**Chatham Chiropractic Center**

466 Southern Blvd Suite 1, Chatham NJ 07928

Dr. Sonal Dalal

**Patient information (please complete using your name as listed on your insurance card):**

Name: _____ Date Of Birth:_____ Today's Date: _____

Address: _____

Street City State Zip code

Home Phone: ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Cell Phone Carrier for text Reminders: _____

Social Security #: _____ □ Male □ Female

Occupation _____ □ Single □ Married □ Divorced □ Widowed

Email Address: _____

Insurance Co. _____ ID#: _____

Who may we thank for referring you to us? _____

Patient Signature: _____

## PATIENT HEALTH ASSESSMENT

**1. What is your present complaint?**

_____

_____

**2. How would you describe your pain:**

□ Sharp □ Soreness □Throbbing □Tingling

□ Dull □ Stiffness □Spasm □ Burning

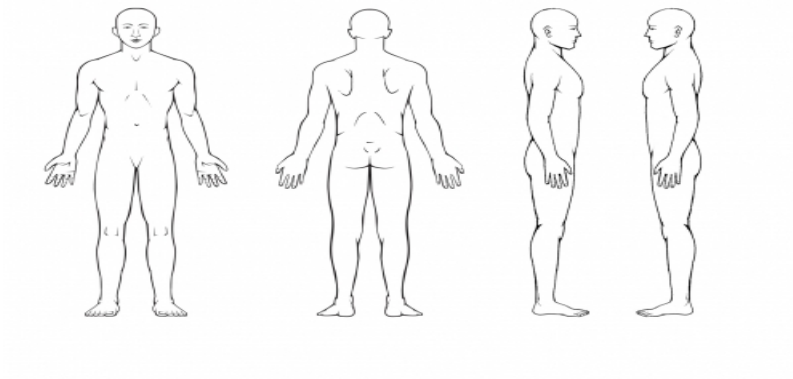
□ Ache □ Weakness □ Numbness □ Shooting

**3. How would you rate the intensity of your pain? (Please circle)**

0 1 2 3 4 5 6 7 8 9 10

(no pain) ⟶ (terrible/unbearable pain)

**4. Please mark on the body below where you feel your pain:**



**5. How often is the pain present?**

□ Constant (80-100%) □Frequent (50-80%) □ Occasional (25-50%) □ Intermittent (25% or less)

**6. When did your problem begin?** (Give an approx. date if possible) _____

**7. Since your problem began is the pain:**

□ Getting worse □ Getting better □ Staying the same

**8. How did your problem begin?**

□ An Auto Accident □ Work related accident □ Other type of accident

□ Gradual □ Sudden □ No specific reason

**9. Describe how the problem began.** _____

_____

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**10. What makes your problem better?**

□ Nothing □ Walking □ Standing □ Sitting
□ Moving around/exercise □ Lying Down □ Inactivity

**11. What makes your problem worse?**

□ Nothing □ Walking □ Standing □ Sitting
□ Moving around/exercise □ Lying Down □ Inactivity

**12. What prior treatments have you received for this present condition?**

□ Medical □ Surgical □ Physical Therapy □Acupuncture □Other: _____

**13. Have you had this problem in the past?** □Yes □No

If yes, please explain: _____

**14. Were you previously treated for an earlier occurrence of this <u>same</u> condition?**

□ Yes □ No

If yes, by whom? □ MD □Chiropractor □ Physical Therapist □ Other

What were the approximate dates, type of treatment and the results? _____

_____

_____

**15. Are you currently taking any medications?** □ Yes □No

if yes, please describe: _____

_____

**16. What is your physical activity at work?**

□ Mostly sitting □ Light manual labor
□ Moderate manual labor □ Heavy manual labor

**17. What general physical activity do you do include exercise.**

□ Mostly sitting □ Light activity □ Moderate activity □ Heavy activity

Describe _____

**18. What is your present general stress level?**

□ No stress □Minimal stress □ Moderate stress □ Greatly stressed

**19. Do you currently smoke tobacco of any kind?** □Yes □Former smoker □Never been a smoker

If yes, how often do you smoke? □ Current every day smoker □Current sometimes smoker

Do you drink alcohol and caffeine? □Yes □ No, If so how often: _____

**20. Please describe your sleeping position at night.**

□ Side Sleeper □Back Sleeper □Stomach Sleeper

How old is your mattress (approx)_____ How many pillows do you sleep with? _____

**21. Do you have a history of:**

□ Cancer □ Diabetes □ Heart Disease □ Motor Vehicle Accident □Surgery □Hospitalization □Pacemaker

If yes, please explain: _____

**22. Are you:**

□ Right Handed □ Left Handed

**23. Height _____ Weight _____ Blood Pressure _____/_____**

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**PATIENT ACKNOWLEDGEMENTS OF CHATHAM CHIROPRACTIC CENTER**
**PLEASE READ THE FOLLOWING CAREFULLY BEFORE INITIALING**

