Welcome to our office: Please thoroughly complete all questions. Thank you!

DRX 9000 New Patient Information

Today's Date: ________________

Patient's Name ________________________________ Date of Birth ____________________

Address ________________________________ City/State/Zip________________________

Social Security # ____________________________ Driver's License # ____________________

Phone: (home):____________________________ Cell: ____________________________

Sex : M ☐ F ☐ Marital Status: Married ☐ Widowed ☐ Divorced ☐ Single ☐ Significant Other ☐

Who Can We Contact In Case of An Emergency? Name: ________________________________

Phone: ________________________ Relationship: ________________________________

Your Occupation: ____________________________ Employer: ________________________

Employer's Address: __________________________ Work Number: ______________________

Personal Email Address: ____

Who May We Thank For Referring You? ____

Acknowledgment of Financial Responsibility

I fully understand that I am financially responsible to ASSOCIATES IN CHIROPRACTIC, P.C. for all services performed. DRX 9000 is a self pay service, and is typically not covered under health plan insurance policies. It is member responsibility to pay at time of service and submit super bill to insurance after payment is made in full if they wish to do so. Associates in Family Chiropractic is not responsible for submitting these services to your health plan and doesn't not guarantee coverage or reimbursements.

Patient Signature: ________________________________ Date:________________

Witness Signature: ________________________________ Date: ________________

Consent and Acknowledgment of DRX 9000 Treatment

With my signature below I give my consent and acknowledgement that all of my concerns have been expressed and competently and thoroughly answered by the staff of Associates in Family Chiropractic and Natural Health Care, P.C. I understand the objective of this program being to relieve my pain and increase my lower back function. And while it is expected that we will meet our objectives for my improvement I also understand that I have a severe, degenerative and chronic condition. And with a condition like mine, meeting these objectives may in fact not be possible and results while unlikely may be such that I nay hove no improvement at all or even feel worse after my program is completed. I am entering into this program hopeful yet with the full understanding that my expectations may not be met and I am fully aware of the possible outcomes.

Patient Signature: ________________________________ Date:________________

Witness Signature: ________________________________ Date: ________________

1. In your own words, Please explain what you believe to be the cause of your back pain problem and in your opinion what do you think the real problem is? ____

____

____

2. List the three most important things you can NO longer do because of this problem:
   1. ______________________________
   2. ______________________________
   3. ______________________________

3. How long have you had this discomfort? Is this your first bout of Back/ Sciatic Pain?______________________

____

4. How has your life changed since your back became a problem? ______________________

____

5. How has this problem affected your daily routine? ______________________

6. Are you still working? ______________________

7. What kind of treatments have you received:

   Epidural, how many? ____________ When (approx.) ____________

   Physical Therapy, Where? ____________ When (approx.) ____________

   Medication, What type? ____________ When (approx.) ____________

   Surgery, What type? ____________ When (approx.) ____________

   Chiropractic, Where? ____________ When (approx.) ____________

   Other ______________________

8. Where did you receive your most recent treatments and for how long? ______________________

____

9. Did any of these treatments work? If so which one(s)? For how long? ______________________

____

10. If not, Why do you think these treatments failed? ______________________

____

11. Is there anything you can do that makes this problem feel better? ______________________

____

12. What activities/ movements are guaranteed to make it worse? ______________________

____

13. Please describe the quality of pain. (Sharp, Dull, Achy, Shooting, Stabbing, Numb, Tingling, etc.)

____

14. What portion of the day do you have this discomfort? Please Circle your response.

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

15. Is it worse in the morning, as the day progresses, or in the evening? ______________________

____

16. If you cannot find a solution to this problem what do you think will happen to you? ______________________

____

17. Have you had an MRI? Circle one. YES or NO

18. Where and When was the MRI preformed? ______________________

19. Are there any other health issues you are concerned with? ______________________

____

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

NOTICE OF PRIVACY AND INFORMATION PRACTICES

This Notice of Privacy Practices is provided to you by _Associates In Family Chiropractic and Natural Health Care, P.C. (hereinafter "we" or "company") as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguard we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

Acknowledgement of Receipt of this Notice. You will be asked to provide a signed acknowledgement of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Our Duties to You Regarding Your Protected Health Information (PHI). PHI is individually identifiable health information. This information includes demographics, for example, age, address, e-mail address, and relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

1. Make sure that your PHI is kept private;
2. Give you this notice of our legal duties and privacy practices related to the use and disclosure of your PHI;
3. Follow the terms of this notice currently in effect; and
4. Communicate any changes in the notice to you.

