EAST HANOVER
CHIROPRACTIC & WELLNESS

460 Ridgedale Ave, Ste 1
East Hanover, NJ 07936
(973)-887-5353
Fax : (973)-887-1151
ehwellnesscenter.com

New Patient Intake Form

Demographic Information: _____ _____
Full Name (as it appears on your insurance card) Preferred Name/Nickname

_____ _____
Street Address City, State Zip Code Phone # Home ☐ Mobile ☐

_____ _____
Email address: we will use for sending home exercise program and clinic info Phone# Home ☐ Mobile ☐

_____ _____ _____
Date of Birth Age Gender

Appointment Confirmation Preferred Method: ☐ Phone Call ☐ Text Message ☐ Email ☐ No reminders please

_____ _____
Employer Occupation Working: Yes/no/modified

_____ _____
Emergency Contact Relationship Phone

Insurance Information: _____ _____
Insurance Carrier Responsible Party

_____ _____
If responsible party is other than self, Primary Subscribers Name and Date of Birth Responsible Party's Phone #

_____ _____
Secondary Insurance Carrier Subscribers Name and Date of Birth Responsible Party

Primary Care Physician: _____ _____
Name of Primary Care Physician Physician Phone #

How did you hear about East Hanover Chiropractic & Wellness Center?

☐ Physician ☐ former patient ☐ sports team/coach ☐ dance school/instructor ☐ internet (Google/Facebook) ☐Other

_____
(Please Specify, so we can say "Thank you")

_____ _____
Patient or Guardian Signature Date

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Patient Medical History

Patient Name _____ Height _____ Weight _____

Type of Injury/Condition _____ Date of Injury/Onset _____

(If Applicable) Type of Surgery/Procedure _____ Date of Surgery _____

Please describe your physical limitations as a result of this injury/surgery: _____

Please describe any activities or movements that aggravate your symptoms: _____

Please describe any treatments, movements or self-care that decrease your symptoms: _____

Please list any previous injury, conditions or surgeries: _____

Have you had any of the following diagnostic test in relating to this injury? *(mark all that apply)*
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Doppler ☐ Ultrasound ☐ Other

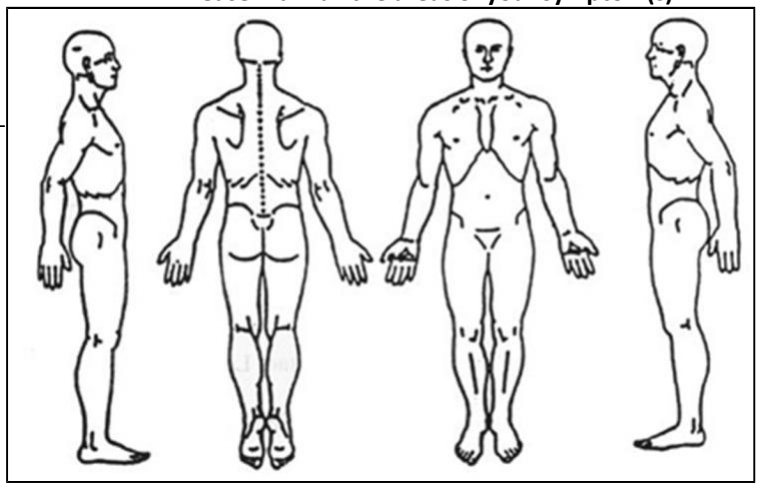
Do you have any allergies? _____

Which of the following describes your pain:
(mark all that apply) ☐ Sharp ☐ Achy ☐ Burning
☐ Tingling ☐ Numbness ☐ Other: _____

Please rate your pain: *(0= none, 5=moderate, 10= Severe)*

At present:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10

Please mark all the areas of your symptom(s):



Are you currently taking ANY medications? ☐ YES ☐ NO
Please list ALL medication/dosages: _____

Fall History: Is your injury the result of a fall? ☐ Yes ☐ No Have you fallen twice or more in the past year? ☐ Yes ☐ No
Dates of falls: _____

Health Habits and Lifestyle:

Do you eat a well-balanced diet? ☐Yes ☐No
Do you smoke/vape? ☐Yes ☐No
Do you drink alcohol? ☐Yes ☐No
Do you exercise regularly? ☐Yes ☐No

Do you drink water regularly? ☐Yes ☐No # of glasses each day: _____
Daily amount: _____ For how long? _____
#/day? _____ Days/week? _____
How often? _____ Type / program? _____

Medical History

Please read the following and indicate if you have been diagnosed with any of the following conditions:

