

CHIROPRACTIC HEALTH CLINIC OF SPARTA  
33 WOODPORT ROAD SPARTA NJ 07871  
PH: 973-726-4226 FAX: 973-726-4227  
INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Marital Status: S M W D Number of Children \_\_\_\_\_

Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years on Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Your Social Security # \_\_\_\_\_

Do you have Medicare? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you have Medicaid? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Spouse or Parent \_\_\_\_\_ Their birthdate \_\_\_\_\_

Spouse Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Years On Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone # \_\_\_\_\_ Spouse's SS# \_\_\_\_\_

Driver's License # \_\_\_\_\_

Referred to our office by: \_\_\_\_\_ Insurance \_\_\_\_\_ Patient \_\_\_\_\_ Internet \_\_\_\_\_ Staff \_\_\_\_\_ Physician  
\_\_\_\_\_ Office Sign \_\_\_\_\_ Other (Please explain) \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

Does your spouse have health insurance at work? Yes \_\_\_\_\_ No \_\_\_\_\_

How payment will be made: \_\_\_\_\_ Cash \_\_\_\_\_ Credit Card \_\_\_\_\_ Check

Type of Insurance: \_\_\_\_\_ Health Insurance \_\_\_\_\_ Worker's Comp. \_\_\_\_\_ Automobile Insurance Policy

Is your condition due to an accident? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of accident? \_\_\_\_\_

Type of accident? Auto \_\_\_\_\_ Work/On Job \_\_\_\_\_ At Home \_\_\_\_\_ Other \_\_\_\_\_

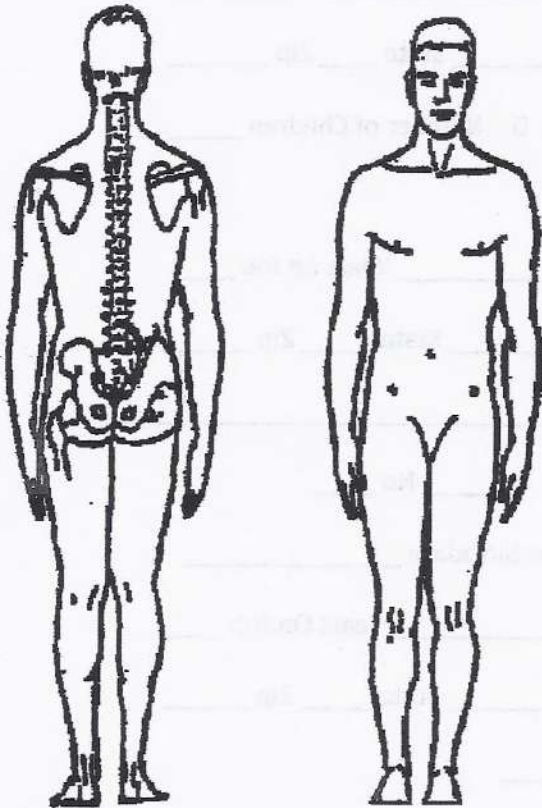
Please list ALL accidents, date of accident(s) and injury sustained in accident. \_\_\_\_\_  
\_\_\_\_\_

**CHIROPRACTIC HEALTH CLINIC OF SPARTA  
33 WOODPORT ROAD SPARTA NJ 07871  
PH: 973-726-4226 FAX: 973-726-4227  
INFORMATION/APPLICATION FOR CARE**

---

**COMPLETE THESE DIAGRAMS**

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.



**MAJOR COMPLAINTS**

(Please list any condition you are being treated for or are experiencing.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS**

(Please list any medications you are currently taking including over the counter medications.)

Name	Dosage information
_____	_____
_____	_____
_____	_____
_____	_____

If needed, please list on a separate piece of paper

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.  
Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.



# CHIROPRACTIC HEALTH CLINIC OF SPARTA

## Confidential Patient Case History

List surgical operation and years: \_\_\_\_\_  
 \_\_\_\_\_

Age of mattress: \_\_\_\_\_  Comfortable  Uncomfortable  Do you use a bed board? \_\_\_\_\_

Are you wearing:  Heel lifts  Sole lifts  Inner soles  Arch supports

Have you ever had any mental or emotional disorders?  Yes  No When? \_\_\_\_\_

Have others in your family had such disorders?  Yes  No When? \_\_\_\_\_

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for anything other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
DO YOU:			
Now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Think you may need vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have an allergy to any drug?	<input type="checkbox"/>	<input type="checkbox"/>	_____

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_



# CHIROPRACTIC HEALTH CLINIC OF SPARTA

## Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name \_\_\_\_\_ Date \_\_\_\_\_

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O - OCCASIONAL F - FREQUENT  
C - CONSTANT

O F C

**GENERAL**

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

**MUSCLE & JOINT**

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

O F C

**GASTRO-INTESTINAL**

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

**EYES, EARS, NOSE & THROAT**

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

O F C

**CARDIO-VASCULAR**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

**RESPIRATORY**

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

**SKIN**

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

**GENITO-URINARY**

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

**FOR WOMEN ONLY**

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes  No Are you pregnant?

**CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cold sores     | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Scarlet fever    |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Gout          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Lumbago       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Malaria       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea           | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Whooping cough   |

# HEALTH CLINIC OF SPARTA

---

## 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 the 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 whether 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.

33 WOODPORT ROAD  
SPARTA NJ 07871  
PH: 973-726-4226 FAX: 973-726-4227



# HEALTH CLINIC OF SPARTA

---

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 expected immediately; regardless of any claims submitted.
8. If you have 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

33 WOODPORT ROAD  
SPARTA NJ 07871  
PH: 973-726-4226 FAX: 973-726-4227

# CHIROPRACTIC HEALTH CLINIC OF SPARTA

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

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

- Your personal health information, including 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 insurance carrier, an HMO, PPO, or your employer, if they are or may be responsible for the payment of your services,
- Your name, address, phone number, email address, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider,
  - 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 you, but our professional judgement believes that you intend for us to provide care,
  - If we are ordered by the courts or another appropriate agency.
- Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written request.*

We normally provide information about your health to you in person at the time you receive chiropractic care. We may also mail information to you 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 different form please advise us as to your preferences in writing.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or 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 the privacy of your patient files and health protected 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. Any change in our policy will apply for all of your health information in our files.

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

If you have a complaint regarding our privacy notice, our privacy practices, or would like further information about our privacy policies and practices please contact our office.

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

---

Name (Please Print)

Signature

Date

*If you are a minor, or being represented by another party:*

---

Name (Please print)

Signature

Date

33 WOODPORT ROAD  
SPARTA, NJ 07871  
973-726-4226



# CHIROPRACTIC HEALTH CLINIC OF SPARTA

## **Patient authorization regarding chiropractic care being provided in an "open-door" adjusting environment.**

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving doors between patient care areas open, which may result in patients occasionally being within sight of one another and some ongoing routine details of care discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient history, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open-door" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an "open-door" adjusting environment, other arrangements will be made for you. Your decision will have no effect on your care from Chiropractic Health Clinic of Sparta or on your relationship with our staff.

## **Patient authorization for appointment reminders and scheduling related matters.**

It is our desire of our staff to use your name, address, email address, and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from Chiropractic Health Clinic of Sparta or your relationship with our staff.

Your signature indicates your authorization of these activities.

---

Name (Printed)

Signature

Date

33 WOODPORT ROAD  
SPARTA, NJ 07871  
973-726-4226



CHIROPRACTIC HEALTH CLINIC OF SPARTA  
33 WOODPORT ROAD SPARTA NJ 07871  
PH: 973-726-4226 FAX: 973-726-4227

**AUTHORIZATION, ASSIGNMENT & RELEASE FORM**

**AUTHORIZATION AND ASSIGNMENT**

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges Incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of New Jersey
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effect until revoked by both parties.

\_\_\_\_\_  
Patient/Insured Signature

\_\_\_\_\_  
Date

**RECORDS RELEASE**

To \_\_\_\_\_, I hereby authorize you to release to Dr. Michael Feld any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Insured Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Patient's date of birth:

\_\_\_\_\_  
Print Patient Name

**RELEASE FROM CARE**

I, \_\_\_\_\_ hereby understand that Dr. Michael Feld is releasing me from care, for my accident dated \_\_\_\_\_, and that I have reached [ ] pre-accident status or [ ] maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

## CHIROPRACTIC HEALTH CLINIC OF SPARTA

Dr. Michael L. Feld, DC

Dr. John J. Willix, DC

Dr. Robert L. Feld, DC

Dr. Jared M. Duddy, DC

33 Woodport Road, Sparta, NJ 07871

Tel. 973.726.4226/Fax. 973.726.4227

### INFORMED CONSENT AND XRAY FORM

DATE \_\_\_\_\_

I, \_\_\_\_\_, the undersigned patient, consent to the treatment(s) provided by the clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff.

I, \_\_\_\_\_, understand that the doctor may deem it medically necessary to have x-rays taken before treatment is rendered in the event the doctor suspects there may be a contraindication to treatment.

Even after stating this in the above statement, I still decline from taking any x-rays and therefore do not hold the doctor or the practice accountable for any injuries that occur since no x-rays were taken.

YOUR SIGNATURE \_\_\_\_\_

WITNESS \_\_\_\_\_