Vassar Chiropractic and Rehabilitation **Dr. Justin Vassar**

Patient Name: _____ **Date:** _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex ❒ M ❒ F Marital Status ❒ M ❒ S ❒ D ❒ W Date of Birth_____ Age_____

Social Security #_____

Occupation_____

Employer_____

Referred by: _____

Have you ever received Chiropractic Care? ❒ Yes ❒ No If yes, when? _____

Name of most recent Chiropractor: _____

1. **Reasons for seeking chiropractic care:**

Primary reason:

_____

Secondary reason:

_____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____

_____

_____

3. **Past Health History:**

   A. **Please indicate if you have a history of any of the following:**
   ❒ Anticoagulant use ❒ Heart problems/high blood pressure/chest pain ❒ Bleeding problems
   ❒ Lung problems/shortness of breath ❒ Cancer ❒ Diabetes ❒ Psychiatric disorders
   ❒ Bipolar disorder ❒ Major depression ❒ Schizophrenia ❒ Stroke/TIA's ❒ Other _____
   ❒ None of the above

   B. **Previous Injury or Trauma:**

   _____

   Have you ever broken any bones? Which?

   _____

   C. **Allergies:** _____

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D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

4. Family Health **History:**

Do you have a family history of? (Please indicate all that apply)

❒ Cancer ❒ Strokes/TIA's ❒ Headaches ❒ Cardiac disease ❒ Neurological diseases

❒ Adopted/Unknown ❒ Cardiac disease below age 40 ❒ Psychiatric disease ❒ Diabetes

❒ Other _____ ❒ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death	Age at death

Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

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Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
❒ Asthma/difficulty breathing ❒ COPD ❒ Emphysema ❒ Other _____ ❒ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
❒ Heart surgeries ❒ Congestive heart failure ❒ Murmurs or valvular disease ❒ Heart attacks/MIs ❒ Heart disease/problems ❒ Hypertension ❒ Pacemaker ❒ Angina/chest pain ❒ Irregular heartbeat ❒ Other _____
❒ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
❒ Visual changes/loss of vision ❒ One-sided weakness of face or body ❒ History of seizures ❒ One-sided decreased feeling in the face or body ❒ Headaches ❒ Memory loss ❒ Tremors ❒ Vertigo ❒ Loss of sense of smell
❒ Strokes/TIAs ❒ Other _____ ❒ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
❒ Thyroid disease ❒ Hormone replacement therapy ❒ Injectable steroid replacements ❒ Diabetes
❒ Other _____ ❒ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
❒ Renal calculi/stones ❒ Hematuria (blood in the urine) ❒ Incontinence (can't control) ❒ Bladder Infections
❒ Difficulty urinating ❒ Kidney disease ❒ Dialysis ❒ Other _____ ❒ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
❒ Nausea ❒ Difficulty swallowing ❒ Ulcerative disease ❒ Frequent abdominal pain ❒ Hiatal hernia ❒ Constipation
❒ Pancreatic disease ❒ Irritable bowel/colitis ❒ Hepatitis or liver disease ❒ Bloody or black tarry stools
❒ Vomiting blood ❒ Bowel incontinence ❒ Gastroesophageal reflux/heartburn ❒ Other _____ ❒ None of the above

Have you had any of the following **hematological (blood-related)** issues?
❒ Anemia ❒ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) ❒ HIV positive
❒ Abnormal bleeding/bruising ❒ Sickle-cell anemia ❒ Enlarged lymph nodes ❒ Hemophilia
❒ Hypercoagulation or deep venous thrombosis/history of blood clots ❒ Anticoagulant therapy ❒ Regular aspirin use
❒ Other _____ ❒ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
❒ Significant burns ❒ Significant rashes ❒ Skin grafts ❒ Psoriatic disorders ❒ Other _____ ❒ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
❒ Rheumatoid arthritis ❒ Gout ❒ Osteoarthritis ❒ Broken bones ❒ Spinal fracture ❒ Spinal surgery ❒ Joint surgery
❒ Arthritis (unknown type) ❒ Scoliosis ❒ Metal implants ❒ Other _____ ❒ None of the above

Have you had any of the following **psychological** issues?
❒ Psychiatric diagnosis ❒ Depression ❒ Suicidal ideations ❒ Bipolar disorder ❒ Homicidal ideations ❒ Schizophrenia
❒ Psychiatric hospitalizations ❒ Other _____ ❒ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Justin Vassar, DC/Vassar Chiropractic and Rehabilitation for services performed.

Patient or Guardian Signature _____ Date_____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our 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, pay your health care bills, to support the operations of the physician's practice, 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 health care 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 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, marketing, and fund raising activities, and conduction 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 included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you 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.

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.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

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Patient Name: _____ **Date:** _____

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, 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, and is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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.

Signature of Patient: _____ Date: _____

To be completed by the patient's representative, if necessary, e.g., if patient is a minor or physically or otherwise legally incapacitated.

Signature of Patient's Representative: _____ Date: _____

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OFFICE POLICIES

1. Please be on time for your- appointment. Being late or making last minute cancellations will cause scheduling disruptions, which can interfere with the quality of care you and other patients receive.
2. Please do not wear strong perfumes or colognes. We see many patients with allergies or respiratory problems. Strong scents can impair their progress.
3. Continued cancellations or missed appointments may result in being released from care. If you need to reschedule an appointment, please call within 24 hours of your scheduled appointment.
4. We may schedule you for multiple appointments. This will help ensure a convenient appointment time for you, as well as provide you with the highest level of care possible.
5. If you need to spend extra time discussing your health concerns with your doctor, please let our staff know so we may schedule your next appointment accordingly.
6. Please notify your doctor of any changes in your health status, regardless of the significance.
7. Please be respectful and considerate.

FINANCIAL POLICIES

1. We accept the following forms of payment: Cash, personal checks, debit cards, and credit cards (Visa, Amex, Discover and Master Card).
2. Payment is expected at the time of the visit.
3. The office will be insurance as a courtesy to you for in-network coverage.
4. The Patient is always responsible for the payment of their care. An insurance contract is between the patient and the insurance company.
5. Insurance coverage is never guaranteed. If there are any problems between the insurance company and the patient, the latter may file a grievance directly with your insurance company. Your signature below authorizes assignment to this office for collection of benefits and also authorizes this office to release daily chart notes when necessary for the processing of claims.
6. The office manager may approve account balances. Active monthly payments are required. Accounts with balances 30 days past due may be charged a service fee of 8% per year compounded annually.
7. Any account where no payment has been received for sixty days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient. NSF checks or rejected credit card payments will be charged a service fee of $25 per occurrence.
8. We do offer a time of service discount for those without insurance coverage or who are out-of-network.
9. In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering you our time of service discount Please ask us if you have any questions regarding this.
10. Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.
11. Your insurance company determines benefits when they receive our billings. Any statements made by our staff regarding your coverage in no way guarantees that your care here will be covered by your insurance company, and you will be responsible for your account, regardless of insurance.

By signing below, I acknowledge that I understand the policies as contained herein.

Patient or Patient Representative: _____ Date: _____/_____/_____

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