DEBORAH C. ROSE, D.C., P.C.

PLEASE PRINT

GENERAL INFORMATION:

PATIENT LAST NAME _____ FIRST NAME _____

ADDRESS _____ CARE OF _____ *(Parent or financially responsible person)*

CITY _____ STATE _____ ZIP _____ PHONE (WORK) _____

DRIVER'S LIC. # _____ NO. CHILDREN _____ PHONE (HOME) _____

OUT OF STATE ADDRESS _____ PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____ NATIVE LANGUAGE _____

SEX ☐ M ☐ F	☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -

PATIENT'S EMPLOYER'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ OCCUPATION _____

EMPLOYED

☐ FULL TIME ☐ PART TIME
☐ RETIRED ☐ NOT EMPLOYED

STUDENT

☐ FULL TIME ☐ PART TIME
☐ NON STUDENT

INSURANCE INFORMATION:

PATIENT NAME _____

COMMERCIAL INSURANCE AND MEDICARE ONLY

PRIMARY INSURANCE COMPANY NAME _____

TYPE ☐ GROUP ☐ PRIVATE
MEMBERSHIP/CERT. # _____
POLICY/GROUP# _____

COMPLETE ONLY IF PATIENT IS NOT THE INSURED
INSURED'S INFORMATION
INSURED'S NAME _____
☐ M ☐ F ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
PATIENT'S RELATIONSHIP TO INSURED _____
INSURED'S DATE OF BIRTH / /
INSURED'S EMPLOYER _____

SECONDARY INSURANCE COMPANY NAME _____

TYPE ☐ GROUP ☐ PRIVATE
MEMBERSHIP/CERT. # _____
POLICY/GROUP# _____

INSURED'S NAME _____
☐ M ☐ F ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
PATIENT'S RELATIONSHIP TO INSURED _____
INSURED'S DATE OF BIRTH / /
INSURED'S EMPLOYER _____

AUTOMOBILE ACCIDENT / WORKERS COMPENSATION ONLY

INSURANCE CO. _____ CLAIM # _____ POLICY # _____

ADDRESS _____ PHONE # _____

CITY _____ STATE _____ ZIP _____ ADJUSTER'S NAME _____

ATTORNEY'S NAME _____ CONTACT NAME _____ PHONE _____

ADDRESS _____

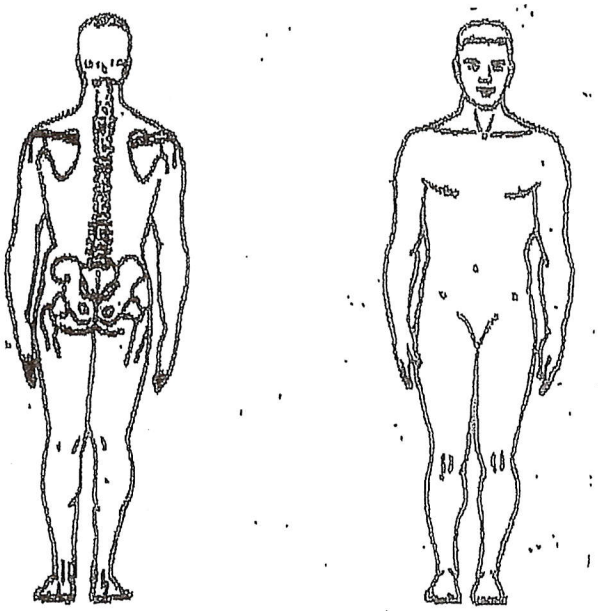
RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature _____ **Date** _____

Patient History

Please mark the exact location of your pain/discomfort on the diagram below.



Major Complaint
(please describe only your major problem)

_____

_____

_____

_____

_____

_____

_____

*How did this condition develop? (What caused it? How did it start?)*_____

_____

*What makes this condition worse?*_____

Are you pregnant? Yes or No or NA

*Have you ever received treatment for this condition? Yes or No (circle one) If yes, where, and what were the results?*_____

_____

*Have you had surgery? Yes or No (circle one) If yes, what kind and where?*_____

_____

*Drugs you are currently taking (prescription and over the counter)*_____

_____

*Have you ever been in an automobile accident? Yes or No (circle one) If yes, when?*_____

_____

*Any Chiropractor consulted in the past? Yes or No (circle one) If yes, who and when?*_____

_____

*Signed*_____ *Date*_____

NEW PATIENT QUESTIONARE Please fill out completely

Name: _____ Date: _____

Musculoskeletal: Neck pain, back pain, painful limb, generalized muscle aches, muscle spasms, joint pain, swelling or stiffness, fractures, dislocations, arthritis, gout, restricted joint motion, weakness.

