Chiropractic Registration and History

Patient Information

Date ____

SS/HIC/Patient ID # ____

Patient Name ____
Last Name

____
First Name Middle Initial

Address ____

City ____

State ____ Zip ____

E-mail ____

Sex ☐ M ☐ F Age ____

Birthdate ____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

Occupation ____

Patient Employer/School ____

Employer/School Address ____

____

Employer/School Phone (____) ____

Spouse's Name ____

Birthdate ____

SS# ____

Spouse's Employer ____

Whom may we thank for referring you? ____

Insurance

Who is responsib e for this account? ____

Relationship to Patient ____

Insurance Co. ____

Group # ____

Is patient coverec by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____

Birthdate ____ SS# ____

Relationship to Patient ____

Insurance Co. ____

Group # ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____ and assign directly to
Name of Insurance Company(ies)

Dr. ____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____ ____
Date Relationship to Patient

Phone Numbers

Home Phone (____) ____ Cell Phone (____) ____

Best time and place to reach you ____

IN CASE OF EMERGENCY, CONTACT

Name ____ Relationship ____

Home Phone (____) ____ Work Phone (____) ____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date ____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ____

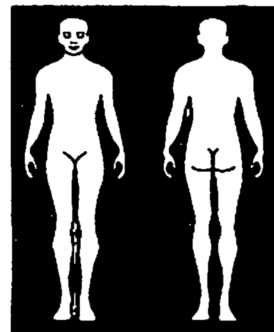
Patient Condition

Reason for Visit ____

When did your symptoms appear? ____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ____

Is it constant or does it come and go? ____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other_______________

Name and address of other doctor(s) who have treated you for your condition _______________

Date of Last: Physical Exam Spinal X-Ray Blood Test

Spinal Exam Chest X-Ray Urine Test

Dental X-Ray_______________ MRI, CT-Scan, Bone Scan_______________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _______________		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _______________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _______________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _______________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _______________

Are you pregnant? ☐ Yes ☐ No Due Date_______________

Injuries/Surgeries you have had	Description	Date
Falls	_______________	_______________
Head Injuries	_______________	_______________
Broken Bones	_______________	_______________
Dislocations	_______________	_______________
Surgeries	_______________	_______________

Medications	Allergies	Vitamins/Herbs/Minerals
_______________	_______________	_______________
_______________	_______________	_______________
_______________	_______________	_______________
Pharmacy Name _______________	_______________	_______________
Pharmacy Phone (_____) _______________	_______________	_______________

To properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain; no restrictions	Mild Pain; no restrictions	Moderate Pain; need to go slowly	Moderate Pain; need some assistance	Severe Pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all work activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No Pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

____
Patient's Signature

____
Date

FINANCIAL POLICY

PATIENTS WITH INSURANCE COVERAGE:

We will be glad to help patients obtain the appropriate benefit information from their insurance carriers and bill them directly as a courtesy to the patient. However, we are not responsible for any misinformation that we may receive from insurance carriers regarding a patient's benefit coverage. Ultimately, the patient is responsible for the payments on the account.

We will be happy to request a pre-estimate of benefits from a patient's insurance carrier if requested. Routine treatment is generally performed without submitting a request for a pre-estimate of benefits. For managed-care plans (HMOs), referrals are required. Without a referral, the patient may be responsible for all of the cost of the visit.

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Sometimes, there is a co-payment or co-insurance amount required by the patient as part of their insurance agreement. Even if a patient has double coverage (this is possible if the patient is covered by their personal and spousal insurance), there may still be a portion that will be the patient's responsibility. **Please feel free to ask any questions you may have regarding your insurance policy and plan, or anything you may not understand.**

For patients who are receiving treatment over a period of time, we appreciate payment at the time of treatment. Our office assistants will be glad to help patients arrange a payment schedule if necessary.

PATIENTS WITHOUT INSURANCE COVERAGE:

Patients without insurance benefits are requested to pay for services rendered at the time of the visit. We accept cash, check, MasterCard, and Visa payments.

ADDITIONAL TERMS:

Checks returned by a patient's banks are subject to a **$20.00** processing charge. Accounts unpaid after 30 days from the date of billing are subject to a finance charge at the rate of **1.25% per month**. If a patient's account is referred to collections, the patient will be responsible for collection costs in the amount of **30%** of the outstanding balance, together with court costs and reasonable attorney's fees.

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide the best care possible.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF DR. BARRY L. SILVERMAN and THE HEALING ARTS CENTER OF PHILADELPHIA.

______________________________ PATIENT/GUARDIAN SIGNATURE

_______________ DATE

______________________________ PRINTED NAME OF THE PATIENT/GUARDIAN

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 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 information to another healthcare provider or 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 information and billing records to another party if they are potentially responsible for the payment of services rendered.
- We may have to disclose your information within our practice for quality control or other operational purposes.

Your right to limit uses or disclosures

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 the notice before you sign this consent form (& 164.520). We reserve the right to change our privacy practices as described in the notice. If we make a change to our privacy practices, we will notify you 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.

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

______________________	______________________
Printed Name	Signature
______________________	______________________
Authorized Representative	Signature
	______________________
	Date Signed

The
Healing Arts Center
of PHILADELPHIA

123 Chestnut Street, Ste. 204 * Philadelphia, PA 19106
p: 215-627-3782 * f: 215-627-3695

Thank you for selecting the Healing Arts Center for your health and wellness needs. We look forward to treating you. In an effort to provide the best care and accommodation for our patients and providers, we ask that you review our cancellation policy listed below.

All providers kindly request **24-hour (one business day) notice** when canceling. If you need to cancel a Monday appointment, please contact our office by 2 p.m. Saturday.

Our fees for canceling without notice vary by provider due to their individual charge schedules. Please refer to your provider below:

Provider	Service	Fee
Barry Silverman, DC	Chiropractic	$35 flat fee
Steve Mavros, L.Ac.	Acupuncture & Herbal Medicine	50% of visit
Sheri McLellan-Krauss	Acupuncture	50% of visit
Julie Schwartz	Acupuncture	50% of visit
Matt Skahill	Acupuncture	50% of visit
Jerrold Friedman, MD	Physiatry/Medical Acupuncture	$75 flat fee
Steven Rosenzweig, MD	Integrative Medicine	$150/new patient $75/established

If you have any questions about this policy, please feel free to ask a member of our staff. Due to the large number of clients we serve, exceptions to the policy will only be made under reasonable circumstances.

We do offer you the courtesy of a phone call or email one day prior to the visit to help remind you of your appointment. If you need to cancel and reschedule the appointment, you may do so at that time without incurring a charge.

By signing below, you are indicating that you have read and understood this policy.

____ ____________________

Name Date

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:____

Address: ____

Date of Birth: ____________________ Date of Request: ____________________

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

____

Patient Health Information authorized to be disclosed:

____

____

For the specific purpose of (describe in detail)

____

____

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected Patient Health Information.

____________________________________ __________________

Signature of Patient or Patient's Authorized Representative *Date*

____________________________________ __________________

Authorized Signature of Facility *Date*

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