New Patient Intake Form

Sea Girt Spine and Rehabilitation Center

800 Highway 71

Sea Girt, NJ 08750

PATIENT INFORMATION (Please print)				
Patient Name			Date of Birth	Age
Address	City		State	Zip
Phone	Work		Cell	
Best Time/Which # to Call		Email		
Social Security Number	Sex: Male ___ Female ___	Marital Status: Single___ Married___ Divorced ___ Widowed___		
Occupation	Employer & Telephone Number			
Emergency Contact & Relationship		Phone		
Website referral or who referred you?				

INSURANCE INFORMATION	
PRIMARY INSURANCE	
Name of Insurance Company	HSA Acct: Y / N
Address	
Policy #	Group #
Subscriber Name	D.O.B
Subscriber SS #	
SECONDARY INSURANCE	
Name of Insurance Company	
Address	
Policy #	Policy #
Subscriber Name	Subscriber Name
Subscriber SS #	

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Sea Girt Spine and Rehabilitation for any services furnished me by the physician. I authorize any holder of medical information about me to be released to the Center of Medicare and Medicaid services and its agents any information to determine these benefits payable for related services.

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Patient Signature **Date**

I, undersigned, authorize payment of medical benefits to Sea Girt Spine and Rehabilitation for any service furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize you to release to my insurance company or their agent, information concerning health care, treatment, or supply provided to me. This information will be used for purpose of evaluating and administering claims benefits.

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Patient Signature **Date**

Patient Information – Page 2

List of chief complaints in order of severity:

1. ____ For how long: ________________________
2. ____ For how long: ________________________
3. ____ For how long: ________________________

Where is the pain? ____

Does the pain travel? Yes No

If yes, where? ____

What is the severity of your problem?

(best) 1 2 3 4 5 6 7 8 9 10 (worst)

How are your symptoms affecting your lifestyle? (i.e. job, relationships, recreational activities, household chores)

____

Circle any activities that *aggravate* the condition:

Walking Lifting Coughing Sitting Bending Sneezing Sleeping Other

Circle any activities that *alleviate* the condition:

Rest Standing Heat Exercise Lying Down Ice Sitting Massage Other

Do you currently have, or have you had any of the following condition or symptoms?

__Headaches	__Fatigue	__Loss of balance	__Shoulder pain
__Knee pain	__Vertigo	__Nervousness	__Neck pain
__High Blood Pressure	__Wrist of hand pain	__Cancer	__Low back pain
__Shortness of Breath	__Chest pain	__HIV	__Other
__Loss of smell/taste	__Heart condition	__Dizziness	________________
__Numbness or tingling	__Stomach problems	__Depression	________________
__Hip pain	__Ringing in ears	__Anxiety	________________

List your hospitalizations, operation, and/or serious illness:

____

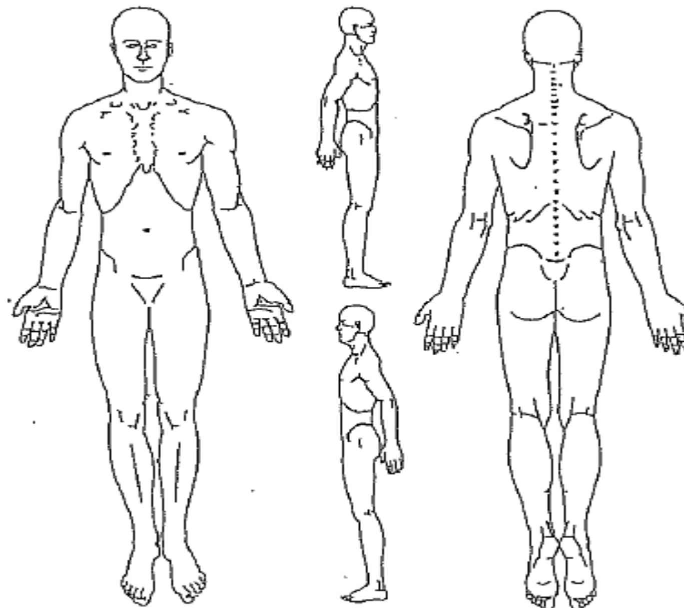
____

List all the medications you are currently taking:

____

____

Indicate on the diagram where your pain is:



<u>**Informed Consent to Chiropractic Treatment**</u>

Coastal Spine and Rehabilitation Center
800 Highway 71
Sea Girt, NJ 08750

<u>**The nature of chiropractic treatment:**</u> The doctor will use his/her hands on a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or dry hydrotherapy may also be used.

<u>**Possible Risks:**</u> As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

<u>**Probability of risks occurring:**</u> The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

<u>**Other treatment options which could be considered may include the following:**</u>

- *Over-the-counter* analgesics. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in a conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

<u>**Risks of remaining untreated:**</u> Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition and make future rehabilitation more difficult.

<u>**Unusual risks:**</u> I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent.

______________________________	______________________________	____________
Printed Name	*Signature*	*Date*

<u>**Witness:**</u>

______________________________	______________________________	____________
Printed Name	*Signature*	*Date*

HIPPA COMPLIANCE ACKNOWLEDGEMENT

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
THIS NOTICE IS IN EFFECT AS OF April 15, 2003

PATIENT'S STATEMENT OF AUTHORIZATION AND ACKNOWLEDGEMENT

a) Is required by Federal Law to maintain the privacy of your protected health information (PHI), and to provide you with a copy of this Privacy Notice detailing COASTAL SPINE AND REHABILITATION CENTER legal duties and privacy practices with respect to your PHI.
b) May be required by State Law to maintain greater restrictions on the use or release of your PHI than that which is provided under federal law, COASTAL SPINE AND REHABILITATION CENTER IS required to, and will comply with all required State statutes.
c) Is required to abide by the terms of this Privacy Notice.
d) Reserves the right to change the terms of this Privacy Notice to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
e) Will distribute any revised Privacy Notice to you prior implementation.
f) Will comply with our complaint policy, and will not retaliate against you for filling a complaint.

By subscribing my name below, I acknowledge that I have read and understood this Privacy Notice. Furthermore, I give COASTAL SPINE AND REHABILITATION CENTER THE EXPRESSED WRITTEN CONSENT TO DISPLAY MY NAME IN ANY "In-Office" usages including, but not limited to sign-in sheet, files, and charts. I, also understand that if my name is requested to be used for promotional purposes outside of the office, a separate acknowledge of permission will be made in writing

ACCEPT TERMS:

____ _______________________
PATIENT SIGNATURE DATE