Company reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Company will provide each patient with a copy of any revisions of its Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.

Permitted Uses: Treatment, Payment and Healthcare Operations. We may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples include, but are not limited to requested preschool, life insurance or sports physicals; referral to nursing homes, foster care homes, or home health agencies; or referrals to other providers for treatment. Payment examples include, but are not limited to completing a claim form to obtain payment from an insurer or activities that we might undertake to determine eligibility or coverage for benefits. Healthcare operations include, but are not limited to, investigations, implementing compliance programs, oversight or staff performance reviews, and internal quality control assurance including auditing of records.

Other Permitted Uses. Company is permitted or required to use or disclose protected health information without the individual's written authorization in certain circumstances. These include the following:

1. Required Uses and Disclosures. By law, we must disclose your health information to you unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose health information to the Secretary of the Department of Health and Human Services for investigations or determinations of our compliance with laws on the protection of your health information. We may use or disclose your PHI if a law or regulation requires the use or disclosure.
2. Business Associates. We will share your PHI with third party "business associates" who perform various activities for us. Examples are billing services or transcription services. The business associates will be required to sign a Business Associate Agreement and they will be required to protect your health information.
3. Contacting You. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may call you by name in the waiting room when your health care provider is ready to see you.
4. Treatment Alternatives. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about services we offer. We may also send you information about products or services that might benefit you.
5. Public Health. We may disclose your PHI to a public health authority who is permitted by law to collect or receive the information. The disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence.
6. Communicable Diseases. We may disclose your PHI, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.
7. Health Oversight. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefits programs, other government regulatory programs, and civil rights laws.

8. Food and Drug Administration. We may disclose your protected health information to a person or company required by the FDA to do the following: report adverse events, product defects, or problems and biologic product deviations; tract products; enable product recalls; make repairs or replacements; or conduct post-marketing surveillance as required.
9. Legal Proceedings. We may disclose PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
10. Law Enforcement. We may disclose PHI for law enforcement purposes, including responses to legal proceedings, information requests for identification and location, circumstances pertaining to victims of a crime, deaths suspected from criminal conduct, crimes occurring at our office site, and medical emergencies believed to result from criminal conduct.
11. Coroners, Funeral Directors and Organ Donations. We may disclose PHI to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose PHI to funeral directors if authorized by law. PHI may be used and disclosed for cadaveric organ, eye, or tissue donations.
12. Research. We may disclose your PHI to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
13. Criminal Activity. Under applicable federal and state laws, we may disclose your PHI if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
14. Military Activity and National Security. When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities believed necessary or appropriate military command authorities to ensure the proper execution of the military mission including determination of fitness for duty; (2) for determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including protective services to the President or others.
15. Workers' Compensation. We may disclose your PHI to comply with workers' compensation laws and other similar legally established programs. We will act consistently with the law of the Commonwealth of Pennsylvania and will make disclosures following such laws.
16. Inmates. We may use or disclose your PHI if you are an inmate of a correctional facility, and we created or received your PHI information while providing care to you. This disclosure would be necessary (1) for the institution to provide you with care, (2) for your health and safety or that of others, or (3) for the safety and security of the correctional institution.
17. Parental Access. We may use or disclose PHI to parents, guardians and persons acting in a similar legal status. We will act consistently with the law of the Commonwealth of Pennsylvania and will make disclosures following such laws.
18. Family Members. Unless you object, we may release protected health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends the condition that you are in. You will be provided a form to list specific people who we may speak to regarding your medical care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
19. Fundraising. Company may use protected health information about you to contact you in an effort to raise money for our practice and its operations. We may disclose protected health information to a related foundation so that the foundation may contact you in raising money. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services. If you do not want us to contact you for fundraising efforts, you must notify our practice in writing.