Breasts: Nodule or mass, thickening, dimpling , redness, pain or discomfort, nipple discharge, fibrocystic disease, breast biopsy or breast cancer, mastectomy __right, __left.

Skin: Rashes, recurrent lesions, rosacea, chronic ulcer, pressure sore, psoriasis, itching, pigment changes, nail changes, thinning hair, hair loss, photosensitivity, Raynaud's phenomenon, skin cancer.

Neurologic: Fainting spells, dizziness, incoordination, difficulty walking, falls, tremor, involuntary movements, slurred speech, tingling/numbness, paralysis, stroke, spinal cord injury, head injury or concussion, confusion, changes in memory, change in behavior or personality headaches, seizures.

Psychiatric: Nervousness, anxiety, panic disorder, claustrophobia, agoraphobia, post-traumatic stress disorder, victim of abuse, attention deficit disorder, hyperactivity, compulsive behavior, uncontrollable anger, depression, hallucinations, suicidal or homicidal thoughts, psychiatric treatment or hospitalizations.

Current or past use of recreational drugs: _____
Prescription drug dependence: _____
Alcohol: dependence withdrawal or treatment: _____

Endocrine: Heat or cold intolerance, excessive thirst or hunger, thyroid problem, diabetes, hypoglycemia, excessive sweating.

Hematologic: Anemia, easy bruising, prolonged bleeding, history of transfusion, cancer, chemotherapy, radiation therapy, swollen glands/lymph nodes.

Allergy/Immunology: Food allergies_____, lactose intolerance, seasonal allergies, latex allergy, dermatitis, eczema, adverse reaction to vaccination, contrast, antibiotics or other drugs_____, impaired immunity, herpes, shingles.

NEW PATIENT QUESTIONAIRE – Please fill out completely

Name: _____ Date: _____

Comprehensive Review of Systems: Circle all these that apply

Constitutional: Fevers, night sweats, poor appetite, unexplained weight loss or gain, insomnia, fatigue, excessive daytime sleepiness.

Current weight: _____ **Weight 1 year ago:** _____

Height: _____ **Height loss?** _____ Yes _____ No

Eyes: Glasses or contact lenses, eye pain, dry eyes, excessive tearing, double vision, light sensitivity, cataracts, glaucoma, other visual disturbance.

Ears: Hearing loss, hearing aid, right ear _____ left ear _____, ringing in ears, sensitivity to noise, balance disturbance, dizziness, vertigo, earaches, recurrent ear infection, excessive ear wax.

Nose: Frequent colds, nasal congestion, recurrent or chronic sinusitis, nosebleeds, deviated septum, nasal polyps, loss of sense smell.

Mouth: Dry mouth, bleeding gums, dentures, mouth ulcers, altered taste, loss of sense of taste.

Throat: Frequent sore throats, hoarseness, difficulty swallowing.

Cardiovascular: High blood pressure, low blood pressure, heart murmur, rheumatic fever, mitral valve prolapsed, palpitations, shortness of breath on minimal exertion, sleep apnea, pain which deep breathing.

Respiratory: Asthma, wheezing, bronchitis, pneumonia, chronic cough, emphysema/COPD, excessive phlegm production, coughing blood, shortness of breath on minimal exertion, sleep apnea, pain with deep breathing.

Gastrointestinal: Chronic heartburn/indigestion, nausea, vomiting, food intolerance _____, hiatal hernia, gastric reflux, ulcer, gallstones, jaundice, cirrhosis, abdominal or umbilical hernia, hemorrhoids, blood in stool, irritable bowel syndrome, diverticulitis, abdominal pain, bloating, constipation, laxative or enema dependence, chronic diarrhea, fecal incontinence.

Urinary: Excessive or frequent urination, painful urination, blood in urine, recurrent urinary infections, urethral discharge, difficulty starting or stopping stream, incontinence, kidney or bladder stones, kidney disease.

