

# New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

## Patient Data

First Name  Last Name  Date  Email\*

\* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

## Mailing address

Address  City  State  Zip

Telephone (Work)  (home)  Referred By

Age  Birth Date  Social Security #  Number of Children

Occupation  Employer

Marital Status  Spouse's Name  Spouse's Occupation

Spouse's Employer  Spouse's Health Status

Emergency Contact  Phone

## Current Complaints

Nature of Injury:  Automobile\*  Work  Other

Please describe:

Date of Injury  Date symptoms appeared

Have you ever had same condition?  No  Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care?  No  Yes

If yes, please describe

## Insurance Information

Name of party responsible for payment  Phone

Do you have health insurance?  No  Yes Name of company

**\* If an auto accident, please provide:**

Insurance Company Name  Contact Person

Phone:  Claim #

## Signatures

Name of the insured \_\_\_\_\_

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's or guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

Have you been treated for any conditions in the last year?  No  Yes

If yes, please describe

Date of last physical exam  Is there a chance that you are pregnant?  No  Yes

Have you had X-rays taken?  No  Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

## Family History

**Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

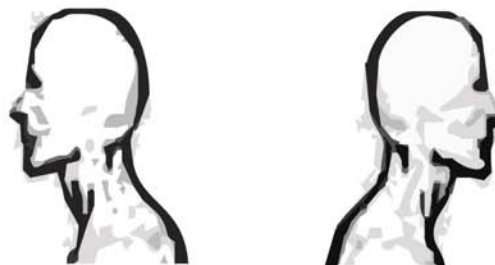
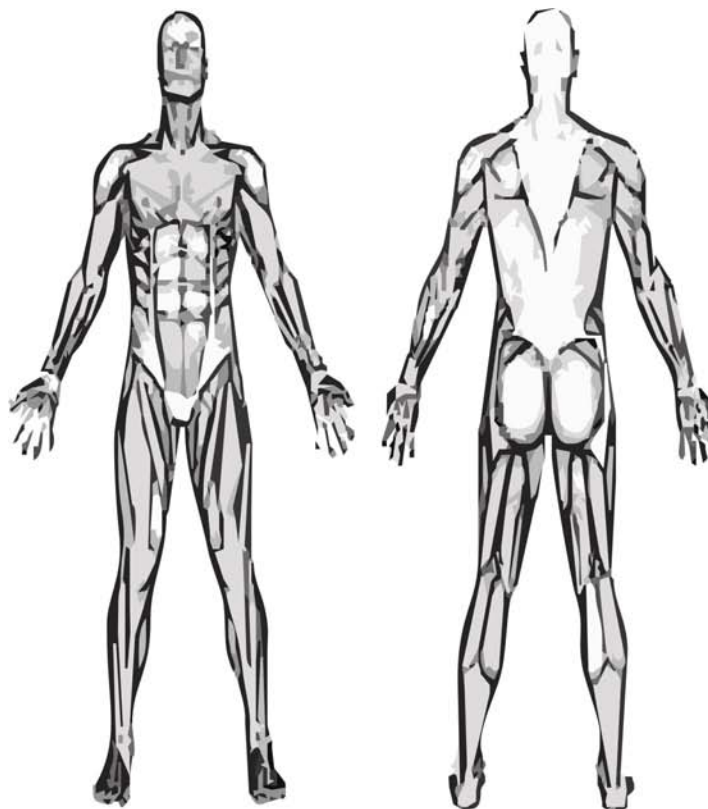
Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Have you ever suffered from:**

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

- A**=Ache                      **O**=Other
- B**=Burning                   **P**=Pins & Needles
- N**=Numbness                **S**=Stabbing



# CHIROPRACTIC AUTHORIZATION RELEASE & EXPLANATION

## HOLDING FEE FORM

I, \_\_\_\_\_ hereby understand that the fee of \_\_\_\_\_ that I am presently paying  
*Patient Name*  
\_\_\_\_\_ is a partial payment (holding-fee) until such time that my insurance company  
*Doctor or Clinic Name*  
acknowledges this claim and pays this Doctor/Chiropractic Clinic directly in full, all monies due for services rendered on my behalf.

\_\_\_\_\_  
*Patient signature or authorized person acting on patient's behalf*

\_\_\_\_\_  
*Date*

## PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

A. I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment below.

\_\_\_\_\_  
*Patient signature or authorized person acting on patient's behalf*

\_\_\_\_\_  
*Date*

B. I authorize payment of any medical benefits from \_\_\_\_\_  
to be paid directly to \_\_\_\_\_ for any services rendered to me.  
*Doctor or Clinic Name*

\_\_\_\_\_  
*Patient signature or authorized person acting on patient's behalf*

\_\_\_\_\_  
*Date*

## AUTHORIZATION AND ASSIGNMENT

In consideration of you providing care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state/province of \_\_\_\_\_.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed \_\_\_\_\_  
\_\_\_\_\_, are paid in full. *Doctor or Clinic Name*

\_\_\_\_\_  
*Patient signature or person acting on patient's behalf*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Staff Signature*

\_\_\_\_\_  
*Date*

## RECORDS RELEASE

To \_\_\_\_\_, I hereby authorize you to release to \_\_\_\_\_  
any Information including the diagnosis and records of any examination or treatment rendered to me during the period between \_\_\_\_\_ and \_\_\_\_\_.

