CONIGLIO CHIROPRACTIC L.L.C.
1144 MANTUA PIKE
MANTUA, NJ 08051

PATIENT REGISTRATION

PATIENT'S NAME: _____ PHONE #: _____

CELL#:_____ EMAIL:_____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

SS #: _____ DATE OF BIRTH: _____ AGE: _____

Preferred Language (Circle one): English / Spanish / Other
Race (Circle one): American Indian / Asian / Black or African American / White(Caucasian) /other / I Decline to Answer

EMPLOYER: _____ TELEPHONE: _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

IN CASE OF EMERGENCY: _____ PHONE #: _____

LEGAL GUARDIAN (IF MINOR): _____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

SS #: _____ DATE OF BIRTH: _____ AGE: _____

EMPLOYER: _____ TELEPHONE: _____

WHO REFERRED YOU TO OUR OFFICE? _____
WOULD YOU BE INTERESTED IN REFERRING YOUR FAMILY MEMBERS? _____

BILLING RESPONSIBILITIES:

INSURANCE COMPANY: _____ PHONE #: _____

ID/CLAIM #: _____ GROUP #: _____

INSURED'S NAME: _____ SS #: _____

INSURED'S DATE OF BIRTH: _____

CHIROPRACTIC BENEFITS ARE QUOTED TO US BY YOUR INSURANCE CARRIER. THE BENEFITS ARE SUBJECT TO THE TERMS AND PROVISIONS OF YOUR PLAN AND ARE NOT NECESSARILY A GUARANTEE OF PAYMENT.

1. I authorize my insurance benefits to be paid directly to Coniglio Chiropractic L.L.C.
2. I am financially responsible for any non-covered services.
3. I authorize the facility to release medical information for billing.

*SIGNATURE: _____ DATE: _____

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT, SELF-PAYING AND APPOINTMENT SCHEDULING

Coniglio Chiropractic L.L.C. is pleased to accept your insurance assignment, as soon as the responsible party verifies your exact coverage. We will file forms to assist you in every way we can. It must be fully understood that the contract is between you and your insurance company. You are fully responsible for any amount that is not paid by your insurance.

1. You are required to sign an "Authorization to Pay Physician" form and any other assignment documents required by your insurance company on your first visit.
2. Our office does not guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your insurance claim is denied, you are responsible for the full amount.
3. Our office will ***NOT*** enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. If circumstance warrants, your insurance assignment may be withdrawn.
4. You are required to pay the percentage of your responsibility as you go along. (E.g. if your insurance pays 80% of your care, you pay 20% on each visit).
5. Any insurance balance over 60 days past due is subject to late payment penalties at 1.5% per month.
6. I agree to pay any collection and/or attorney fees that may arise as a result of any unpaid balance being forwarded to a collection agency and/or attorney to cause payment.
7. All returned checks are subject to a $25 service fee and a late payment fee (see below).
8. A late payment fee will be assessed if payment on balance is not received by the 10th of the month.
9. Late Payment Fee: $15 if the balance is $0 - $99; $25 if the balance is $100 - $999.99; and $35 if the balance is $1000 or more. (Balance means Previous Balance on Statement that shows the Late Fee.)
10. A $50.00 fee will be charged if an appointment is missed without prior rescheduling.
11. For your health this is a Smoke-Free property.
12. I have read and understand the above office policy and agree to its terms.

_____ _____

SIGNATURE OF PATIENT/GUARDINAN DATE

Name: _____ Patient #: _____ Date: _____
Age _____ Male Female Single Married Divorced Widowed # of Children _____
Occupation _____
Reason for consulting our office? _____
_____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS

Research is showing that many of the health challenges that occur later in life have their origins during the development years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

	YES	NO	UNSURE	COMMENTS
Did you have any childhood illnesses?				_____
Did you have any serious falls as a child?				_____
Did you play youth sports?				_____
Did you take / use any drugs?				_____
Did you have any surgery?				_____
Have you fallen / jumped from a height over three feet? (i.e. – crib, bunk bed, trees)				_____
Were you involved in any car accidents as a child?				_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?				_____
Did you suffer any other traumas (physical or emotional)				_____
Were you vaccinated?				_____
As a child, were you under regular Chiropractic care?				_____

ADULT – (18 to present)

Do / did you smoke?				_____
Do / did you drink alcohol?				_____
Have you been in any accidents?				_____
Have you had any surgery?				_____
Do / did you play any adult sports?				_____
Do / did you participate in extreme sports?				_____

On a scale of 1 – 10 describe your stress level:
(1 = none / 10 = Extreme)
Occupational _____
Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (√) here _____ **"Wish to have Chiropractic Wellness Services"** and skip to **"Family Health Profile."** Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it…

Sharp Dull Comes and goes Travels Constant

Since the problem started, it is… About the same Getting better Getting worse

What makes it worse: _____

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list)

Chiropractor _____

Medical Doctor _____

Other _____

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem.