Genitoreproductive: Impotence, sexually transmitted diseases, pregnant or possibly pregnant, premenstrual syndrome, endometriosis, irregular menses, last menstrual period __/__/__, menopausal symptoms, age at menopause, post-menopausal bleeding, discharge, itching, sores, painful intercourse, decreases libido, number or pregnancies __, miscarriages or abortions last PAP smear __/__/__

DEBORAH C. ROSE, D.C., PC

200 WHITE ROAD, SUITE 110

LITTLE SILVER, NJ 07739

Phone: (732) 530-7229

Fax: (732) 530-4665

24 Hour Appointment Cancellation Policy

As a courtesy to staff and patients, a 24 hour cancellation policy is now in effect.

Your regular payment for that visit will be incurred (with a minimum of $30 and maximum of $60) to all patients who fail to cancel 24 hours prior to their scheduled appointment.

By signing below, you acknowledge that you have read and understand the Cancellation Policy.

Thank you for your cooperation.

_____ _____

Print name Signature

_____

Date

DEBORAH C. ROSE, D.C., PC

200 WHITE ROAD, SUITE 110

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Patient Payment Responsibility

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best care possible. The following is a statement of our financial policies that outlines patient and practice responsibilities. Please feel free to contact us at (732) 530-7229 if you have any questions.

All Insurance Carriers

I uderstand claims will be filed with my insurance company. I will be responsible at the time of service for all co-pays, co-insurance, deductibles and services not covered by my plan. 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 insurance, any fees for professional services rendered to me will be immediately due and payable.

Medicare

The physician accepts assignment for Medicare. We will file any secondary insurance claims. You may be asked to sign a waiver for procedures that Medicare does not cover. You have the right to refuse these procedures. You will be asked to sign a waiver stating that you have refused these procedures.

HMO's

The patient is responsible for obtaining and maintaining valid referrals for any and all covered services. If the patient chooses to undergo any services without a valid referral, the patient is financially responsible for the full charges. Any and all co-pays are due at the time of service.

Self-Pay Patients: Full payment is due at time of service. We accept cash, checks, Visa and Mastercard.

Collections and Returned Checks: Delinquent accounts will be forwarded to our collection agency. Any collection fee will be added to the unpaid balance. In the event litigation is necessary, you will be liable for court costs and attorney fees. A $35.00 fee will be charged for all returned checks.

Change of Insurance: It is your responsibility to provide our office with any insurance changes. Claims denied due to "untimely billing" will be the patient's responsibility, if we are not initially provided with the correct billing information, which resulted in late submission.

Medical Records: Your medical records will be held in the strictest confidence. If you request a copy of your records to be sent to another physician or to yourself, a written authorization will be required. We will notify you with the processing fees and any additional costs that may incur. Only the records requested will be forwarded. Should you bring in another physician's records to us, you may want to consider keeping a copy for yourself. I hereby give my consent to the physician Deborah C. Rose D.C., PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. With this consent the physician Deborah C. Rose . D.C., PC may call my home or other alternative location and leave a message on a voicemail in reference to any items hat assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory and/or pertinent results. The physician Deborah C. Rose D.C. PC may mail to my home or other alternate location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements. By signing below, I acknowledge that I have read and understand the information presented above and hereby authorize Deborah C. Rose D.C., PC to treat my condition as he or she deems appropriate through use of manipulation throughout my spine, electrical muscle stimulation and heat or ice therapy. I agree to be fully responsible for any and all charges for services rendered and not covered by my insurance plan. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature, Guardian or Spouse's signature of Authorizing care _____Date_____

NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)

Entity Name, Address, Tel., Email:

_____

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:
We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:
We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:
We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:
We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:
We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:
We can use or share your information for health research.

Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:
We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Additional Items:
1) Open Room: We utilize an open adjusting therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested.

Contact information:
Compliance officer name, contact email, tel., & effective date of notice:

_____

PATIENT ACKNOWLEDGMENT OF HIPAA NOTICE

Entity Name, Address, Tel., Email:

_____

Notice to Patient:

We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

Patient Acknowledgment:

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____

Patient Printed Name

_____

Patient Signature or legal representative

_____

If legal representative, state relationship

_____

Date

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details):

_____

_____

Name of patient

_____

Name of staff member

_____

Signature of staff member

_____

Date