Unlock Your Natural Healing

OAKLAND SPINE & PHYSICAL THERAPY
Feel Better. Live Life.

WELCOME TO OUR OFFICE!

Name_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone_____ E-Mail_____

Birthdate _____ Age_____ SS# _____ Marital Status: M W D S

Employer _____ Work Phone _____ Occupation _____

Name & Birthdate of Primary Insured_____ Spouse Name _____

Primary Care Medical Doctor — Name & Location _____

Do you have a: **CareCredit Account** ❑ Yes ❑ No **Health Saving Account (HSA)** ❑ Yes ❑ No

Most patients are referred to our office by a caring family member or friend. What **first** brought you in contact with our office?

❑ **Referral:** Patient/Friend L_k c8]]]]]]]___]]]]]]]]]]_____]
❑ **Pcdcpp_j8 Bmarmp-Mrfcp** L_k c8]]]]]]]]]]___]]]]]]]]_____
❑ **Pcdcpp_j8 MQNR C k njmwcc** L_k c8 _____
❑ **Newspaper** Name:_____
❑ **Event** Name:_____
❑ **Returning Patient** What brought you back? _____
_____

❑ **Billboard** Rt.23 / CVS / Rt. 4
❑ **Postcard** Which one? _____
❑ **ZocDoc**
❑ **Website**
❑ **Facebook**
❑ **Groupon**
❑ **TV / Commercial**
❑ **Building Sign**

Please describe the primary health complaint you are experiencing. _____

_____

_____

How long have you had this condition? _____

Doctor treating condition: _____ Treatment Received: _____

Other Doctor: _____ Other Treatment: _____

Date of most recent x-rays: _____ Date of most recent MRI: _____

Please list all surgeries _____

What medications are you currently taking and for what conditions? _____

_____

Is this condition related to an automobile accident or injury suffered at your job? ❑ Yes ❑ No

Are you or could you be pregnant? ❑ Yes ❑ No

Do you take antibiotics when you go to the dentist? ❑ Yes ❑ No

The above information is true and accurate to the best of my knowledge.

Patient Signature _____ **Date** _____

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Name_____

PATIENT HEALTH HISTORY

Please place an "X" next to any current conditions and a "P" next to any past conditions:

GENERAL
___ Recent weight gain/loss
___ Fever
___ Fatigue
___ Sweats easily
___ Night Sweats

SKIN
___ Rash or itching/eczema
___ Change in skin color
___ Change in hair / nails
___ Non-healing sores
___ Change in appearance of moles
Other:_____

MUSCULOSKELETAL
___ Low back pain
___ Mid back pain
___ Upper back pain
___ Neck pain
___ Shoulder pain R / L
___ Arm problems R / L
___ Leg problems R / L
___ Hip pain R / L
___ Foot problems R / L
___ Painful, stiff, or swollen joints
___ Weak muscles
___ Joint replacement
___ Fractured bones
Other:_____

VISION
___ Glaucoma
___ Eye disease or Injury
___ Cataracts
Other:_____

WOMEN ONLY
Are you pregnant? Yes No
Due Date: _____

EARS, NOSE, & THROAT
___ Tinnitus (Ringing in ear)
___ Migraines / Headaches
___ Dizziness
___ Hearing loss
___ Allergies / Sinusitis
___ Bleeding gums or mouth sores
___ Dental problems
___ Swollen throat or lymph glands
___ Jaw Pain / TMJ
Other:_____

ENDOCRINE / HEMATOLOGIC / LYMPHATIC
___ Thyroid problems
___ Diabetes
___ Cold extremities (hands or feet)
___ Heat or cold intolerance
___ Glandular / Hormonal problems
___ Anemia
___ Immune system disorder (HIV/AIDS)
___ Cancer
Other:_____

CARDIOVASCULAR
___ Chest pain / tight chest
___ Irregular heartbeat
___ Pacemaker
___ Heart attack
___ Hypertension (high blood pressure)
___ Hypotension (low blood pressure)
___ Edema
___ Stroke / Concussion
Other:_____

GENITOURINARY
___ Sexual Dysfunction
___ Incontinence / Bed Wetting
___ Frequent Urination
___ Kidney Stones
Other:_____

RESPIRATORY
___ Difficulty breathing
___ Persistent cough
___ Asthma
___ Bronchitis
___ COPD
___ Emphysema
Other:_____

GASTROINTESTINAL
___ Loss of appetite / Heavy appetite
___ Cravings
___ Change in bowel movements
___ Abdominal Pain / Ulcer / Colitis
___ Frequent Diarrhea / Constipation
Other:_____

PSYCHOLOGICAL
___ Anxiety
___ Nervousness
___ Depression
___ Sleep Problems
___ Memory Loss / Confusion
___ Easily stressed
Other:_____

REPRODUCTIVE
___ Breast pain / lump
___ Painful or irregular menses
___ Clots
___ Infertility
___ Prostate problems
___ Erectile dysfunction
___ Cramps
___ Menopause
___ # of pregnancies
___ # of miscarriages
___ Age of 1st menses
Do you use birth control? y n
Date of last menses: _____

The above information is true and accurate to the best of my knowledge.

