Health Questionnaire

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Cell Phone Number: _____

Cell Phone Carrier: _____ (we send appointment reminders via text)

Email Address: _____ Age: _____ Birth Date : _____

Marital Status: M S D W Number of Children: _____

Occupation: _____ Referred By: _____

Health Information

What are your complaints? _____

_____

How long have you had this condition? _____

Have you had this condition in the past? _____

What aggravates your condition? _____

Is the condition getting worse? Yes _____ No _____

Constant: Yes _____ No _____ Comes and goes: Yes _____ No _____

Have you had previous chiropractic care? _____

How long has it been since you felt well? _____

Name the Doctors who have treated this condition? _____

List surgical operations and year:

_____

Medications you are presently taking now: _____

Were you ever in an automobile accident? Yes _____ No _____

Please describe and give dates: _____

Health Questionnaire

Were you ever injured at work? Yes _____ No _____

Please describe and give dates: _____

_____

Have you had any other personal injuries or accidents? Yes _____ No _____

Please describe all details and give dates: _____

Date of your last physical examination: _____

Family doctor: _____

HAVE YOU EVER SUFFERED FROM THE FOLLOWING

Dizziness _____ Backaches _____ Heart Trouble _____ Diabetes _____ Arthritis _____

Headaches _____ Asthma _____ Neuritis _____ Digestive Disorder _____

Nervousness _____ Sinus Trouble _____ Neck Pain _____

Are there any other ailments or conditions you have had in the past?

_____

Please list any treatments or Physicians you have had or seen for these conditions:

_____

_____

_____

BY SIGNING BELOW, I HEREBY ACKNOWEDGE THAT I HAVE COMPLETELY READ AND FULLY UNDERSTAND THE HEALTH QUESTIONARE. I GIVE MY CONSENT FOR TREATMENT BY THE HEALTHCARE PHYSICIAN. INCLUDING THERAPY AND REHABILITATION SERVICES AND OTHER NECESSARY TREATMENT AS PRESCRIBED BY MY PHYSICIAN. I FURTHER UNDERSTAND THAT MY PHYSICIAN SHALL BE KEPT INFORMED REGARDING MY CURRENT HEALTH STATUS AND MY RESPONSE TO ANY TREATMENT RECEIVED. AS WITH ANY COURSE OF TREATMENT OR THERAPY, THERE IS ALWAYS THE POSSIBILITY OF AN UNEXPECTED COMPLICATION AND NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS OF TREATMENT.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Dr. Frank J. Mandarino
Dr. Michael A. Carducci
Chiropractic Physicians
436 Route 79, Suite 21
Morganville, New Jersey 07751
Telephone (732) 617-8000
Fax (732) 591-1000

PATIENT AGREEMENT FOR SERVICES RENDERED

I understand that the insurance payment for the fees incurred for my Chiropractic/Physical Medicine visits may be sent to me directly.

I agree to endorse and forward any payment or non-payment, along with the Explanation of Benefits and all other documents I receive from my insurance carrier. Copies will be made available to me by the provider. I am also aware that all payments made directly to me will be made known to the provider as well.

Patient Name: _____

Patient Signature: _____

Date: _____

Informed Consent

Laser therapy is a safe, non-invasive, FDA cleared modality for the treatment of pain and the temporary increase of microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes and invisible laser radiation, therefore, appropriate eye protection is required at all times during treatment.

Effects of your treatment will continue for up to 18 hours. Individuals respond uniquely to treatment, you may see immediate results after the first treatment or depending on the severity of your condition you may require several treatments before you begin to feel results.

Increased soreness may occur after your first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program.

You are required to complete the Patient Intake Form prior to treatment to ensure that laser therapy is a viable option for you.

- ☐ I understand the above and consent to treatment

- ☐ I understand that failing to complete any part of my treatment program will reduce my chances of success.

Patient Signature	Date
Print Patient Name	Physician Signature

Instrument Assisted Soft Tissue Mobilization

Please answer the following questions. Read the statements concerning Instrument Assisted Soft Tissue Mobilization (IASTM) and sign below. If you have any questions, please speak with your clinician.

1.	Do you bruise easily?	Yes	No
2.	Do you bleed for a long period of time after you cut yourself?	Yes	No
3.	Are you taking blood thinners or anticoagulants?	Yes	No
4.	Do you take aspirin on a regular basis?	Yes	No
5.	Do you take cortisone on a regular basis?	Yes	No
6.	Have you ever had inflamed veins o blood clots?	Yes	No
7.	Do you have surgical implants in your body?	Yes	No
8.	Do you have diabetes or kidney disease?	Yes	No
9.	Do you currently have any infections?	Yes	No
10.	Do you have uncontrolled high blood pressure?	Yes	No

Instrument Assisted Soft Tissue Mobilization (IASTM) is an instrument assisted variation of traditional cross fiber or transverse friction massage. The IASTM instruments consist of stainless steel tools of various sizes and contours. IASTM is a form of treatment used to "break up" or "soften" scar tissue, thus allowing for the return of normal function in the area being treated.

