Holbrook Chiropractic, PC *233 Union Ave Suite 102, Holbrook, NY 11741 ❖ 631-981-2222*

Name: ____

Home Phone: _________________ Work Phone: ________________ Ext________ Cell Phone _________________

Email Address____

Home Address____City, State, Zip_______________________________

Social Security #_____________________________________ Date of Birth ________________________________

Marital Status: M S W D # Children__________ Spouses Name: _______________________________________

Primary Care or Referring Physician: ___________________________________ Phone: ______________________

Whom may we contact in case of an emergency? _________________________ Phone:_______________________

Whom may we thank for referring you to us? ____

Health Information- -

Have you had previous chiropractic care? ( ) Yes ( ) No

Are your injuries accident related? ( ) Yes ( ) No Did you sustain an injury at work? ( ) Yes ( ) No

If yes when___________________ Describe____

What is your major complaint? ____

When did your problem begin?______________________ How long have you had your symptoms?_______________

Other Doctors who recently treated this condition____

Since your symptoms began have they ( ) Increased ( ) Decreased ( ) Stayed the same

Are your symptoms ( ) Always present ( ) Frequent ( ) Occasional ( ) On and Off

How bad is you pain or ache? 1 2 3 4 5 6 7 8 9 10 Describe your pain ( ) Sharp ( ) Shooting ( ) Dull/ache

( ) Stiff ( ) Tingling ( ) Numbness ( ) Burning ( ) Throbbing ( ) Knife like ( ) Other______________________

What makes symptoms worse?____

What makes symptoms better? ____

Have you ever suffered from:

	PAST	PRESENT		PAST	PRESENT
Dizziness	( )	( )	Stroke	( )	( )
Convulsions	( )	( )	Heart problems	( )	( )
Loss of bladder control	( )	( )	Asthma	( )	( )
Abdominal pain	( )	( )	Cancer	( )	( )
Aortic aneurysm	( )	( )	Prostate problems	( )	( )
Difficulty swallowing	( )	( )	Blood disorder	( )	( )
High blood pressure	( )	( )	Diabetes	( )	( )
Kidney stones	( )	( )	HIV/AIDS	( )	( )
Other_____________________	( )	( )	Other______________	( )	( )

Health Information (continued)

Present weight_____lbs Height_____feet____inches Right handed ( ) Left handed ( )

Sleeping Position: Back ( ) Side ( ) Stomach ( ) Pillows: How many_____ cervical ( ) orthopedic ( )

Age of mattress:_____ Comfortable ( ) Uncomfortable ( ) Are you wearing orthotics? Yes ( ) No ( )

Are you pregnant?: Yes ( ) No ( ) Due date_____Are you a new patient to this practice? Yes ( ) No ( )

List surgical operations and year_____

List medications you are currently taking_____

Have you had any diagnostic testing or radiological studies preformed in the past year for your current condition? (i.e. x-ray, MRI, EMG/NCV) Yes ( ) No ( )

If yes, where _____Phone Number _____

Insurance Information

Do you have health insurance Yes ( ) No ( )

Are you currently employeed Yes ( ) No ( )

Have you ever served in the military? Yes ( ) No ( )

Is your spouse or other family member employed? Yes ( ) No ( )

Are you covered under an employer or union policy? Yes ( ) No ( )

Insurance Company_____

Member Id or Policy # _____Group #_____

Do you have a secondary insurance policy Yes ( ) No ( )

Are you covered by your spouse's insurance policy? Yes ( ) No ( )

Have you made changes to Medicare in open enrollment Yes ( ) No ( )

Are you covered under any other care plan Yes ( ) No ( )

If Yes, name of company_____ Policy Number _____

Spouse's Social Security Number _____ Date of Birth _____

Spouse's Employer _____Telephone Number_____

Address_____

I understand that health and accident policies are an arrangement between an insurance company and myself and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. Furthermore, I understand that Holbrook Chiropractic, PC will prepare any necessary reports and forms to assist me in making collections from the insurance and that any amount authorized to be paid directly to Holbrook Chiropractic, PC will be credited to my account on receipt. However, I clearly understand and agree that, regardless of my insurance status, all services rendered to me are charged directly to to me and 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 immediatley due and payable. In the event of non payment, I am legally responsible for any collection fees involved in satisfying my debt. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information

Patients signature_____ Date_____

Gaurdian or Spouse's Signature_____ Date _____

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Suite 102
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Electronic Health Records Intake Form

In compliance with requirements for the government EHR/EMR program

First Name_____ **Last Name**_____

Email Address:_____@_____

Preferred method of communication for patient reminders (circle one) Email / Phone / Mail

Date of Birth_____**Gender** (circle one) Male Female **Preferred Language**_____

Smoking status (circle one) **Smoking start date** (optional)_____
Every day smoker / Occasional smoker /Former smoker / Never smoked

CMS requires providers to report both race and ethnicity
Race (circle one) American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander/ I decline to answer

Ethnicity (circle one) Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

□ I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank because of the nature and frequency of chiropractic care.)

