# NEW PATIENT REGISTRATION

## SOFIA CHIROPRACTIC

*Please print clearly to help avoid billing errors*

Patient Last Name _____ First _____ MI _____

Mailing Address _____ Apt or Unit # _____

City _____ State _____ Zip _____

Home Telephone _____ Cell Number _____ Work Telephone _____ E-mail address _____

Date of Birth _____ Age _____ Social Security # _____

**Is your pain due to** an auto accident a work injury other

**Circle One:** White Black Hispanic/Latino Other **Preferred Language:** English Spanish

**Marital Status:** Single Married Divorced Widow/Widower

**Employment Status:** Employed Full Time Employed Part Time Unemployed Retired Student

***Assingment and Release:*** *I hereby authorize and direct my insurance benefits to be paid directly to Dr. Mark Sofia and I understand that I am financially responsible for any and all non-covered services provided by Dr. Sofia. I also understand that a 33% collection fee will be added to any remaining unpaid balance.*

**Signature:** _____ Date: _____

********** *Below for Office Use Only* **********

**DIAGS:** (1) _____ (2) _____ (3) _____ (4) _____

(5)_____ (6)_____ (7)_____

## INITIAL VISIT PROCEDURES

**Date of Service:** _____ **Amount Paid This Visit: $** _____

| | | | | | |
|---|---|---|---|---|---|
| New Exam Level: 1 2 3 4 5 | 9894____ Manip. | 97124 Massage | 97110 Thera Ex . | 97112 Neuro Re-Ed | 97140 Man. Therapy |
| A4595 | | | | | |
| G CODES: G_____ G_____ G_____ | 97010 H/C Packs | 97032 E-Stim / Attn | 97012 Mech. Trac. | 97035 Ultrasound | |

☐ Check Box to Block Pt. Statements

PLEASE ATTACH A COPY OF THE INS. CARD

# Confidential Patient Information

*Please complete this questionnaire. Your answers will help us determine if Chiropractic can help you.*
*If we do not sincerely believe that your condition will respond satisfactorily we will not accept your case.*

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How were you referred to our office?_____
What is your occupation?_____
Who is your primary care physician?_____
Have you had x-ray in the past year?_____Where?_____
Have you had previous chiropractic care?_____

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Major Complaint _____

Other Complaint _____

How long have you had this condition? _____

Have you had a similar condition in the past? Yes [ ] No [ ]

Is this condition interfering with your? Work Sleep Daily Routine

How long has it been since you have felt good? _____

What aggravates the condition?_____

What makes it feel better? _____

Other Doctors you have seen for this condition?_____

Are you taking any medication? _____

For what condition are you taking the medication? _____

Do you have a history of fainting? Yes [ ] No [ ]

Do you have a pacemaker? Yes [ ] No [ ]

Have you had surgery, falls or accidents? Yes [ ] No [ ] (please explain)
_____
_____

Date of last Physical_____
Date of last Menstrual Period _____
Is there any chance that you may be pregnant? Yes [ ] No [ ]

| **Do you currently or have you ever suffered from?** | |
|---|---|
| Headaches | Yes [ ] No [ ] |
| Neck Pain | Yes [ ] No [ ] |
| Arm Pain | Yes [ ] No [ ] |
| Shoulder Pain | Yes [ ] No [ ] |
| Back Pain | Yes [ ] No [ ] |
| Hip/Leg pain | Yes [ ] No [ ] |
| Chest Pain | Yes [ ] No [ ] |
| Abdominal Pain | Yes [ ] No [ ] |
| Sinus Trouble | Yes [ ] No [ ] |
| Heart Trouble | Yes [ ] No [ ] |
| Cancer | Yes [ ] No [ ] |
| Tuberculosis | Yes [ ] No [ ] |
| High Blood Pressure | Yes [ ] No [ ] |
| Low Blood Pressure | Yes [ ] No [ ] |
| Female Problems | Yes [ ] No [ ] |
| Prostate Problems | Yes [ ] No [ ] |
| Kidney Problems | Yes [ ] No [ ] |
| Bladder Problems | Yes [ ] No [ ] |
| Asthma | Yes [ ] No [ ] |
| Gall Bladder | Yes [ ] No [ ] |
| Digestive Disorder | Yes [ ] No [ ] |
| Constipation | Yes [ ] No [ ] |
| Diarrhea | Yes [ ] No [ ] |
| Diabetes | Yes [ ] No [ ] |
| Swollen Joints | Yes [ ] No [ ] |
| Insomnia | Yes [ ] No [ ] |
| Dizziness | Yes [ ] No [ ] |
| Numbness | Yes [ ] No [ ] |
| Nervousness | Yes [ ] No [ ] |
| Depression | Yes [ ] No [ ] |
| Anxiety | Yes [ ] No [ ] |
| Fatigue | Yes [ ] No [ ] |
| Anemia | Yes [ ] No [ ] |
| Poor Memory | Yes [ ] No [ ] |

# SOFIA CHIROPRACTIC

## 25 MARSTON ST SUITE 205
## LAWRENCE, MA. 01841
## INFORMED CONSENT

### CHIROPRACTIC

Chiropractic is system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this office. We will always give you our best care and if results are not acceptable, we will refer you to another provider who we feel will assist your condition.