\_\_\_\_\_  
*Patient signature or person acting on patient's behalf*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Staff/Witness Signature*

\_\_\_\_\_  
*Date*

## **NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW YOU'RE HEALTH INFORMATION  
MAY BE USED AND DISCLOSED AND HOW TO  
ACCESS THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact **Dr. Craig Leavitt** of our clinic at **(732) 530-1525** located at **180 White Road, Suite 206, Little Silver, New Jersey 07739**.

### **WHO WILL FOLLOW THIS NOTICE**

This notice describes the health information privacy practices followed by our employees, staff and other clinic personnel. The practices described in this notice will also be followed by the healthcare providers you consult with by telephone (when your regular healthcare provider from our clinic is not available) who will provide "on-call coverage" for your healthcare provider.

### **YOUR HEALTH INFORMATION**

This notice applies to the information and records we have about your health, health status, and services you receive at our clinic.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For Treatment** We may use health information about you to provide you with health treatment or services. We may disclose health information about you to doctors, nurses, technicians, clinic staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your health history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our clinic may share information about you and disclose information to people who do not work in our clinic in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your health care outside this clinic and may require information about you that we have.

**For Payment** We may use and disclose health information about you so that the treatment and services you receive at this clinic may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you

obtain prior approval, or to determine whether your plan will cover the treatment.

**For Health Care Operations** We may use and disclose health information about you in order to run the clinic and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

**Appointment Reminders** We may contact you as a reminder that you have an appointment for treatment or health care at the clinic.

**Treatment Alternatives** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Products and Services** We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

## **SPECIAL SITUATIONS**

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

**To Avert a Serious Threat to Health or Safety** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required By Law** We will disclose health information about you when required to do so by federal, state or local law.

**Research** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the clinic.

**Organ and Tissue Donation** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

**Military, Veterans, National Security and Intelligence** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Health Oversight Activities** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

**Law Enforcement** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**Coroners, Health Examiners and Funeral Directors** We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Information Not Personally Identifiable** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Family and Friends** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to

disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, health supplies, or X-rays.

### **OTHER USES AND DISCLOSURES OF HEALTH INFORMATION**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

### **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy** You have the right to inspect and copy your health information, such as health and billing records, that we use to make decisions about your care. You must submit a written request to **Dr. Craig Leavitt** in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. Should such a review be required be mandated by Federal or State law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

**Right to Amend** Should you believe that your health information in our records are incorrect or incomplete, you may submit a request to amend the alleged incorrect or incomplete information. Such right to request an amendment is available as long as your health records are maintained by our clinic.

To request an amendment, complete and submit a Health Record Amendment/Correction Form to **Dr. Craig Leavitt**. We retain the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:



available to make the amendment.

- b) Is not part of the records maintained at our clinic.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

**Right to an Accounting of Disclosures** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to **Dr. Craig Leavitt**. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

**We are Not Required to Agree to Your Request** If we agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Health Information* to **Dr. Craig Leavitt**.

**Right to Request Confidential Communications** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Health Information And/Or Confidential Communication* to **Dr. Craig Leavitt**. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact **Dr. Craig Leavitt**.

### **THIS NOTICE IS SUBJECT TO CHANGE**

We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the clinic with its effective date in the top

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with our clinic, contact **Dr. Craig Leavitt, Compliance Officer, (732) 530-1525** located at **180 White Road, Suite 206, Little Silver, New Jersey 07739**. You will not be penalized for filing a complaint.

**EFFECTIVE DATE OF THIS NOTICE**

Please note that the effective date of this notice shall be April 13, 2003 as mandated by Federal Law and subject to change.

**PATIENT ACKNOWLEDGEMENT OF  
RECEIPT OF NOTICE**

I hereby acknowledge receipt of the Notice of Privacy Practices for **Dr. Craig Leavitt** regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting **Dr. Craig Leavitt, (732) 530-1525** located at **180 White Road, Suite 206, Little Silver, New Jersey 07739**.

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for **Dr. Craig Leavitt**.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Legal Representative  
if required

\_\_\_\_\_  
Date

If signed by patient's legal representative, please state representative's relationship to patient:

\_\_\_\_\_