Allergies	Y	N	Diabetes	Y	N	Metal implants	Y	N
Anemia	Y	N	Dizziness/ringing in ears/vertigo	Y	N	Multiple Sclerosis	Y	N
Anxiety	Y	N	Emphysema/Chronic Bronchitis	Y	N	Neurological disorder	Y	N
Arthritis	Y	N	Fibromyalgia/Chronic Fatigue	Y	N	Numbness/tingling	Y	N
Asthma	Y	N	Fractures	Y	N	Osteoporosis/Osteopenia	Y	N
Bladder/Bowel problems	Y	N	Gastrointestinal Problems	Y	N	Pain Syndromes/CRPS	Y	N
Cancer	Y	N	Gallbladder problems	Y	N	Parkinson's	Y	N
Cardiac Disease/Conditions	Y	N	Headache/Migraines	Y	N	Seizures	Y	N
Cardiac pacemaker/	Y	N	Hepatitis	Y	N	Speech problems	Y	N
Defibrillator	Y	N	Hernia	Y	N	Strokes	Y	N
Circulation problems	Y	N	High blood pressure	Y	N	Thyroid problems	Y	N
Currently pregnant	Y	N	Incontinence	Y	N	Vision problems	Y	N
Depression	Y	N	Kidney problems	Y	N			

Please describe in detail any diagnosis marked "Y"**:** _____

_____

_____

Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No If yes, how far along/expected due date?_____

Have you breast feeding? ☐ Yes ☐ No

Have you suffered from any illness not listed here? ☐ Yes ☐ No If yes, please explain:_____

Treatment History

Have you been treated for this condition before? By whom? _____

Was it helpful? ☐Yes ☐No Please explain: _____

What are your goals for Chiropractic? _____

What do you hope to get out of your treatment? _____

What are your current physical or fitness goals?_____

Please list any important dates (such as return to sport/big performance/games coming up that you want to be ready to participate):

_____

Is there anything else you would like to include or ask your Chiropractor? _____

_____

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CHIROPRACTIC & WELLNESS

Commitment to Chiropractic

Late, No-Show, Cancellation and Re-scheduling Policies

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we feel it is our duty to do everything within our power to emphasize the importance of your commitment. The following policies are in place to motivate commitment.

Commitment to your appointments

- With the exception of serious emergencies your recovery depends upon attending all your appointments.
- If you need to reschedule or cancel, it is in your best interest to reschedule the missed appointment to a date as close to the cancelled or rescheduled visit as possible.
- Please Note: In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care. We will inform your physician of the fact that your service has been discontinued due to noncompliance with the prescribed rehabilitation order.

Late Policy

- If you are less than 15 minutes late and have contacted East Hanover Chiropractic & Wellness Center to warn us that you'll be late, you may complete the remaining time scheduled for your session, **knowing that you will not receive a full session**.
- If you are more than 15 minutes late and have not contacted East Hanover Chiropractic & Wellness Center, we hold the right to consider your appointment a "No-Show." As per the no-show policy, we reserve the right to charge you a $25 fee.

No-Show Policy

- If you schedule an appointment and do not come to your appointment, or if you arrive more than 15 minutes late to a scheduled appointment, we reserve the right to charge you $50 no-show fee.
- Text Reminders: While we send out text reminders, ultimately, the responsibility for remembering your appointments is YOURS. If reminder calls do not go out, and you do not show up for your appointment, you will still be charged the $50 no-show fee.

Cancellation Policy

- If you need to reschedule a session, you are more than welcome to do so, as long as you provide more than 24 hours' notice before your scheduled appointment.
- Late Cancel: If you cancel within 24 hours of your appointment this is considered a Late Cancellation and we reserve the right to charge you a $25 cancellation fee.

Re-Schedule Policy

- If you need to cancel a session, you are more than welcome to do so, as long as you provide more than 24 hours' notice before your scheduled appointment.
- Late Reschedule: If you try to reschedule an appointment within 24 hours of your appointment this is considered a Late Reschedule and we reserve the right to charge you a $25 cancellation fee unless:
    - You reschedule your appointment to later the same day (if there is time available). OR
    - We are able to fill your vacated slot with another client.

Paying, Cancellation, and No-Show Fees

- Cancellation and No-Show fees are not billable to any form of insurance.
- To resume treatment following a late cancel, late reschedule, or no-show, the $25-$50 fee will be due before your next visit. If you refuse to pay the fee, we reserve the right to turn your care back to your referring physician.

We truly do not want to have to charge you for sessions you did not attend. These policies are in place because we've found that they encourage patient compliance to their rehabilitation goals (not because we want to profit from your lack of compliance). Thank you for your understanding and participation.

By signing below, you acknowledge that you have read, understand, and agree to all the policies listed above.

_____ _____

Patient or Guardian Signature Date

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Payment and Insurance Policy

FINANCIAL POLICY:
It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided unless we are preferred providers of your insurance plan. We ask that you make copayments, co-insurance and deductibles at the time of each visit.