Patient Signature _____ **Date:** _____

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ASSIGNMENT OF BENEFITS

Patient Name _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____

Name of Policyholder_____ Policy Number _____

1. I, the undersigned, hereafter referred to as “the patient” do hereby assign all of my rights and interests to Chiropractic Works, LLC, hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier.

2. I, irrevocably assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me.

3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.

4. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.

Signed _____

Patient’s Name_____ Dated _____

Witness _____

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ABBREVIATED NOTICE OF PRIVACY POLICY FOR OAKLAND SPINE & PHYSICAL THERAPY

Effective October 1, 2005

We collect your personal health information from you through treatment, payment or other means as applicable. Your personal health information is protected by federal law. Generally we do not use or disclose your information without your permission. Once permission has been obtained, we must disclose your personal health information in accordance with the specific terms of permission. The following is an outline of the circumstances under which we are permitted by law to use or disclose your personal health information. You may request a copy of the detailed privacy policy with a written request sent to: **OAKLAND SPINE & PHYSICAL THERAPY** – 340 Ramapo Valley Rd. • Oakland, NJ 07436

1. Without your consent we may use or disclose your personal health information in order to provide you with services and treatments you may require or request, or to collect payment for services and/or to conduct other operations otherwise permitted or required by law. We can also disclose your personal health information within and among our workforce to accomplish the same purposes.
2. As required by law we may use or disclose your personal health information to the extent that such use or disclosure as required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.
3. All other situations with your specific authorization. Except as otherwise permitted or required, as outlined above, we may not use or disclose your personal health information without your written permission. You may revoke your authorization at any time except in some circumstances.
4. Miscellaneous activities NOTICE: We may contact you to provide appointment reminders or information about treatments or other health-related benefits and services that may be of interest to you.

YOUR RIGHTS WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION

1. Right to request restrictions on use or disclosure
2. Right to receive confidential information
3. Right to receive confidential communications
4. Right to inspect and copy your personal health information
5. Right to amend your personal health information
6. Right to receive accounting of disclosures of your personal health information
7. Right to file a complaint with us and the Secretary of the DHHS if you believe your privacy rights have been violated. You may submit your complaint in writing by mail to our privacy officer, **OAKLAND SPINE & PHYSICAL THERAPY**, within 180 days of when you knew or should have known the act of omission complained of occurred. You will not be retaliated against for filing any complaint.

We reserve the right to amend this privacy policy at any time for which we will provide you with notice within 60 days of the effective date of such revision, amendment or change.

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PRIVACY PRACTICES ACKNOWLEDGMENT

I. ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE

I have received/reviewed a copy of OAKLAND SPINE & PHYSICAL THERAPY'S Notice of Privacy Practices:

_____

Patient's Name | Date of Birth | Signature of Patient/Parent | Date

II. **Open Adjusting Rooms:** Due to the open office floor plan, sensitive matters should be discussed in private. Please make the doctor aware of any such issues so appropriate arrangements can be made for privacy.

III. DESIGNATION OF RELATIVES, FRIENDS AND OTHER CAREGIVERS FOR HEALTHCARE DISCLOSURE

I agree that OAKLAND SPINE & PHYSICAL THERAPY may disclose certain healthcare information to persons involved with my healthcare decisions or payment. I designate the following person(s) listed below as being involved with my healthcare for the purpose of OAKLAND SPINE & PHYSICAL THERAPY making limited information disclosure for the above purpose. I UNDERSTAND I AM NOT REQUIRED TO LIST ANYONE. I also understand I may change the designees in writing at any time.

Print Name _____ Relationship _____ Last 4 Digits of SS# _____

INFORMED CONSENT

I hereby request and consent to the performance of: physical examination and any other diagnostic tests such as x-rays to diagnose my condition(s), and of spinal adjustments, extremity adjustments, physical therapy, and axial decompression. If during the course of care the doctors encounter non-chiropractic or unusual findings, they may recommend I consult a specialist for the area in question. I have had the opportunity to discuss with the doctor or office personnel that results are not guaranteed and the rare risks of treatment. I do not expect the doctors to be able to anticipate and explain all risks and complications, and wish to rely upon the doctor's judgment during the course of treatment, based upon the facts then known, that is in my best interest. This consent will cover the entire course of my treatment for present conditions or any future conditions for which I seek treatment.

I have read and understand the terms above and grant permission for care:

Patient's Signature _____ Date _____

In case of emergency, contact _____ Phone # _____

Complete if patient under 18 years of age:

Child Name: _____

As parent/legal guardian of above child, I understand the terms above and grant permission for treatment.

Parent/Guardian Signature _____ Date _____