Welcome to Sparta Chiropractic and Wellness Center

Patient Information

Thank you for choosing Sparta Chiropractic and Wellness Center for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help!

Name: _____ SS/HIC/Patient ID#: _____
First Middle Last

Address: _____City:_____ State: _____ Zip Code: _____

Birthdate: _____ Email Address: _____

Home #: _____Cell #: _____ Work #:_____

Do you prefer to receive calls at: □Home □ Work □ Cell □ No Preference

□Married □Widowed □ Single □ Minor □ Separated □ Divorced □ Partnered for ____ years

Patient Employer/School:_____ Occupation:_____

Employer/School Address: _____City:_____State: _____ Zip Code:_____

Spouse or parent's name: _____ Employer:_____ Work Phone:_____

Whom may we thank for referring you to us? _____Have you ever visited our website before? _____

Person to contact in case of emergency: _____ Phone #: _____

Responsible Party

Name of person responsible for this account: _____Relationship to patient: _____

Phone #: _____Address: _____ City: _____ State: _____ Zip : _____

Birthday:_____ Name of Employer: _____ Work Phone#: _____

Symptoms

Reason for the visit: _____When did you first notice the symptoms? _____

Is the condition getting progressively worse? _____Where specifically is the problem located?_____

Which activities are difficult to perform? □Sitting □Standing □Walking □Bending □Lying Down

Type of Pain:

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting

□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

Rate the severity of your pain (1 = mild pain or discomfort, to 10 = severe pain) **1 2 3 4 5 6 7 8 9 10**

Is the pain constant or does it come and go? _____

What treatment have you received for your condition? □Medication □ Surgery □ Physical Therapy□ Other

Name and address of your primary care physician? _____

List any types of surgeries which you have had and the dates which they occurred:_____

Please list all medications you are currently taking:

_____

Allergies: _____

Women: Are you pregnant? □Yes □ No Nursing? □Yes □ No Birth Control Pills? □Yes □ No

Daily Habits

What type of exercise do you perform on a daily basis? □None □ Moderate □ Heavy Description:

_____

What do your daily work habits include?_____

What vitamins do you currently take? _____ Nutritional Supplements? _____

Do you smoke? □Yes □ No How much per day?_____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily?____

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Guardian or Personal Representative Relationship to Patient

To: Sparta Chiropractic and Wellness Center
IN CONSIDERATION OF YOUR UNDERTAKING TO TREAT ME, I AGREE TO THE FOLLOWING:

AUTHORIZATION TO RELEASE INFORMATION (aka you allow us to coordinate your care in our office with your primary care physician)

You are authorized to release any information you deem appropriate concerning my physical condition to my primary care physician to coordinate my care, any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, I hereby release you of any consequence thereof.

SIGNED X_____

Requested Information

Statement of Non-Accident (aka your injuries are NOT due to an auto accident)

I, _____ am currently receiving chiropractic care at Sparta Chiropractic and Wellness Center. Please know that this care is not related to any accident, workers' compensation injury or any other type of injury in which a third party is liable for these bills.
I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by Sparta Chiropractic and Wellness Center. If you have any questions, do not hesitate to contact me personally.

_____ **X**_____ Date: _____
Patient's Name Signature

TERMS OF ACCEPTANCE (aka you are aware you are at a chiropractor's office)

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Please print your name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

__**X**_____ _____
Signature Date

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____.

__**X**_____ _____
Signature Date

SPARTA CHIROPRACTIC AND WELLNESS CENTER

Dr. Eric Loewrigkeit and Associates

Consent for Purposes of Treatment, Payment & Healthcare Operations

(aka nothing will leave our office concerning your care without your expressed consent)

In this document, 'I" and "my" refer to the patient,
and "Chiropractor" refers to the doctors of Sparta Chiropractic and Wellness Center.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at
17 Woodport Road, Sparta. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

X_____ Signature of Patient or Representative
Date _____ _____ Printed Name

X_____ Signature of Personal Representative
Date _____ _____ Printed Name

The Chiropractic Office of Dr. Eric Loewrigkeit and Associates

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

In the course of your care as a patient at Sparta Chiropractic and Wellness Center we may use or disclose personal and health related information about you in the following ways:

*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.

*Your name, address, phone number, and your health care records may be used to contact you reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding appointment regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain about alternatives to your the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy Notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

The Privacy Officer

If you would like further information about our privacy policies and practices please contact:

The Privacy Officer at 973-726-9041

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this Office or with the Secretary your care will continue and you will not be disadvantaged by this office or our Staff in any many whatsoever.

OFFICE POLICY

Your care and the results of your care are a direct reflection of our office. The following guidelines are for your benefit to ensure the best results in the shortest period of time.

1. For the first 90 days, schedule your visits between your spinal check-ups (re-exams).

2. When emergencies arise and you cannot keep a scheduled appointment, please call prior to your appointment to reschedule. You can usually be rescheduled for the same day. To get the best results possible, make up missed appointments within 7 days.

3. If there is inclimate weather, the practice will be open or closed based on what Sparta School District chooses to do. If there is a delayed opening, the practice will open its doors at 10am.

4. If you are ill from a cold, flu, virus, headache, etc., make sure you KEEP your scheduled appointment, and tell the Doctor about it so that he can perform additional procedures or give you guidance to help that condition.

5. Please inform the Doctor immediately about anything that aggravates your present condition or should a new one develop.

6. Our office is open 4 mornings and evenings per week for your convenience: Monday, Wednesday and Friday 9-12 noon and 2-6 pm, Tuesday 2-6 pm, Saturday 8-11 am. (Unless a notice is posted for special hours.)

7. In some cases, insurance checks will be sent to you. You are responsible for making sure those checks make it our office.

8. All arrangements for smooth claim processing should be made with our office staff. Be cooperative in supplying all the insurance information within one week.

9. All financial arrangements should be directed to the front desk, not to the Doctor.

10. These policies are designed to aid in making your health care the most effective and efficient as possible.