APPONAUG CHIROPRACTIC CENTER
CONFIDENTIAL PATIENT INFORMATION

Last Name: _____First Name: _____MI: ____
Gender: M F Date of Birth: ___/___/____ Age: _____ SS#:_____
Marital Status: S M D W Spouses Name: _____How many children?___
Home Address: _____ Apt#_____
City: _____ State: _____ Zip: _____
Home Phone#:_____ Work #: _____ Cell#:_____
E-Mail Address:_____May we e-mail you our newsletter? Y N
Employer Name: _____Occupation:_____
Employer Address: _____
City: _____ State: _____ Zip: _____
In the event of emergency, who should we contact?
Name: _____ Phone #:_____

Referred by? _____ Yellow pages/Sign/Self/Coupon
Reason for this appointment: _____
Other Doctors seen for this condition: _____
Have you been treated by a physician in the last year? Yes No
Describe: _____
Have you ever suffered from?

Headache□	Neck Pain□	Arm Pain□	Diabetes□
Dizziness□	Mid back Pain□	Shoulder Pain□	Asthma□
Migraines□	Low Back Pain□	Wrist Pain□	Cancer□
Hip Pain□	Digestive Problems□	Elbow Pain□	Stroke□ Leg Pain□
Chest Pain□			
Knee Pain□	Heart Trouble□		
Foot Pain□			

Primary Insurance Company: _____
Insured's Name: _____ID/Policy #:_____

Are you covered by additional insurance? Yes No

Secondary Insurance Company: _____
Insured's Name: _____ID/Policy #:_____

PAYMENT IS EXPECTED AT TIME OF VISIT

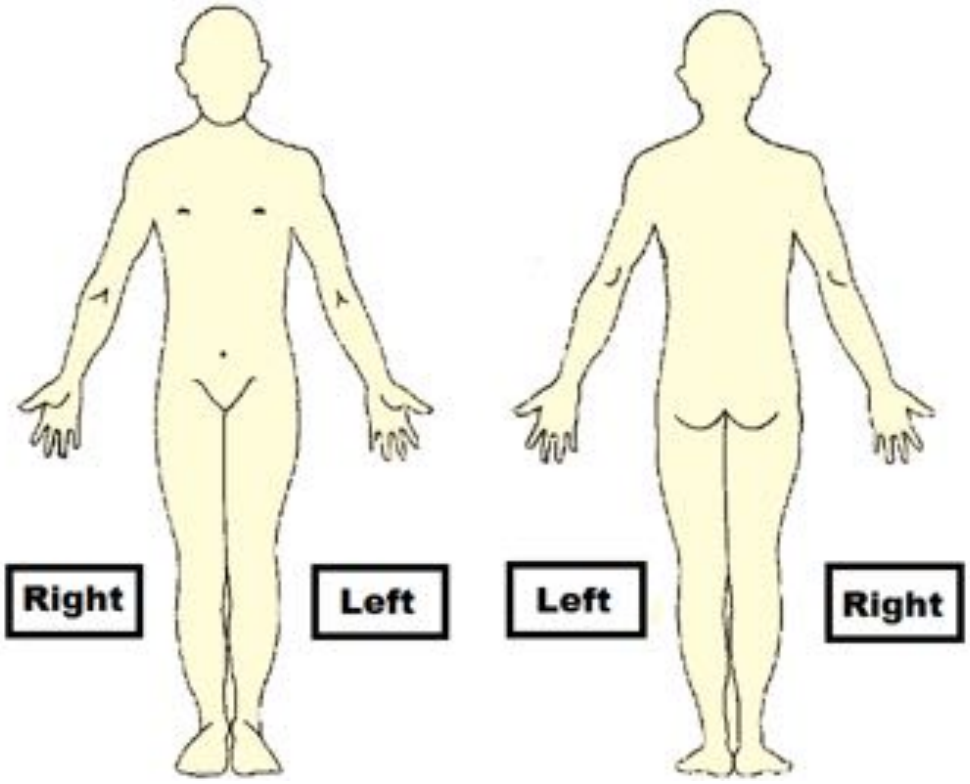
I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. Furthermore, I understand that Appponaug Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Apponaug Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature: _____ Date: _____

Pain Chart/ Analog Scale

Show the areas of pain or unusual feeling by using the symbols below. Include all affected areas.