**Insurance Information – Copayments and Responsibility**

I understand that regardless of insurance enrollment, I am ultimately responsible for all costs of treatment rendered and it is my responsibility to understand my healthcare coverage including copayments, deductibles and coinsurance and VISIT LIMITS. Payment of copays, deductibles, and non-covered procedures is expected at the time of service. This office will only submit insurance claims for those companies with which we participate. Our staff is available to assist you, but is not responsible for knowledge of each patient's individual insurance plan requirements. Please refer to your health plan member services or benefit handbook. Insurance companies do not pay for maintenance care/wellness care. A patient is considered to be receiving maintenance/wellness care when he/she has reached maximum medical improvement and is still receiving treatment. If the treating Chiropractor or your insurance company determine that your care has reached maintenance status, your will be responsible for services rendered at prevailing office rates. It should be understood that some fees may not be reimburse dully or that certain procedures are not covered by your insurance. You will be financially responsible for any balances due as a result of such action by your insurance company. Checks returned for insufficient funds will be charged an additional $50.00 fee. An administrative fee of $10.00 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or collection fee, at the provider's current rate may be charged on all past due balances owed to the provider. Your signature below signifies your understanding and willingness to comply with this policy.

Patient / Guardian Initials _____

**Referral Information**

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Physician and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral, the expiration date of my referral, and obtain new referrals as needed. I understand that should I fail to have a valid referral for my visits, my insurance company will deny the claim. Ultimately I will be responsible for the office visits not covered by my insurance.

Patient / Guardian Initials _____

**Insurance Cards**

New patients or those with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. If I am unable to present one, I may pay in full at the time of service and submit a claim to my insurance carrier at my convenience. I understand by signing below that I am responsible for notifying the office of any changes to my insurance/contact information.

Patient / Guardian Initials _____

**Cancellation/ No Show Policy**

Should you be unable to keep your appointment, please contact the office 24 hours prior to your appointment to cancel. Missed appointments or "No Shows" will result in a $50.00 fee after two consecutive missed appointments. This fee is not reimbursable by your insurance company. If you are running late, but plan on keeping your appointment, out of courtesy to us and other patients, call the office as soon as possible. We will do our best to adjust our schedule accordingly.

Patient / Guardian Initials _____

**HIPAA Policy**

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits Chatham Chiropractic Center from discussing appointments, medication, test results, or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA form.

Name of Individual _____ Relationship to Patient _____
Name of Individual _____ Relationship to Patient _____

**I acknowledge the practice's adherence to the Notice of Privacy Practices related to the Health Insurance Portability and Accountability act of 1996 and may request a personal copy at any time.**

SIGNATURE: _____ TODAY'S DATE: _____

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## INFORMED CONSENT

**TO THE PATIENT:** Please read the *ENTIRE* document prior to signing it. It is important that you understand the information contained in this document. If anything in this document is unclear to you please make sure to ask questions before signing.

**The nature of the chiropractic Adjustment**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click" much as you would experience when you "crack" your knuckles. You may feel a sense of movement.

**Analysis/Examination/Treatment**

As part of the analysis, examination, and treatment you are consenting to the following procedures:

| | | |
|---|---|---|
| Spinal manipulative therapy | Palpation | EMS |
| Range of motion test | Orthopedic Testing | Ultrasound |
| Basic Neurological testing | Muscle strength Testing | Laser Therapy |
| Postural Analysis | Hot/Cold Therapy | |
| Other | Vital Signs | |

**The material risks inherent in chiropractic adjustment**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costo vertebral strain 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 an 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.

**The probability of those risks occurring:**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which 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.

**The availability and nature of the other treatment options**:

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
- Hospitalization
- 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.

**The risks and dangers of attendant to remaining untreated**

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 complicated treatment making it more difficult and less effective the longer it's postponed.

**PLEASE DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

**I have read [ ] or have read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with _____ and 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.**

**Date:_____** **Date: _____**

**Patient/Guardian Signature:_____** **Doctor's Signature _____**

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## SPECIFIC AUTHORIZATIONS

☐ I give permission to Chatham Chiropractic Center to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, holiday related cards, information about treatment alternatives or other health related information.

☐ If Chatham Chiropractic Center contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

By signing this form you are giving Chatham Chiropractic Center permission to use and disclose your protected health information in accordance with directives listed above.

***You have the right to revoke your authorization at any time, please ask for details regarding this.**

Patient Signature: X _____ EXP. Date _____

## NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that Chatham Chiropractic Center has informed me of the Notice of Privacy Practices, which describes the Practice's policies and procedures regarding the use and disclosure of my protected health information created, received or maintained by the practice. If I would like a copy, I understand that Chatham Chiropractic Center will be able to supply one for me at the time I request it. I also understand that it is posted on the Chatham Chiropractic bulletin board available for me to read anytime.

I understand that Chatham Chiropractic Center protects my medical information by using encrypted e-mail and password protected computers which are accessible only by doctors and staff at Chatham Chiropractic Center.

_____ SIGNATURE

_____ PRINT NAME

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*Date: _____*

*To whom it may concern:*

*I _____, give consent to Chatham Chiropractic Center and the individual doctors to treat my condition without X-rays. I realize that X-rays are the standard tool utilized to assess my condition.*

*I release Chatham Chiropractic Center and the individual doctors from any liability of kind, nature, or character whatsoever arising from said treatment and from the lack of information that would be available if films were taken.*

_____

*(Patient's signature)*