Authorization Required. Company will not make any other use or disclosure of your protected health information without your written and valid authorization. Such use or disclosure must be consistent with such authorization. Authorization is specifically required for the following:

1. Psychotherapy Notes. We must obtain an authorization for any use or disclosure of psychotherapy notes, except: to carry out the following treatment, payment, or health care operations: (A) use by the originator of the psychotherapy notes for treatment; (B) use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (C) use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual.
2. Marketing. We must obtain an authorization for any use or disclosure of protected health information for marketing, except if the communication is in the form of: (A) A face-to-face communication made by a covered entity to an individual; or (B) A promotional gift of nominal value provided by the covered entity. If the marketing involves financial remuneration to us from a third party, the authorization must state that such remuneration is involved.
3. Sale of protected health information. We must obtain an authorization for any disclosure of protected health information which is a sale of protected health information. The authorization must state that the disclosure will result in remuneration to the covered entity.

Revoking Authorization. You may revoke the authorization at any time provided that the revocation is in writing, except to the extent that: (A) we have not taken action in reliance thereon or (B) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Patient Rights. Patients have been granted individual rights under the HIPAA Legislation. These include the following:

1. Inspect and copy. You have the right to inspect and copy protected health information that may be used to make decisions about your care. You have the right to a paper copy. Usually, this includes medical and billing records, but does not include psychotherapy notes, information complied in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding, or Protected Health Information that is subject to or exempt from the Clinical Laboratories Act of 1988. To inspect and copy protected health information

that may be used to make decisions about you, you must submit your request in writing us. If you request a copy of the information, we may charge a fee for the costs of copying (including labor), mailing or other supplies associated with your request.

2. Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained in the designated record set. To request an amendment, your request must be made in writing and submitted to us. You must provide a reason that supports your request and we may 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 was not created by us, unless the person or entity that created the information is no longer available to make the amendment, is not part of the protected health information kept by or for our practice; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our organization will review your request and the 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.
3. Accounting of disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you that was not made for treatment, payment and health care operations and there are certain exceptions to this right. To request this list or accounting of disclosures, you must submit your request in writing to us. Your request must state a time period, which may not be longer than six years prior to the date you request the accounting. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, 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. The accounting must be provided to you no later than 60 days after the receipt of your request, unless we utilize the 30-day extension period.
4. Restrictions on uses or disclosures. You have the right to request a restriction or limitation on the protected 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 protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to us. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. Either you or we may terminate the restriction upon notification of the other.
5. Confidential communications. You have the right to request that we communicate with you about medical 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 must make your request in writing to us. We will 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.
6. Complaints. You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. It is Company's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards. You may file a Complaint with us by sending a written complaint to us.

You will be asked to outline or define specific instances or information that you would like kept completely confidential (between you and us). If you have any questions regarding this Notice of Privacy Practices, please do not hesitate to contact us for more information or clarification. You may contact the following:

Contact information for any individual or Provider you allow your information to be shared with:

NAME: ____ **RELATIONSHIP:** __________________ **PHONE:** ___________________________

NAME: ____ **RELATIONSHIP:** __________________ **PHONE:** ___________________________

The effective date of this agreement is this ________ day of ________________________, 20_____

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of ______HIPAA__________ Notice of Privacy Practices.

____ ________________________

Signature of patient or personal representative Date

Office Use Only:
Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: ____ Refused to sign ☐ Physically unable to sign ☐

Employee Signature:____ Date:____________________________

Associates in Family Chiropractic
156 East Avenue, Norwalk CT 06851
203-838-1555

FINANCIAL RESPONSIBILTY FORM

INSURANCE COVERAGE

- It is your **(patient's)** responsibility to know your insurance coverage benefits, policy provisions, exclusions and limitations as well as authorization requirements. This Information is furnished by your insurance.
- Office staff will attempt to verify insurance coverage at the time of service, but it is **not a guarantee of coverage**, nor is it guaranteed that the insurance company will give us accurate information. Thus, we recommend each patient calls on their own behalf as well. However, if your coverage is not in effect at the time of service, financial responsibility for payment is yours.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES

- Co-payments, co-insurance and/or deductibles are the **patient's responsibility**.
- Co-payments are due at the time of the visits. If you do not make your copayment at the time of your visit, **an additional; $10.00 fee may be charged.**
- Deductible details are determined by the contract you have with your insurance carrier. Office staff does not know how much each patient's deductible amount is or how much has been met at the time of your visit.

