverage.**
2. If your insurance company does not honor the doctor's assignment of payment, in which they send the checks directly to our office, payment will be due from you at the time of service. Upon your payment, we will gladly give you a statement for you to submit to your insurance company for reimbursement.
3. In the event your insurance company begins a review of charges, and they cannot guarantee benefits will be paid until the review is concluded, you will be responsible for all unpaid charges.
4. Your co-insurance (co-payment), deductible and non-covered or reduced charges, must be paid at the time of each visit.
5. If your insurance carrier has not paid a claim within 60 days of submission, you will be required to take an active part in the recovery of your claim. After 90 days you will be responsible for payment in full and must be reimbursed from your insurance company.
6. In the event you are placed on maintenance care (once a month or longer), you may be responsible for full payment at the time of service, unless there is a prior written agreement or special program. We will no longer submit to your insurance company unless they cover this type of care.
7. You are ultimately responsible for full payment of any and all services rendered, regardless of any insurance coverage or agreement you have made. We are not responsible if your insurance company has incorrectly informed us of your coverage and/or in the event your policy changes without notification to us of the changes in your coverage. If you fail to communicate with our office and cooperate with payment on your account and it becomes more than 90 days delinquent, you will become responsible for any and all court, collection and/or attorney fees, and interest (1.5% per month or 18% APR) etc., which will be applied to your unpaid balance.
8. Many managed care insurance company policies have restrictions applied to chiropractic care. During the course of your treatment in our office, Drs. Jeffrey or Valerie Peltzman may recommend treatment that he/she feels is reasonable and necessary to achieve control or resolution of your condition. Some of these procedures are not covered under your insurance policy. Furthermore, your insurance company may deny further treatment prior to completion of Drs. Peltzman's recommended treatment program. You will be notified by your insurance carrier of their denial of payment for further chiropractic treatment. Continuation of your recommended treatment program following the date of denial will be the patient's responsibility.

This insurance assignment policy is to be followed and we ask that you sign this form as acknowledgement that you fully understand and accept the terms and full responsibility for your account in our office.

Patient Name: _____

Street Address: _____ City: _____ State: _____

_____ _____
Patient Signature Date

_____ _____
Witness Date

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