CHIROPRACTIC REGISTRATION AND HISTORY

❶ PATIENT INFORMATION

Date _____

SS/HIC/Patient ID# _____

Patient Name _____
Last name

_____
First name Middle Initial

Address _____

City _____

State _____ Zip _____

Sex ☐ Male ☐ Female Age _____

Birth date_____

☐ Married ☐ Single ☐ Divorced ☐ Minor

☐ Widowed ☐ Separated ☐ Partnered

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Spouses Name _____

Spouses Employer _____

How did you come to find us? ☐ Search Engine/Google
☐ Phone Book ☐ Doctor Referral ☐ other _____
Would you like important updates emailed to you?
EMAIL ADDRESS: _____

❷ INSURANCE INFORMATION

Insurance Company _____

Policy # _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Company _____

Policy # _____

Group # _____

ASSIGNMNET AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with the above named company(ies) and assign directly to Dr . Marotta 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 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 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

_____ _____
Date Relationship to Patient

❸ PHONE NUMBERS

Home Phone ( ) _____ Cell # ( ) _____

Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone ( ) _____ Work Phone ( )_____

❹ ACCIDENT INFORMATION

Is this condition due to an accident ? ☐ Yes ☐ No

Date of accident _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Ins. ☐ Employer ☐ Work Comp ☐ Other

❺ PATIENT CONDITION

Reason for visit _____

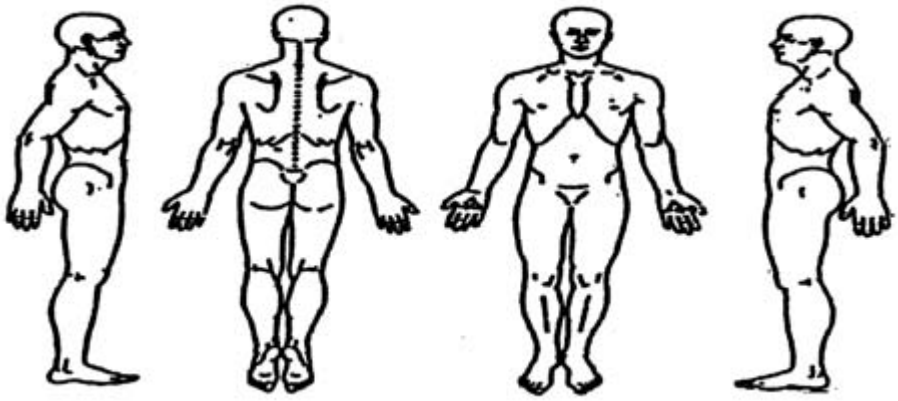
When did your symptoms appear? _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Massage Therapist □ Primary Care Physician
□ Orthopedist □ ER physician □ Other:_____
□ Neurologist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What alleviates your problem? _____

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

16. What is your: Height_____ **Weight** _____ **Age** _____

Occupation _____

17. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

19. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

21. List all prescription medications you are currently taking:

_____

22. List all of the over-the-counter medications you are currently taking:

_____

23. List all surgical procedures you have had:

_____

24. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

25. What activities do you do outside of work?

_____

26. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

27. Have you had significant past trauma? □ No □ Yes
Have you ever been to a chiropractor before? □ No □ Yes how long ago? _____
28. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

WORKING WITH A HEALTHCARE PROVIDER IS A PARTNERSHIP OF SHARED RESPONSIBILITY

OUR RESPONSIBILITY:

1. We will provide a friendly, helpful, and courteous staff.
2. We strive to keep waiting time to a minimum. Most patients are seen within minutes of signing in.
3. We will provide a clear explanation of any health problems and the strategies to solve them.
4. We will help to verify your insurance to see what is and what is not covered.
5. We will submit your insurance claims using the appropriate codes and notes the same day of your visit, given that you have provided us with your most up-to-date insurance information.
6. After 30 days, if your insurance has not responded, we will resubmit the entire claim.
7. If your insurance has still not responded or not paid the entire bill after 60 days, we will then bill you. We will expect this bill to be paid within 30 days.

YOUR RESPONSIBILITY:

1. We realize that life is hectic and unpredictable. **If you cannot make a scheduled appointment, we expect a phone call at least one hour before the time**. We give everyone one (1) warning but we will charge you the cost of an office visit for any missed appointments from then on. Insurance does not pay this fee.

