ENTRANCE APPLICATION & HISTORY OF COMPLAINT

DATE_____PATIENT ID#_____

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help you.

Patient Information

(Please Print)

Name_____

First Middle Initial Last

Address_____City_____State_____Zip_____

Sex: _____Female _____Male Birthdate_____Age_____Height_____Weight_____

Driver's License #_____ State_____

Social Security #_____E-mail_____

Cell Phone (_____)_____Cell Carrier_____

Home Phone (_____)_____ Work Phone (_____)_____

Do you prefer to receive calls at: _____Home _____Work _____Cell _____No Preference

_____Married _____Widowed _____Single _____Minor _____Separated _____Divorced

Patient Employer/School_____Occupation_____

Employer/School Address_____City_____State_____Zip_____

Spouse or Parent's name_____Employer_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency_____ Phone (_____)_____

Name of person responsible for this account_____

Relationship to patient_____ Phone (_____)_____

Have you had any surgeries: ☐ No ☐ Yes If yes, Last Surgery Date:_____

Please list all surgeries:_____

_____

Symptoms

Please list your First Chief Complaint (only one):_____Date of onset:_____

What is the cause of your complaint? _____Auto Accident _____Work Injury _____Other Accident _____Illness

_____Aggravation of a congenital condition _____Unknown

Please describe how THIS ONSET of your chief complaint started (give specific details):

_____

_____

How often is this pain experienced: _____Constant _____Frequent _____Occasional _____Intermittent

(76-100%) (51-75%) (26-50%) (1-25%)

Is this condition getting progressively worse? _____No _____Yes

Type of Pain: _____Sharp _____Dull _____Throbbing _____Numbness _____Shooting _____Burning

_____Tingling _____Cramps _____Stiffness _____Swelling _____Other

Rate the severity of your pain (1-mild pain / discomfort to 10-severe pain):_____

Other Complaints (if any)

***Secondary complaint:**_____

How often is this pain experienced: _____Constant _____Frequent _____Occasional _____Intermittent

(76-100%) (51-75%) (26-50%) (1-25%)

Is this condition getting progressively worse? _____No _____Yes

Type of Pain: _____Sharp _____Dull _____Throbbing _____Numbness _____Shooting _____Burning

_____Tingling _____Cramps _____Stiffness _____Swelling _____Other

Rate the severity of your pain (1-mild pain / discomfort to 10-severe pain):_____

***Third complaint:**_____

How often is this pain experienced: _____Constant _____Frequent _____Occasional _____Intermittent

(76-100%) (51-75%) (26-50%) (1-25%)

Is this condition getting progressively worse? _____No _____Yes

Type of Pain: _____Sharp _____Dull _____Throbbing _____Numbness _____Shooting _____Burning

_____Tingling _____Cramps _____Stiffness _____Swelling _____Other

Rate the severity of your pain (1-mild pain / discomfort to 10-severe pain):_____

Present Illness / Conditions:					
☐ AIDS	☐ Cirrhosis/hepatitis	☐ Gout	☐ Kidney trouble	☐ Pacemaker	☐ Stroke
☐ Allergies	☐ Concentration loss	☐ Hay Fever	☐ Low Blood Pressure	☐ Prostate trouble	☐ Thyroid trouble
☐ Anemia	☐ Depression	☐ Headaches	☐ Lumps	☐ Rheumatic fever	☐ Tuberculosis
☐ Arthritis	☐ Diabetes	☐ Heart Problems	☐ Masses	☐ Rheumatoid Arthritis	
☐ Asthma	☐ Dislocated Joints	☐ Hernia	☐ Mental/Emotional Difficulty	☐ Scoliosis	☐ Ulcer
☐ Bone fracture	☐ Diverticulitis	☐ Herniated Discs	☐ Migraines	☐ Seizures	☐ Vertigo
☐ Cancer	☐ Dizziness	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Spinal Disc Problems	
☐ Chills	☐ Epilepsy	☐ HIV / ARC	☐ Osteoporosis	☐ STDs	
Other:					

Family History – Please mark if your siblings, parents or grandparents have had any of the following:					
☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STDs	☐ Stroke
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/Hepatitis	☐ HIV / ARC	☐ Mental/Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated Joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitis
Other:					

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week? _____	Cigarettes? ☐ No ☐ Yes Packs per day? _____	Caffeine? ☐ No ☐ Yes Drinks per day? _____	Exercise? ☐ No ☐ Yes Hours/week_____ (circle one) Light / Moderate / Strenuous
What vitamins do you take?			
Interested in nutritional supplements to improve your health and/or speed your recovery? ☐ No ☐ Yes			
Interested in a structured weight management program that would not involve drugs/medication? ☐ No ☐ Yes			

Please list all medications you are currently taking: _____

Please list any allergies you may have: _____

Are you aware of any pre-existing structural pathology related to your complaints? If yes, please describe: _____