Patient Signature:_____ Date:_____

For office use only

Height:_____ Weight:_____ Blood Pressure:_____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr Douglas Glassman and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Douglas Glassman and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:	To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated)
_____	_____
Print Patient's Name	Print Name of Patient
	_____
	Print Name of Representative
_____	_____
Signature of Patient	Signature of Representative

This form should be maintained in the patient's health record.

HOLBROOK CHIROPRACTIC, PC

Douglas Glassman, DC

233 Union Avenue, Suite 102

(631) 981 – 2222 (bus) (631) 981 – 2279 (fax)

Taking care of your spinal health needs since 1991

PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Holbrook Chiropractic P.C, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Holbrook Chiropractic, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Holbrook Chiropractic, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Holbrook Chiropractic, PC Privacy Officer at (233 Union Avenue Suite 102 Holbrook NY 11741).

With this consent, Holbrook Chiropractic, PC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Holbrook Chiropractic, PC, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Holbrook Chiropractic, PC, may send text message or e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Holbrook Chiropractic, PC, restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form. I am consenting to Holbrook Chiropractic, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Holbrook Chiropractic, PC may decline to provide treatment to me.

_____ _____

Name of Patient or Legal Gaurdian Signature of Patient or Legal Gaurdian

_____ _____

Cell Phone Number Email Address

_____

Wireless Carrier

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I,_____, HAVE RECEIVED A COPY OF HOLBROOK CHIROPRACTIC'S NOTICE OF PRIVACY PRACTICES.

_____ _____

SIGNATURE OF PATIENT DATE

ASSIGNMENTS OF BENEFITS FORM

HOLBROOK CHIROPRACTIC, P.C.
233 Union Avenue, Suite 102
Holbrook NY, 11741
(631) 981-2222

Date:_____
Patient:_____
Id#_____
Group#_____

I, _____,(patient name)
understand that services rendered to me by Holbrook Chiropractic, PC are my financial responsibility and that the Provider will bill my insurance company,

_____ (Insurance company name)
as a courtesy. I authorize my insurance company to pay my benefits directly to Holbrook Chiropractic, PC and I understand that I will be fully responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosed to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of

the claim by_____(Insurance company)

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward payment to Holbrook Chiropractic, PC within 48 hours. I agree that if I fail to send payment to the Provider and they are forced to proceed with the collections process; I will be responisible for any cost incurred by the office to retrieve their monies.

I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ Signature of Policyholder

_____ Patient/GuardianPrinted Name

HOLBROOK CHIROPRACTIC, P.C.

233 Union Avenue
Suite 102
Holbrook NY, 11741
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Dear Patient,

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect balances as outlined by your carrier. Writing off patient responsibility balance could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum had not been correctly calculated.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Patient Name:_____ Date: _____

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Medical Records Release

Date:_____

Patient Name:_____
Re: Records Request

I,_____, hereby authorize the release of my medical records including copies of any and all diagnostic studies such as x-rays, MRI's, or any other imaging, any and all reports, or copies contained in my file to be transferred, sent, mailed or faxed to the following:

Holbrook Chiropractic, PC
PO Box 129
Holbrook, NY 11741

Fax: 631 – 981 – 2279

Thank you for your prompt attention to this matter.

_____
Patient Signature

PATIENT PREGNANCY DISCLAIMER

This certifies that concerns regarding pregnancy and radiation expossure 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 doctors, and/or Holbrook Chiropractic, P.C. from responsibilty for potential damage arising from this procedure.

At this time:

_____ I am sure that I am not pregnant.

_____ It is possible that I could be pregnant.

_____ I am pregnant.

_____ _____

Patient Signature Date

_____ _____

Parent Signature Date

Holbrook Chiropractic, PC Financial Policy

Thank you for choosing Holbrook Chiropractic, PC as your chiropractic care provider. We are committed to providing you with the highest quality of care at a reasonable cost. Acknowledgement and understanding of our financial policy must signed prior to treating with Dr. Glassman. Your clear understanding of our financial policy is important to our professional relationship as it may avoid unnecessary billing issues that may happen as a result of incorrect insurance information and misunderstanding. Please ask if you have any questions at all.