Are You Pregnant? YES NO

Headaches	Pins and needles in legs	Fainting	Neck pain
Pins and Needles in arms	Loss of smell	Back Pain	Loss of Balance
Dizziness	Buzzing in Ears	Ringing in Ears	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach Upset
Fatigue	Depression	Irritability	Tension
Sleeping problems	Neck stiff	Cold Hands	Cold feet
Diarrhea	Constipation	Fever	Hot Flashes
Cold Sweats	Lights bother eyes	Problem Urinating	Heartburn
Mood swings	Menstrual Pain	Menstrual Irregularity	Ulcers

List any medications you are taking _____

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

Have you ever:

Bought bottled water:	**Yes**	**No**	**When Last?** _____
Belonged to a health club:	**Yes**	**No**	**When Last?** _____
Consumed vitamins or supplements:	**Yes**	**No**	**When Last?** _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____

Signature Date

Coniglio Chiropractic L.L.C.

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustments and other professional procedures, including various modes of physio-therapy, acupuncture and diagnostic services, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or any other licensed professionals who now or in the future treat me while employed by, working or associated with, or serving as backup for the doctor named below, including those working at the office.

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use their hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which they feel at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

This office includes nutritional recommendations in the treatment of patients. The goal of nutrition is to support the body to improve its overall health and not to treat a specific disease or symptom. All medication changes must be made by my medical physician. I understand nutritional supplements have been proven to be extremely safe when taken as directed. There is always a chance for an adverse reaction from any product. If I feel I am having a reaction to a product, I will stop using the product until I can discuss the matter. The products are sold retail and there is a NO refund policy.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, and 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 other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have had the opportunity to discuss with the doctor and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks of treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

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 right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice 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 Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Professional Care. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Coniglio Chiropractic, LLC 1144 Mantua Pike, Mantua, NJ 08051 856-468-4200 856-468-2233 info@greatspine.com	**Authorization to Release Protected Health Information**	**For Office Use Only** **PHI:** □ Mailed □ Picked Up □ Faxed **ID Verified:** □ Yes □ No **Date Received:** _____ **Date Processed:** _____ **Processed By:** _____

Please complete this form in its entirety so that we may fulfill your request promptly.

Patient's Name: _____ **Date of Birth:** _____

Street Address: _____

City/State/Zip: _____

Telephone #: _____ **Fax#:** _____

Email Address: _____

Authorization for use/disclosure of information:

I am the patient, or legally authorized representative of the patient, listed above. I voluntarily authorize and direct my health care provider _____ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below:

□ **Myself**

□ **Another Individual:** _____

□ **Facility/Company/Organization:** _____

Street Address: _____

City/State/Zip: _____

Telephone#: _____ **Fax#:** _____

Email Address: _____

Information to be disclosed:

This authorization permits the above provider to disclose the following medical records:

□ **My complete patient file, including information relating to any medical history, mental or physical condition and any treatment received by me.**

□ **All of my health information described above except for the following:** _____

_____

□ **Only records for dates of service from** ___/___/___ **to** ___/___/___

□ **Only records related to a specific event, incident or illness (please describe or indicate date of event, incident or illness)** _____

□ **Only the following types of information (please check all that apply):**

- □ **History and Physical**
- □ **Clinic Notes**
- □ **Lab Reports**
- □ **Radiology Reports**
- □ **Radiology Images**
- □ **Billing Information**

Inspect/Copy:
I understand that I have the right to inspect or copy the protected health information to be used or disclosed under this Authorization.

Term:
This Authorization will remain in effect:

□ **From the date of this Authorization until** __/__/_____

□ **Until the Provider fulfills this request.**

□ **Until the following event occurs:**_____

If none of the above are indicated, then this authorization will expire 60 days from the date of signature.

Redisclosure:
I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.

Refusal to sign/right to revoke:
I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation:
I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Coniglio Chiropractic, LLC at 1144 Mantua Pike, Mantua, NJ 08051]. The revocation will be effective immediately upon the clinic's receipt of my written notice, except that the revocation will not have any effect on disclosures that relied upon this Authorization and were made prior to receipt of the my written revocation.

Questions:
I may contact Coniglio Chiropractic, LLC with questions about the privacy of my health information at 1144 Mantua Pike, Mantua, NJ 08051 by telephone at 856-468-4200, or by email at info@greatspine.com.

_____ _____ _____

Signature **Date** **Printed Name**

If the patient is unable to sign this Authorization, please complete the information below. By signing this form for someone else, you - as the parent, guardian, a party acting in loco parentis, or legal representative - are indicating that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

_____ _____ _____

Name of Guardian/Representative **Date** **Legal Relationship**

Note: This Authorization does not extend to HIV testing or results, psychotherapy notes, or drug or alcohol treatment records that are protected by federal law.