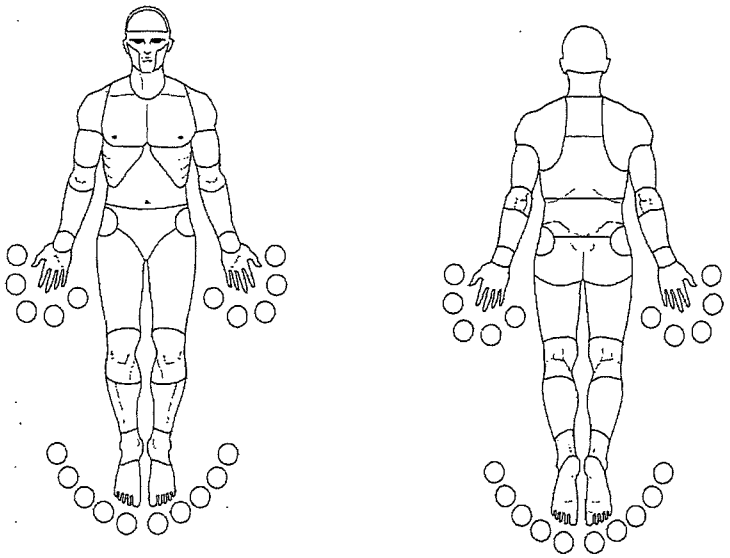
_____

Would you like a copy of the report of findings sent to your family doctor? _____ Yes _____ No

If yes, what is your doctor's name and address? _____

_____

Please mark below (X) on the areas where your pain is located



CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

_____

Patient's Signature Date

X-RAY QUESTIONNAIRE: **FOR WOMEN ONLY**

Our consultation and examination may indicate that X-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name:_____

- ☐ There is a possibility that I may be pregnant at this time.
- ☐ Yes. I am definitely pregnant.
- ☐ No. I am definitely not pregnant at this time.
- ☐ I request that x-ray films not be taken because _____

_____

_____

Date of last menstrual period: _____

_____

Patient's Signature Date

ASSIGNMENT OF BENEFITS, AUTHORIZATION FOR RELEASE OF INFORMATION, AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Assignment of Benefits/Financial Responsibility

The undersigned hereby authorizes Adelphia Chiropractic Health Center, P.C. (hereinafter "the Provider") to file on my behalf for payment of any medical benefits arising out of any insurance or health plan benefits and hereby assign the benefits to the Provider. I certify that the information reported with regard to my insurance coverage, health care benefits and medical history is accurate and complete. I understand that I am liable for payment to the Provider for all co-insurance, copays and deductibles as required by my insurance or health benefits plan and I also acknowledge that I am responsible for payment of any charges not covered by my insurance or health benefits plan. Payment is required at the time services are rendered unless other payment arrangements are made in advance.

Designation of Authorized Representative

The undersigned also designates the Provider to the fullest extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") as provided in 29 CFR 2560-503(b)(4) and under any applicable state and federal law to pursue claims and appeals on my behalf and exercise all rights connected with my health care benefits, pursuing insurance or plan reimbursement and to pursue any other applicable remedies as may be necessary and with regards to my health benefit plan or insurance policy along with any incidental powers and duties to effectuate same.

Authorization for Release of Information

The undersigned authorizes the Provider to release any medical or other information necessary to determine benefits to my insurance carrier, employer, plan administrator, or any other payer including any information regarding my illness and treatments and for the processing of benefits or insurance claims generated in the course of examination or treatment. The undersigned hereby authorizes Adelphia Chiropractic Health Center P.C. (employer) to furnish to the Provider a copy of all health care plan documents or information requested by the Provider and pursuant to 29 U.S.C. § 1024(b)(4), which includes but is not limited to the latest summary plan documents, plan descriptions, latest annual reports, terminal reports, applicable collective bargaining agreements, trust agreements, contracts or other instruments.

Revocation and Acknowledgement

A photocopy of this authorization shall be considered the same as the original and can be used to process insurance of health benefit claims. The undersigned acknowledges that he/she has the right to revoke this authorization and designation of authorized representative, in writing, by sending notification to the Provider; however, the undersigned understands that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Date:_____ Patient:_____

Date:_____ Insured:_____

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine if proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check—it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due.
5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full immediately; regardless of any claims submitted.
8. If you owe a bill whether you have insurance or not, you, the patient, will be responsible for any necessary collection fees and/or legal fees if applicable.
9. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for **Adelphia Chiropractic Health Center P.C**. regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights contained therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting **Doctors George or Anastasios Hatzakos** of our clinic at **[610-253-2225] at 1306 Knox Avenue Easton, Pennsylvania 18040.**

My signature herein below constitutes full acknowledgement that I have been furnished a copy of the Notice of Privacy Practices for **Adelphia Chiropractic Health Center P.C.**

_____ _____

Patient Signature Date

_____ _____

Patient's Legal Representative Date

If signed by patient's legal representative, please state representative's relationship to patient:

_____

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Exercise and Fitness
- ❑ Diet and Nutrition
- ❑ Stress Management
- ❑ Wellness Topics
- ❑ Women's Health Issues

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.