Insurance: Health and accident policies are an arrangement between the insurance company and patient. It is the responsibility of the patient to know what coverage, benefits, and eligibility you have.
Holbrook Chiropractic, PC will prepare any necessary reports and forms to assist you in making collections from your insurance company. Any amount authorized to be paid directly to Holbrook Chiropractic, PC will be credited to your account on receipt. Regardless of insurance status, all services rendered are charged directly to the patient. Your insurance carrier makes the final determination regarding eligibility and coverage. You agree to pay any portion not covered by your insurance.

Self-Pay Patients: All self pay patients and patients who present without proof of insurance are required to pay for their services on the day of the visit. Payment plans may be made and a separate agreement will be provided.

Forms of payment: We accept Cash, Checks, Visa, MasterCard and Discover.

Co-Payments: If your insurance requires a patient co-pay we are obligated by your insurance carrier to collect this at the time of service. Failure to collect the co-pay at each visit puts both the patient and Holbrook Chiropractic, PC in default of the insurance contract. Please be prepared to pay the co-pay at each visit. Some insurance carriers impose more than one co-pay for each visit, e.g. co-pay for office visit plus a co-pay for an x-ray. We may not be aware of your insurance carrier's multiple co-pay policy and therefore may bill you for any uncollected co-pay at a later time based on the Explanation of Benefits from your insurance.

Deductibles: If your coverage includes a patient deductible you may be asked to pay a portion of your unmet deductible at the time of service. Any remaining balance will be billed upon receipt of the insurance carriers Explanation of Benefits.

Referrals: If your insurance plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment or prior to. If you do not have a referral you may have to reschedule or be considered a Self- Pay patient.

Non-Participating Insurance Plans or "Out of Network": As a service to our patients, we bill as a non-participating provider if seen out of network. We will do our best to notify you ahead of time if we are aware of any potential out-of-pocket costs, but you must be aware of your own insurance benefits, and are responsible for them. <u>You are responsible for care not covered by your out-of-network insurance plan.</u> All outstanding balances are the responsibility of the patient.

No-Fault/Workers Comp Cases: Patients must report the complete circumstances of the motor vehicle accident or Workers compensation incident to the front desk staff and complete the appropriate form(s) indicating date of injury, claim number, and insurance company name, address, phone number, and contact person's name (i.e. adjuster, case manager) prior to receiving services. We must verify that your claim is open and active for the injury you are being treated for prior to services being started.
No-Fault/Workers Comp Cases cont.: For Workers Comp. cases we are required to adhere to strict Medical Treatment Guidelines when rendering care. If the guidelines are not followed, the Workers Compensation insurance carriers will deny *part or all* of your medical claim which will affect physician reimbursement as well as employee benefits. If the insurance denies the claim and you have private health insurance, it must be billed.

Returned Check Fees: Any returned check from the bank for non-payment or insufficient funds shall result in the patient's account being assessed a $30.00 fee per check returned.

Minors: Minors under the age of 18 MUST be accompanied by a parent or legal guardian for all services. The parent or legal guardian must also complete the Minor Treatment Form to have on file in the child's chart.

Outstanding Balances: If you have any outstanding self-pay or insurance designated outstanding balances for co-pays, deductibles, and other unpaid out-of-pocket expenses you will be asked to remit payment at your next visit. Chronic non- payment of bills may constitute separation from the practice.

Collections: If no attempt at payment of your balance is made within 90 days, the account may be forwarded to a collection attorney. We value our patients and make every attempt to work with them. However, when a patient makes no attempt at payment or communication with us, we regretfully seek outside collection assistance. Please understand, we do not handle the accounts from this point forward. Their methods are their own, and in addition to the uncollected balance you are legally responsible for any collection fees involved in satisfying the debt.

Third Party Insurance Forms: Your employer, insurance carrier, accident/sickness insurance, etc. may ask you to complete a disability, FMLA or other form which requires information regarding your care from your physician. A $15.00 charge per form is required prior to completion. Please allow up to 10 business days for form completion. ***Please be aware: Holbrook Chiropractic, PC will not complete ANY form regarding permanent disability status.*** *Your medical records will be available if you require documentation of treatment from our office for your disability case.*

Medical Records: Written authorization for release of your medical records is required. The law allows up to 30 days for processing all medical records requests. There may be a fee required for processing, copying, and mailing of the records prior to releasing records.

I have read all the information on both sides of this sheet and I agree to comply with the financial policies. In addition Holbrook Chiropractic, PC has my permission to provide medical documentation in order to obtain reimbursement.

_____ _____

Printed Patient Name Date

_____ _____

Patient Signature (or Parent or Legal Guardian) Date

Holbrook Chiropractic, PC 233 Union Ave Suite 102 Holbrook NY 11741