320 White Horse Ave, Trenton, NJ 08610 • Phone: 609-585-9222 • Fax: 609-581-8097

PATIENT INFORMATION

Name ____ ____________________________
Last Name First Name Initial Social Security #

Address ____

City ______________________ State ______ Zip _________ Home Phone _________________________

Cell Phone _______________ Carrier _____________Email ___________________________________

Sex ❒ M ❒ F Age ____ Birth Date ___________ ❒Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Patient employed by ____________________________________ Occupation _______________________

Business Address ____

Business Phone ______________________________ Business Email ____________________________

Notify in case of emergency _________________________ Phone ________________________________

Whom may we thank for referring you? ____

REASON FOR VISIT

Have you ever seen a chiropractor? ❒Yes ❒No If yes, when and why? __________________________

Your reason for THIS visit: ____

Please describe your current pain and its location ____

When did symptoms begin (date)?__________Have you had similar conditions in the past? _______________

Is pain getting ❒ Worse ❒ Better ❒ Same ❒ Comes and goes How often do you have this pain? ____________

Have you been treated by a medical physical for this condition? _____________________________________

If so, when and where? ____

Activities/movements that are difficult/painful: ❒ Sitting ❒ Walking ❒ Bending ❒ Lying down ❒ Lifting

Type of pain: ❒ Sharp ❒ Dull ❒ Throbbing ❒ Aching ❒ Burning ❒ Tingling ❒ Numbness ❒ Cramping

❒ Stiffness ❒ Swelling ❒ Other ____

Is pain interfering with: ❒ Work ❒ Sleep ❒ Daily Routine ❒ Recreation

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Please list any serious injuries or surgeries you have had in the last 10 years:

	DESCRIPTION	DATE
Falls	______	______
Head Injuries	______	______
Broken Bones	______	______
Dislocations	______	______
Surgeries	______	______
Other serious injuries	______	______

Women: Are you pregnant? ❒ Y ❒ N If so, how far along? ______ Nursing ❒ Y ❒ N

MEDICAL CONDITIONS

❒ Heart Attack/Stroke	❒ Arthritis	❒ Ringing in Ears	❒ Ulcer/Colitis
❒ Congenital Heart Defect	❒ Frequent Neck Pain	❒ Anemia	❒ Gout
❒ Alcohol/Drug Abuse	❒ Jaw Pain	❒ Diabetes/Tuberculosis	❒ Numbness, where?
❒ Fainting/Seizures/Epilepsy	❒ Wrist Pain	❒ Dizziness	______
❒ Shingles	❒ Shoulder Pain	❒ Emphysema/Glaucoma	❒ Tingling, where?
❒ Psychiatric Problems	❒ Arm Pain	❒ Kidney Problems	______
❒ Difficulty Breathing	❒ Leg Pain	❒ Artificial Bones/Joints	❒ Muscle Spasms, where?
❒ Severe/Frequent Earaches	❒ Lower Back Pain	❒ Cancer	______
❒ HIV Positive/AIDS	❒ Hepatitis	❒ Severe/Frequent Headaches	

PERSONAL HABITS

	Heavy	Moderate	Light	None
Alcohol	❒	❒	❒	❒
Coffee	❒	❒	❒	❒
Tobacco	❒	❒	❒	❒
Drugs	❒	❒	❒	❒
Exercise	❒	❒	❒	❒
Sleep	❒	❒	❒	❒
Appetite	❒	❒	❒	❒

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will information the chiropractor.

I authorize my insurance company to pay to Fischer Chiropractic Center all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature of all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________ Date ______________

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PERSONAL INFORMATION SHEET

Name (Last, First) [ ] Date: [ ]

Preferred Spoken Language [ ] Gender: ❒ Male ❒ Female

Race:
- ❒ White
- ❒ African American
- ❒ Asian
- ❒ American Indian
- ❒ Native Hawaiian/Other Pacific Islander
- ❒ Other ______________________________

Ethnicity (Irish, Italian…): [ ]

Are you a smoker? ❒ YES ❒ NO
Do you have diabetes? ❒ YES ❒ NO
Do you have high blood pressure? ❒ YES ❒ NO

MEDICATIONS mg how often	**ALLERGY reaction**

Signature ____ Date ________________________________

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RECORDS RELEASE

I,____ request a copy of my medical records to be released to Fischer Chiropractic Center for the purpose of review.

Date: ___________________

Patient Signature: ______________________________________

Print Name: ____

Witness Signature: _____________________________________

Print Name: ____

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NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed by Fischer Chiropractic Center and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of the Notice upon request.

Patient Health Information
Under federal law, your patient's health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related information also includes payment, billing and insurance information

How We Use Your Patient Health Information We use health information about you for treatment, to obtain payment and for health care operations (TPO) including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and HealthCare Operations (TPO).

Treatment We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions and to family members who are helping with your care.

Payment We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments for your health plan.

Health Care Operations We will use and disclose your health information to conduct our standard internal operations including proper administration of records, evaluation of the quality of treatment and to assess the care and outcome of your case and others like it.

Special Uses We may call your home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying our TPO, such as appointment reminders, insurance items and any items related to your clinical care. We may mail to your home or other designated location any items that assist the practice in carrying out the TPO, such as appointment reminders, patients statements. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Release of information to Family/Friends. We may release identifiable health information to a friend or family member that is involved in your care or who assists in taking care of you. For example, a parent/guardian may ask a babysitter to take their child to the doctor's office for the treatment of a cut or other accident. In this example the babysitter may have access to the patient's medical information.

Other Uses and Disclosures: We may use or disclose identifiable health information about you for other reasons even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries or events.

Research: We may use or disclose information for approved medical research

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.

Serious Threat to Health of Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required to military command authorities. We may also disclose information to correctional institutions for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness. In any other situation, we will ask for your written authorization before using or

disclosing any identifiable health information about you. If you choose to sign authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.
Individual Rights: You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising your rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request must be in writing and submitted to the contact listed below. You must provide us with a reason that supports your request. We may deny your request if (a) the request is not submitted in writing (b) this amendment is not, in our opinion, accurate and complete (c) the information is not part of the health information created by, kept by or for the practice or (d) information that you are entitled to inspect and copy.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations. **Our Legal Duty:** We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information and to abide by the terms of the Notice currently in effect.
Changes in Privacy Practices: We may change our policies at any time. Before we make a significant change, we will change our Notice and post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.
Complaints: If you are concerned that we have violated your privacy rights or if you disagree with a decision we made about your records you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.
Contact Person: If you have any questions, requests or complaints, please contact:
Cheryl Krakowski
Business Manager
320 Whitehorse Avenue
Trenton, NJ 08610
(609) 585-9222

I have received a copy of the Notice of Privacy Practices:

____

Patient/Guardian Signature

____

Date

____

Staff Witness

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Informed Consent to Care at Fischer Chiropractic Center

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialists of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctors procedures often depend on environment, underlying causes and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). When such vertebral subluxation complexes are found, chiropractic adjustments and ancillary procedures may be given in attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedure are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

We like to advise our patients with neck problems of the following: In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. The risk of stroke after cervical adjustment is 0.00025%. To put this in perspective, the risk of stroke in the general population is 0.00057% and the risk of death from taking aspiring and other anti-inflammatory drugs is .04%. Tests will be performed on you to minimize this risk and an appropriate adjustment technique will be applied. Chiropractic care is considered to be one of the safest and most effective forms of care.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, conditions, which do not respond to chiropractic care, may come under control or be helped through drugs or surgery. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy. I have read and understand the foregoing.

________________________________ __________________

Signature Date