2. **We expect that you arrive for your appointment on time**. Late arrivals affect other patients and may cause increased waiting time for yourself and others.

3. The Doctor will recommend specific exercises, stretches, nutrients, and/or activities to use/limit/avoid. If you should choose not to follow the recommendations, you may find that your results are less than optimal.

4. If your insurance does not pay for your visit for any reason, you will be sent a bill which must be paid within 30 days. **Your insurance may send you an explanation of benefit letter stating that you owe us some money. IN MOST CASES YOU WILL NOT, but if you have any questions please ask us**.

5. Please notify us with any changes in your insurance, billing, address, or contact information so we can keep your file current and continue to provide you with quality care.

PATIENT CARE AGREEMENT

AS A PATIENT OF MAROTTA HEALTH AND WELLNESS I AGREE TO THE FOLLOWING:

- If for any reason my insurance company does not make a complete payment to Marotta Health and Wellness (MHAW) within 60 days of my office visit, I understand that I will be sent a bill explaining my amount due. If I do not send a payment to MHAW within the following 30 days, I understand the bill may go to collections.

- In the event that my insurance company denies payment or applies the visit charges to my deductible, I understand that I am responsible for the amount billed by MHAW. If I do not respond to the bill and make a payment within 30 days of the bill being sent, I understand the bill may go to collections.

- In the event that my insurance company sends payment directly to me, I understand that I must remit the full amount of payment to MHAWC.

- If a check that I have written to MHAW is returned, I understand that I am responsible for the associated fees incurred by MHAW.

- If for any reason I am unable to make my appointment and I do not notify MHAW at least one hour before the appointment time, I understand that I may be charged for the cost of an office visit. Here at Marotta Health and Wellness we strive to make your visits worthwhile, and by providing these guidelines, we can continue to offer you the best possible care. If you have any questions or need to make special payment arrangements, please feel free to call us and discuss it. We appreciate your cooperation.

I, _____ (patient name), am insured
by _____(insurance company name) and am seeking care in this office.

I understand that if my insurance company does not cover certain aspects of my care (copay, co-insurance, deductible, out-of-network benefits, fees related to missing referrals, or any other allowable fees), I will be financially responsible. I also understand that if I do not make payments to Marotta Health and Wellness in a timely manner, my account will be forwarded to a Collections Agency.

Thank you for your understanding.

_____(patient signature) DATE:_____

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition;
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services;
- We may need to use your health information within our practice for quality control or other operational purposes.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____
Print Name Authorized Provider Representative

_____ _____
Signature Date

_____
Date

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

This authorization or photocopy hereof, will authorize Marotta Health and Wellness (Antonio Marotta, DC) to furnish and/or receive all information regarding my health care while under their observation or treatment, including the history obtained, X-ray, results of testing preformed and physical findings, diagnosis and prognosis.

_____ _____
(PRINT NAME) (SIGNATURE)

(If the applicant is a minor, parent or guardian shall sign and indicate capacity of relationship)

PRIMARY CARE DOCTOR: _____

ADDRESS: _____

PHONE: _____

FAX: _____

Name and contact information of others which you would like your information disclosed to:

_____ _____ _____

_____ _____ _____

_____ _____ _____

INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and medicine. Chiropractic seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its innate recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and/or VSC are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its innate recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends on the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition. Your doctor of chiropractic may express an opinion as to whether or not you take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regime.

RISK
I have discussed with the doctor any risk that may be associated with chiropractic spinal manipulative therapy. These risks include mild soreness, fracture and the extremely rare and poorly correlated vertebral basilar artery infarction or vertebral artery stroke.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficiency of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

OFFICE POLICIES:
If I am accepted as a patient at Marotta Health and Wellness, I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.

CONSENT TO TREAT:
I also understand that no cures are promised (or implied) and any risks regarding this care at this office will be explained to me upon my request. I now authorize Dr. Antonio Marotta to proceed with any necessary treatment. I have read Dr. Marotta's office policies and consent to treat information, and I agree with them by signing below:

PATIENT SIGNATURE _____ DATE _____