The most common type of adverse reaction to spinal manipulation is some degree of stiffness or soreness that may occur following the first few days of the initial treatment. This is equivalent to the soreness you would experience after initiating a new exercise program. If such soreness occurs after the first one or two treatments, it usually ceases soon. Should soreness continue after this period, it is your duty to report it to us. Unless you communicate with us, we cannot properly treat you. Other more serious complications could include: fracture, disc injuries, dislocations or stroke, but it had been documented that such complications have only occurred in less than one in one million manipulations. At Sofia Chiropractic, we employ simple clinical tests, which are designed to help identify those persons who may be susceptible to an injury.

### CONSENT

By my signature below, I request to the performance of chiropractic care including, but not limited to: examinations, diagnostic x-rays, adjustments and supportive procedures, including carious types of therapeutic modalities. Certain supportive modalities may be suspended in the following cases: pacemaker, pregnancy, prosthesis, cancer, metallic implant, etc. I consent that the licensed doctors of chiropractic associated with this office, who now, or in the future, treat me, will use their own, well-educated judgment in caring for me. I have had the opportunity to discuss with the treating doctor of chiropractic and other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand that in the practice of chiropractic, as in the practice of medicine, there are some risks. I do not expect the doctors to be able to anticipate and explain all risks and complications. I wish to rely on the doctors to exercise their judgment during the course of the procedures which the doctors feel at the time, based upon the facts then known, will perform accordingly in my best interest.

I intend this consent form to cover the entire course of treatment for my present reasons for care and for any future conditions for which I may seek treatment. I have read or have had read to me this consent form. I have had an opportunity to ask questions about the information contained herein. By my signature below, I understand and give permission.

_____ _____ _____

Print Patient's Name Date Signed

_____ _____

Signature of Patient or Guardian Relationship of Guardian/Representative

Witness to Patient's Signature: _____ Date _____

Informing Doctor's Signature: _____ Date _____

# Sofia Chiropractic
# Dr. Mark Sofia

**Consent for Use or Disclosure of Health Information**

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that…

I may be contacted by: phone at home or work, mobile phone, e-mail, or postcard.
Messages may be left: on answering machine/voicemail at home, work, and on mobile phone.
Or with individuals answering my phone at home, or work.

***(Please place a line through any method that you refuse to be contacted by and initial.)***

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules.

**You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.**

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

**I authorize the use or discloser of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.**

**I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.**

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date

## SOFIA CHIROPRACTIC
## DR. MARK SOFIA

### PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Sofia Chiropractic's and Dr. Mark Sofia's *Notice of Privacy Practices for Protected Health Information and HIPPA Policies and Procedures.*

| | |
|---|---|
| Patient Name Printed | Date |
| Patient Signature | Authorized Provider Rep. |
| Personal Representative Printed | Personal Rep. Signature |

Description of personal representative's authority to act for the patient

# Ancillary and Behavioral Health Provider
# Non-Covered Service Waiver Form

## For the Member:

As a private health care insurance carrier subscriber, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider has informed me that my carrier may not pay for this procedure/item because:

- The procedure or item is not considered medically necessary
- It is not a covered benefit under my plan
- He/she is not contracted to perform/provide this procedure/item
- Other:_____

(to be completed by provider if applicable)

Member Name: _____

Member ID #:_____

Member Signature:_____

## For the Provider:

As a participating provider of the above mentioned private health insurance carrier, I certify that I have informed my patient, _____, that certain procedures/items may not be allowed for payment because:

- The procedure of item is not considered medically necessary
- It is not a covered benefit under the member's plan
- I am not contracted to perform procedure or provide this item
- Other:_____

**PROCEDURE/ITEM:_____CODE:_____**

Provider Name:_____

Provider Signature:_____

Sofia Chiropractic
Motion is Life!

Dr. Mark Sofia
RECORDS RELEASE

Patient Name:_____ Date of Birth:_____
Address:_____
SSN:_____ Contact Telephone Number:_____

RECIPIENT

Person or Facility:_____

SPECIFY INFORMATION TO BE DISCLOSED:

- Discharge Summary
- History & Physical
- X-Ray
- MRI
- CT Scans
- Laboratory
- Emergency Room

TREATMENT DATES:_____

PURPOSE OF THE DISCLOSURE: MEDICAL CARE

Signature of Patient:_____

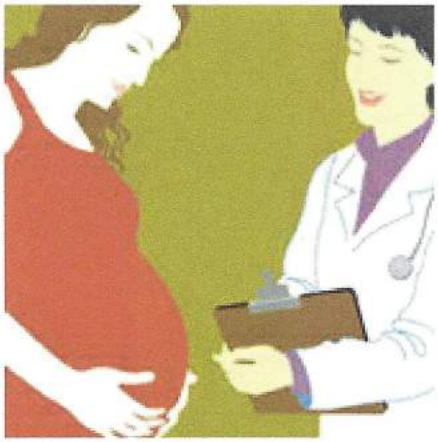
Printed Name of Patient:_____

If the patient is a minor or is otherwise unable to sign this authorization obtain the following signatures:

_____ _____
Signature of Personal Representative Date

_____ _____
Printed name of Personal Representative Relationship to patient or authority to act for patient

25 Marston Street • Suite 205 • Lawrence, MA 01841
Phone 978.687.7117• Fax 978.687.7417
www.sofiachiropractic.com



# PATIENT PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In doing so, I release the doctor/clinic from responsibility for potential damage arising from this procedure.

At the present time (please check one)

- o I am sure that I am not pregnant
- o It is possible that I could be pregnant
- o I am pregnant

_____ _____

Signature-Patient Date

_____ _____

Signature-Witness Date

NOTE: Female patients should be questioned as to the last date of their menstrual cycle and the 10 day rule should always be applied for protection of the patient and possibly fetus.