Power Health & Wellness

Medical Intake Form

Date:___/___/___ Name:_____

DOB:___/___/___ Age:____ Height:_____ Weight: _____

Gender: Male/ Female Married: Y/N Employed: Y/N

Address:_____

City, State, Zip:_____

Cell Phone:_____

Email:_____

Emergency Contact:_____

Phone #:_____

Main Problem!

Area of pain?_____

What caused this pain?_____

When did this pain start?_____

How bad is this pain? Mild/ Moderate/ Severe/ Intolerant

Circle the word(s) that best describe the pain: Aching/ Dull/ Sharp/ Throbbing/ Burning/ Stiff

How often does the pain occur? (circle the one that applies): Occasional/ Frequent/ Constant.

What makes this pain better/worse? _____

Past & Social History!

Have you had any illnesses in the past?_____

Have you had any injuries?_____

Have you been hospitalized?_____

Have you had any surgeries?_____

List any medications you are taking:_____

Ins Name:_____ Plan #:_____

Group #:_____ PPO/HMO:_____

CONFIDENTIALITY POLICY

(Effective April 2003)

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

We are committed to maintaining the confidentiality of our patients' protected health information (PHI). We emphasize the importance of confidentiality through employee training, the implementation of procedures designed to protect the security of our records, and our privacy policy. We restrict access to PHI to those employees who need to know that information to perform their job responsibilities. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard the confidentiality of PHI.

Consent obtained during the admission process to the Center covers use and disclosure of PHI for purposes of treatment, payment and health care operations, including quality assessment and measurement, and disease management activities. Before any PHI is disclosed for purposes of treatment, payment or healthcare operations, agreements with the recipients of such information are entered into to protect the confidentiality of PHI. If a patient is unable to give consent, family or legally appointed representatives will be authorized to release and/or receive access to information about the patient. Business Associates: A Business Associate is an individual or entity under contract with us to perform or assist us in a function or activity which necessitates the use or disclosure of medical information for example: a medical record copy service, consultants, accountants, lawyers, medical transcription and third party billing companies. We require Business Associates to submit a written statement as to how they will protect the confidentiality and dispose of the PHI when use has been completed.

Federal law provides that we may use you PHI without further specific notice to you, or written authorization by you in the following categories:

For your treatment: In diagnosing and treating your injury or illness, we may disclose all or any portion of PHI to attending physicians, consulting physicians, nurses, technicians, medical students, interns, residency programs, continuing education training, to a home health agency or hospital to coordinate specific services, such as prescriptions, lab work, x-rays, and to other health care providers who have a legitimate need for such information in your care and continued treatment.

To obtain payment: We may use and disclose your medical information so that the services and treatment may be billed to, and payment may be collected from, your health insurer, HMO, or other company that arranges or pays the cost of your healthcare.

For health care operations: We may use and disclose your medical information for internal administration and planning that improve the quality and cost-effectiveness of the care that we deliver to you, for example: performance improvement, utilization review, internal auditing, accreditation, certification, licensing, educational and credentialing activities. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning your identity.

We may use or disclose medical information, without further notice to you, or specific authorization by you, where:

1. Required by law
2. Required for public health purposes
3. Required by law to report child abuse and neglect
4. Required by health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional
5. Discipline or Office of Professional Medical Conduct
6. Required to report information about products under the jurisdiction of the Federal Drug Administration
7. Required by law for judicial or administrative proceeding
8. Required for law for enforcement purposes by a law enforcement official

I have received a paper copy of the confidentiality policy, as required by HIPPA of 1996.

Patient Signature: _____ Print Name: _____

Date: _____

Terms of Acceptance

Power Health & Wellness

In order to provide for the most effective healing environment, most effective application of procedures and the strongest possible doctor-patient relationship it is our wish to provide each patient with a set of parameters and declaration that will facilitate the goal of optimum health.

To that end, we ask that you acknowledge the following points regarding your care and the services that are offered through this clinic:

- Chiropractic treatments include spinal adjustments. The chiropractic adjustment process, as defined in the state of New Jersey involves the application of the specific directional thrust to a region or region of the spine. Adjustments can also be performed on extremities, including but on limit to: shoulders, knees, hips, wrists, elbows, and jaws. Physical therapy may include but is not limited to: exercise, traction, stretching, electrical patient stimulation, therapeutic ultrasounds, dry whirlpool, nuero-muscular reduction, myofascial release and therapeutic activities.
- We do not seek to replace with your medical, dental, or other types of health professionals. They retain responsibility for the care and management of medical/dental conditions. We do not offer advice regarding treatment prescribed by others.
- Your compliance with care plans, home and self-care is essential to the maximum healing and optimal health.
- We invite you to speak frankly to the Doctor on any matter related to your care at this facility, including but not limited to the nature of your care, its duration cost.
- It is your responsibility to fully report your medical history and any changes in your health or any medical conditions.
- Payment for your treatment is your responsibility.
- IF YOU RECEIVE PAYMENT FROM YOUR INSURANCE COMPANY FOR SERVICES PERFORMED AT OUR OFFICE IT IS YOUR RESPONSIBILITY TO FORWARD THAT PAYMENT WITH COPIES OF THE ACCOMPANYING DOCUMENTATION TO OUR OFFICE WITHIN SEVEN (7) DAYS.
- If you need forms filled out or letter for your employer or any other party, please allow three (3) business days for it to be completed.
- The supervision of children is sole responsibility of the adult that accompanies them to the office. Please do not ask staff to supervise children.
- It is your responsibility to report any changes in your insurance, address, or phone number.

I _____ have read and fully understand the above statement. All questions pertaining to my care in this office have been answered to my satisfaction.

_____ _____

Signature Date