CREDIT CARD AUTHORIZATION

- I authorize Associates in Family Chiropractic and Natural Health Care to charge my credit card account on file for the following if they are not paid in full at the time of service: Past Services, recurring payments for ongoing care, outstanding balances, missed appointment fee's.
  No charge will be made to your card if you pay on, or prior to your date of service.
- **As office policy, we require a Credit Card to be on file for all Patient Financial Responsibilities.**
- In the event of a declined transaction **an additional $15.00 may be added** to the balance. Please list your e-mail and correct phone number so you can be contacted promptly by the office in regards to your account.

INSURANCE CHANGES

- If you have any change in your insurance coverage – even a small change e.g. your co-payment amount or in the expiration date of the policy, you must notify office staff to avoid claim denial.
- **The office is not responsible for patient failure to update insurance information**.

INSURANCE REQUESTS/REFFERALS

- You are responsible for responding to any requests from your insurance company for additional information. Not doing so well result in a claim denial and you will be responsible for payment.
- It is your responsibility to obtain any referrals by your health plan if required by your policy.

PREVENTIVE (WELL) VISITS/ANNUAL EXAMS

- Tests for your problems/complaints at your well visit may not be considered preventive; this is determined by your insurance and you would be responsible for payment of those needed test.
- If you are seen for a well visit, it is fraudulent to change this to a "problem" visit for payment.

NON-COVERED SERVICES

- You are responsible for payment of **all "non-covered" services** as determined by your insurance after a claim is submitted; office staff would not know this at the time of service.

SELF- PAY SERVICES

- **ALL SELF PAY SERVICES rendered at Associates in Family Chiropractic and Natural Health Care are the responsibility of the receiving party/ or legal guardian.** Self pay services include but are not limited to Acupuncture, BioSet, DRX, Functional Medicine, Consultations and Chiropractic Care. Patients must be active members with ChiroHealthUSA to receive self-pay Chiropractic services within this office.

NO SHOWS/CANCELLATION POLICY

- **Adequate notice is needed if you cannot keep your appointment. Unexpected events can occur resulting in the need to change your appointment, however, at least 48 hours notice is required to cancel/change a new patient appointment and 24 hours notice is required for all other appointments. Failure to provide adequate notice, as well as multiple cancelations may result in a $55.00 charge for standard appointments and $90.00 for New Patient Appointments to your account. These charges are the patient's responsibility, not your insurance company and will be billed to the credit card we have on file if proper notice is not given.**

We emphasize that our relationship is with you the patient, not with your insurance company. It is your responsibility to know your insurance policy details and requirements.

I have read and I understand this financial responsibility form; my signature below indicates my agreement to comply, and that I agree to undergo the tests recommended by my provider.

________________________	________________________	__________
Patient Signature	Print Name	Date

THIS FORM IS REQUIRED AND WILL BE DESTROYED ONCE SECURILY ENTERED. THANK YOU!

CREDIT CARD PRE-AUTHORIZATION FORM

Associates in Family Chiropractic
And Natural Health Care, P. C.
156 East Avenue
Norwalk, CT 06851
(203) 838-1555

Patient Name: ____

I authorize Associates in Family Chiropractic and Natural Health Care to charge my credit card account for the following:

- Past Services
- Recurring Payments for Ongoing Care
- Outstanding Balances
- Missed Appointment Fees

The card on file may also be used for your convenience. For example, the need may arise to make a payment or purchase supplements yet, the form of payment was left at home, we could conveniently charge the card on file upon your request.

No charge will be made to your card if you pay on, or prior to your Date of Service. Understand that all outstanding balances is your responsibility.

____ MASTERCARD ____DISCOVER ____ VISA

CARDHOLDER'S NAME ____
(INCLUDE MIDDLE INITIAL IF ON THE CARD)

BILLING ADDRESS ____

____

CREDIT CARD NUMBER ____ EXP __________

CVV______________ PATIENT'S TELEPHONE NUMBER _________________________

I understand that this form is valid for one year unless I cancel authorization with written notice. I also authorize my balance to be charged to this card in full if care is terminated for 30 days or longer for any reason. I also understand that I am only paying for services rendered, and will not be liable for services not rendered if I discontinue care for any reason.

CARDHOLDER SIGNATURE ____ DATE ____________

INCLUDE EMAIL ADDRESS IF YOU WOULD LIKE AN EMAILED RECEIPT FOR ANY TRANSACTION.

EMAIL ADDRESS____