PATIENT'S RESPONSIBILTY:
It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claims status. _____(Initial)

It is the patient's responsibility to:

- Understand their insurance policy, and to ask questions when they don't.
- Obtain a referral indicating medical necessity for physical therapy services.
- Pay co-pays, co-insurances, and/or deductibles at time of service.
- Promptly pay any patient responsibility indicated by their insurance carrier.
- Contact their insurance carrier when claims have not been paid.
- Obtain updated referrals or prescription for physical therapy when there has been more than a 30-day lapse in care or when their referral is dated more than 30 days previous to their 1st visit.

INSURANCE PATIENTS
ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize East Hanover Chiropractic & Wellness Center to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to East Hanover Chiropractic & Wellness Center. I am aware that if I were to receive any checks from my insurance company that I must not cash them and am to bring them in with everything that comes with them and endorse them over to my Chiropractor. _____(Initial)

MEDICARE PATIENTS – (*please provide card)*
Have you had any PT this year provided in your home or in another outpatient clinic? ☐ Yes ☐ No _____# of visits
Do you currently have Medicare home services? ☐ Yes ☐ No
Medicare ID:_____

SELF PAY PATIENTS:
For patients without insurance or with insurance we are not contracted with, we offer self-pay rates which must be paid at the time of service. _____(Initial)

VOLUNTARY TERMINATION OF TREATMENT:
It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable. _____(Initial)

I have read the above information and **I UNDERSTAND MY RESPONSBILITY FOR THE PAYMENT OF MY ACCOUNT**.

_____ _____
Patient or Guardian Signature Date

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HIPAA Notification

Notice of Privacy Practices for Protected Health Information
Health Insurance Portability & Accountability Act of 1996 (HIPAA)

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

I consent to the use or disclosure of my protected health information by the 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 the Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that 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. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the 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. The 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 the Chiropractor and understand that I have a right to review the 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 the Chiropractor. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The 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 the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient / Personal Representative

_____ _____
Printed Name of Patient / Personal Representative Date

☐ **I acknowledge that I do not wish to obtain a copy of the HIPAA Privacy Policy**

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Consent For Care and Treatment

Dear Patient, Every type of health care is associated with some risk of potential problems. That includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment.

1. I understand that the chiropractor will use his/her hand or a mechanical device upon my body to adjust a joint, and there may be an audible “pop” or “click” as result of joint movement.

2. The practice of health care is not an exact science, but relies upon information relayed by the Patient, information gathered during the examinations (and the doctor’s interpretation thereof), as well as the doctor's judgment and expertise. Chiropractic care is no different.

3. It is not reasonable to expect my doctor to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgement during the course of any procedures that he/she feels at the time to be in my best interest.

4. Though infrequent, as with any health procedure, there are certain complications that may arise during chiropractic health care. These complications include soreness, sprain/strains, dislocation, fractures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.

5. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.

6. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

CONSENT FOR CARE AND TREATMENT:

I, _____hereby agree and give my consent for East Hanover Chiropractic & Wellness Center to furnish Chiropractic care and treatment considered necessary and proper in evaluating or treating my physical condition. _____(initial)

FOR MINORS ONLY: CONSENT FOR CARE: As parent and/or legal guardian, I authorize East Hanover Chiropractic & Wellness Center to treat the minor patient named in the attached forms while I am not present. _____(parent/guardian initial)

By signing this Confidential Patient Information intake form I acknowledge that I have read the above consent, or it has been read to me. I have had the opportunity to ask questions and receive answers; I am comfortable with the information provided and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

Patient Signature (Parent/Guardian if necessary):_____ Date: _____

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Missing Or Changing Appointments Policy

It is our wish that each and every one of our patients receive the very best care and services possible. Your treatment program consists of a specific series of treatment given over a pre-planned time span. If you don't follow the plan, then you will not receive the desired results. If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

Meet all your appointments. Arrange the activities in your life so that this can occur.

If you are unable to make your appointment due to an emergency, please call us and let us know so that we can reschedule your appointment. If you need to change the time of your appointment, plan to come another time on the same day. If the same day is not possible, be sure to make up the missed appointment within 1 week.

With the exception of an unexpected emergency, we require that you notify us 24 hours in advance as to any appointment changes to avoid being charged.

For no call/no show appointments or cancellations less than 5 hours in advance, there is a non-refundable $25.00 service charge that will be billed to your credit card/debit card on file.

By signing below you affirm that you have read, understand and agree to follow the above policy.

Patient Signature:_____ Date:_____

Credit/Debit Card Information: (print legibly)

Name of card holder: _____
Credit card number:_____
Card Type:_____
Expiration date:_____
CVV Code (3 or 4 digit #):_____