Instrument Assisted Soft Tissue Mobilization (IASTM) may produce the following:

1. Local discomfort during the treatment.
2. Reddening of the skin.
3. Superficial tissue bruising.
4. Post treatment soreness.

The Instrument Assisted Soft Tissue Mobilization (IASTM) is designed to minimize discomfort; however the above reactions are normal, and in some instances unavoidable.

The Instrument Assisted Soft Tissue Mobilization (IASTM) has several basic components. Your clinician will determine the protocol for you.

1. Warm up of the treatment area.
2. Instrument Assisted Soft-Tissue Manipulation.
3. High repetition, low load exercise.
4. One to three 30-second stretches.
5. Low repetition, high weight exercise.
6. Ice therapy.
7. Stretching/rehabilitation exercise.

All components of Instrument Assisted Soft Tissue Mobilization (IASTM) have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Print your name_____Date_____

Your signature_____

Dr. Frank J. Mandarino
Dr. Michael A. Carducci
Chiropractic Physicians
Tel: (732) 617-8000
Fax: (732) 591-1000

Date: _____

To: _____

Address: _____

_____

I hereby authorize of my X-rays and medical records or copies of such and request they be transferred to:

436 Route 79, Suite 21
Morganville, New Jersey 07751

Patient Name: _____

Patient Address: _____

_____

Patient SS#: _____

Patient Date of Birth: _____

Patient Signature: _____

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Examination and Consultation X-Rays Ultrasound Electrical Muscle Stimulation Soft Tissue Work	Medicare considers this a non covered service	$20.00 to $125.00 each visit

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

HIPAA Notice of Privacy Practices

HIPAA (the Health Insurance Portability & Accountability Act of 1996) was passed to provide rules for how medical care providers might use your Protected Health Information (PHI). It also provides you with certain rights pertaining to that information. As a provider of healthcare services, Healthcare Practice fully complies with all HIPAA regulations. These regulations require that we provide you with the **HIPAA Notice of Privacy Practices**, which is reproduced below.

Please sign below to acknowledge receipt of this information, and return this form to us at the time of your first visit. Thank you.

I have received the HIPAA Notice of Privacy Practices information from Practice.

Print Name: ____

Signature: ____________________________________ Date: ____________

****

This notice describes how medical information about you may be used and disclosed as per HIPAA regulations, and describes your rights regarding access to this information. Please review it carefully.

This Notice of Privacy Practices describes how the Healthcare Practice may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, acknowledge referrals and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 of HIPAA.
Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

1. **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

2. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

3. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**

4. **You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically.)**

5. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

6. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections please ask to speak with our HIPAA Compliance Officer in person.

I have received the HIPAA Notice of Privacy Practices information from Healthcare Practice.

Print Name: _____

Signature: _____ Date: _____

Fitness Center Waiver and Release of Liability

In consideration of my use of the exercise equipment and facilities provided by New Jersey Sports Chiropractic PC / Monmouth Sports Chiropractic PC, I expressly agree and contract, on behalf of myself, my heirs, executors, administrators, successors and assigns, that the company and its insurers, employees, officers, directors, and associates, shall not be liable for any damages arising from personal injuries (including death) sustained by me, or my guest in, on, or about the premises, or as a result of the use of the equipment or facilities, regardless of whether such injuries result, in whole or in part, from the negligence of the company.

By the execution of this agreement, I accept and assume full responsibility for any and all injuries, damages (both economic and non-economic), and losses of any type, which may occur to me or my guest, and I hereby fully and forever release and discharge the company, its insurers, employees, officers, directors, and associates, from any and all claims, demands, damages, rights of action, or causes of action, present or future, whether the same be known or unknown, anticipated, or unanticipated, resulting from or arising out the use of said equipment and facilities.

I expressly agree to indemnify and hold the company harmless against any and all claims, demands, damages, rights of action, or causes of action, of any person or entity, that may arise from injuries or damages sustained by me or my guest.

I agree to be solely responsible for safety and well being of my guest and myself. I understand that the company does not provide supervision, instruction, or assistance for the use of the facilities and equipment.

I agree to comply with all rules imposed by the company regarding the use of the facilities and equipment. I agree to conduct myself in a controlled and reasonable manner at all times, and to refrain from using any equipment in a manner inconsistent with its intended design and purpose.

I understand and acknowledge that the use of exercise equipment involves risk of serious injury, including permanent disability and death.

I understand and agree that the company is not responsible for property that is lost, stolen, or damaged while in, on, or about the premises.

I understand and agree that my use of the facilities and equipment is only to be undertaken on my own personal time, and that my use of the facilities and equipment is not within the course or scope of my employment.

I HAVE READ THE FOREGOING WAIVER AND RELEASE OF LIABILITY AND VOLUNTARILY EXECUTED THIS DOCUMENT WITH FULL KNOWLEDGE OF ITS CONTENT.

Date:_____

Signature: _____

_____

Print Name