Numbness	Pins & Needles	Burning	Achy	Stabbing
- - - - - - - -	oooooooooo	xxxxxxx	******	//////////



Rate your Neck-Shoulder-Arm Pain (_____)
0 (no pain) 10 (severe)

Rate your Mid Back Pain (_____)
0 (no pain) 10 (severe)

Rate your Low Back and Leg Pain (_____)
0 (no pain) 10 (severe)

Describe your major complaints and symptoms:

_____
_____
_____
_____

Date: _____ Signature: _____

APPONAUG CHIROPRACTIC CENTER

Dr. Christopher Caliri
2525 Post Road
Warwick, RI 02886
(401) 738-9611

BLANKET AUTHORIZATION/RELEASE FORM

____ **Insurance Assignment –** I authorize payment of medical benefits from _____ insurance company to be paid directly to: Christopher Caliri, D.C. for services rendered to me. If my current policy prohibits the direct payment to the doctor, then I also instruct and direct you to make out the check to me and mail it to our office. I also acknowledge that all services rendered to me are ultimately my financial responsibility. I agree to pay any balance that remains after my insurance company has made payment, and any unpaid balance that remains 60 days after services are rendered.

____ **Cash Policy** – I do not have insurance benefits available and agree to pay for all services rendered to me, at the time they incur, unless otherwise agreed to in the form of a financial payment contract.

____ **Records Release** – I hereby authorize the release of my x-rays and medical records from any medical provider, hospital, attorney or insurance company upon receipt of a copy of this form, to Apponaug Chiropractic Center.

____ **Authorize to Release Information** – I authorize your office to release any information you deem appropriate concerning my condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me in this chiropractic office. I hereby release you from any consequences thereof.

____ **Pregnancy Release** – To the best of my knowledge I am not pregnant. I understand that x-ray radiation may pose risks to an unborn child. I consent to having x-rays taken, and I release Dr. Christopher Caliri, and the office from any responsibility that could in any way associate damage to an unborn child with the x-ray examination. If you have any concerns, please consult the doctor.

____ **Termination of Care Waiver** – I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my attending chiropractor, I cannot expect maximum chiropractic results and the doctor has full and complete right to terminate my case and discharge me from care.

____ **Consent to Treat a Minor** – I hereby give my consent for Dr. Christopher Caliri to examine and render treatment to my son/daughter_____
who is a minor.

I have read the above blanket authorization/release form and agree to the _____ items checked off.

_____ _____
Patient Name (print) Patient/Guardian Signature

Date: _____ Witness:_____

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

("Agreement")

I hereby direct any and all insurance carriers, attorney, agencies, governmental departments, companies, individuals, and/or other legal entities ("payer"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of Apponaug Chiropractic Center such sums as may be owing to Apponaug Chiropractic Center for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the office ("charges"). I further grant a contractual lien to Apponaug Chiropractic Center with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by Apponaug Chiropractic Center to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but shall not be limited to, proceeds form any settlement, judgement, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Apponaug Chiropractic Center, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to Apponaug Chiropractic Center to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name of in the office's name, and to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon its request.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Apponaug Chiropractic Center to endorse/sign my name on any and all checks listing me as a payee which are presented to this office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize Apponaug Chiropractic Center to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due Apponaug Chiropractic Center for their services. This Agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Apponaug Chiropractic Center for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of Apponaug Chiropractic Center and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Apponaug Chiropractic Center and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all portions and provisions of the Agreement shall nevertheless, remain in full force and effect.

Patient Name (please print):_____

Patient Signature:_____Date:_____

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature_____Date:_____

Patient Special Recognition Consent

The referral to our practice by satisfied patients is always appreciated. Referrals make what we do possible for others in our service area. Because the referral is so greatly appreciated, we periodically extend special recognition to our referring patients and thank them openly by placing their names on our **Reception Area Referral Board** or in our **Newsletter**. By providing your signature below you are freely authorizing our practice to use your name or photo for the purpose of helping others experience our care. Be assured that all other patient information will be held in the strictest of doctor/patient confidentiality and that you may withdraw your authorization at any time simply by notifying us in writing of your desire to do so.

Thank you for your trust and confidence.

_____ Date ___/___/20____

Patient's Signature

HIPPA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise To You Our Valued Patient….

This is not meant to alarm you; Quite the opposite. We want to assure you that we take the new Federal [HIPPA-Health Insurance Portability and Accountability Act] laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now?

The most significant variable that has motivated the Federal Government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of healthcare business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review-not only how your information is used within our computers, but also with the internet, phones, fax, and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we will assure adherence to those laws and we want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of obtaining payment for services and conducting healthcare business. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make all effort to work with companies with a similar commitment to the security of your health information.

To Conduct Healthcare Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are and important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. The may include postcards, newsletters, flyers, telephone or electronic reminders such as e-mail [unless you tell us in writing that you prefer not to receive reminders.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete and investigation related to public health and or national security.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a proper authorities for the purpose of law enforcement including under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research

Advancing healthcare knowledge often involves learning from the careful study of health histories or prior patients. Formal review and study of health histories as a part of research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction from our patients.

Confidential Communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information in incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or healthcare operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of This Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes. You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgment

This form is an informational sheet on your rights as a patient. Signing below acknowledges that you have read and understand this policy:

_____ _____

Patient Signature Date

Thank You For Your Trust and Confidence