VELOCITY CHIROPRACTIC AND SPORTS REHAB

Patient Information

Date_____Name_____Preferred Name_____

SS#_____DOB_____Age_____Male_____Female_____

Address_____City, State, Zip _____

Cell Phone_____HomePhone_____EmailAddress_____

Referred By_____Status: Student Single Married Other_____

Have you ever seen a chiropractor before? Dates _____

Have you ever seen a Physical/Occuptional Therapist before? Dates_____

Who is your Medical Doctor?_____Phone_____

Employer Name_____Occupation_____

Emergency Contact Name_____Relation_____Phone_____

Primary Insurance Company_____Phone_____
Subscriber ID_____Group#_____
Insured's Name_____Employer_____
Insured's SS#_____Relation_____DOB_____

Secondary Insurance Company_____Phone_____
Subscriber ID_____Group#_____
Insured's Name_____Employer_____
Insured's SS#_____Relation_____DOB_____

Person ultimately responsible for account:

Name_____Relation_____Phone_____

I hereby authorize assignment of my insurance rights and benefits directly to the providerf for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

_____Date_____

Signature of Patient/Guardian

CHIROPRACTIC/PHYSICAL THERAPY/OCCUPATIONAL THERAPY CASE HISTORY

Name_____DOB_____Male_____Female_____

Have you ever received chiropractic care, and/or physical or occupational therapy? _____Yes_____No

Please circle and give dates_____

Primary reason(s) for seeking chiropractic care, physical therapy or occupational therapy:

_____

Chief Complaint_____

Location of complaint_____

Complaint began when and how_____

Please circle the quality of the complaint/pain:

dull aching sharp shooting burning throbbing deep nagging other_____

Does this complaint/pain radiate or travel to any areas of your body? Where?_____

Do you have numbness or tingling in your body? Where?_____

Grade Intensity/severity (no complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain/complaint)

How frequent is complaint present/how long does it last?_____

Does anything aggravate the complaint?_____

Does anything make the complaint better?_____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

_____

PAST HEALTH HISTORY

Previous illnesses_____

Previous injury or trauma_____

Have you ever broken any bones?_____

Allergies_____

Medications_____Reason_____

_____Reason_____

_____Reason_____

Surgeries: Date_____Type_____

Date_____Type_____

Date_____Type_____

Pregnancies: Date of Delivery_____Outcome_____

Date of Delivery_____Outcome_____

Date of Delivery_____Outcome_____

What is the date of your last menstrual period?_____

FAMILY HEALTH HISTORY

Associated health problems of relatives_____

_____

Deaths in immediate family:

Member_____Reason_____Age_____

Member_____Reason_____Age_____

Member_____Reason_____Age_____

SOCIAL AND OCCUPATIONAL HISTORY

Job Description _____Work Schedule_____

Recreational Activities_____

Lifestyle (hobbies, level of exercise, alcohol, tobacco/drug use, diet_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize Velocity Chiropractic and Sports Rehab to provide me with chiropractic care, physical therapy or occupational therapy, in accordance with this state's statutes.

_____Date_____

Signature of Patient/Guardian

DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

_____Myself only

_____My spouse, significant other or parent (specify name)_____

_____Other (specify name)_____

Information to be disclosed:

_____Prognosis

_____Dates of Service

_____Other (please specify)_____

I would like to be contacted at my:

_____Home Phone_____ Work Phone_____

_____Cell Phone_____Other_____

Regarding the office staff or physician leaving information or confirming appointments on my voicemail:

_____Yes, I give my permission for medical information to be left on my voicemail.

_____No, I do not want messages or medical information left on my voicemail.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office's privacy contact at the above address. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA privacy rule or state law.

_____ Date_____

Signature of Patient or Personal Representative

VELOCITY CHIROPRACTIC AND SPORTS REHAB
231 Maple Avenue, Red Bank, NJ 07701
p. 732.530.1164 f. 732.530.2172

NOTICE OF PRIVACY PRACTICES

By federal law, Velocity Chiropractic and Sports Rehab is required to maintain the privacy of your protected health information (hereafter referred to as "PHI"). By law, Velocity Chiropractic and Sports Rehab may use your PHI in rendering treatment to you. We may disclose your PHI to third parties for treatment (for example, another doctor you may see) or to your insurance provider. We may also disclose your PHI if doing so is required by law, required for public health purposes required for victims of abuse, neglect or violence, required by a health oversight for oversight activities authorized by enforcement purpose to a law enforcement official, required by a coroner or medical examiner, required by an organ procurement for research and also if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Unless disclosure is required under law or the above requirements, we are prohibited from disclosing your PHI without your written authorization. Once such authorization is given, it can be revoked at any time by means of a written revocation. You also have the right to request restrictions on certain use and disclosure of your PHI, however we are not required by federal law to agree to your request restriction. You also have the right additionally, if you desire, Velocity Chiropractic and Sports Rehab can provide you with an accounting of all disclosures we have made of your PHI to third parties, except for treatment, payment or health care providers.

At Velocity Chiropractic and Sports Rehab, we have always been very careful to respect the privacy of all our patients and we are happy to comply with the new federal regulations regarding patient privacy.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that we maintain, based on any changes in the law.

AGREED AND ACCEPTED

_____Date_____

Signature of Patient/Guardian

PATIENT FINANCIAL POLICY

Thank you for allowing Velocity Chiropractic and Sports Rehab to assist you with your healthcare and rehabilitation. In the interest of good health care practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary goal is to help our patients experience and maintain good health and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your recovery as stress-free as possible.

PATIENTS WITH INSURANCE: Your insurance plan is an agreement between you and your insurance carrier and you are responsible to know your policy. As a courtesy to you, our office will make an effort to verify your insurance benefits and file claims on your behalf. However, it is ultimately the patient's responsibility to determine benefit information before services are rendered. **Please note that verification of benefits is not a guarantee of payment.** Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company.

REFERRALS/PRESCRIPTIONS: If your insurance company requires a referral or prescription prior to the commencement of treatment, it is your responsibility to obtain it. Failure to do so may result in the patient being responsible for 100% of accrued charges.

PERSONAL INJURY OR AUTO ACCIDENTS: Please notify your auto insurance carrier of your visit to our office. Please provide our office with your claim number, insurance carrier/adjustor and name of attorney, if retained. If your claim is settled, or if you suspend or terminate care, any unpaid fees for services are due by you immediately.

MEDICARE: We do accept assignment from Medicare. You are responsible for your deductible and co-insurance if it is not covered by a supplemental or secondary insurance.

SECONDARY INSURANCE and SCHOOL INSURANCE: Please inform us of any secondary insurance you may have.

PATIENTS WITHOUT INSURANCE: We request that 100% of the first visit be paid at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established in writing prior to treatment.

OUT OF NETWORK PLANS: We do accept assignment from insurance plans that have out of network benefits. You will be responsible for your individual deductible and co-insurance. **Checks mailed to the patient for services rendered by our office are to be endorsed by the payee and immediately furnished to our office.**

CO-PAYS/CO-INSURANCE: Due at time of visit. For your convenience, we accept cash, personal check, MasterCard and Visa.

APPOINTMENTS: It is important to maintain the treatment plan designed for you. Appointment time slots are carefully chosen based on the patient's plan of care. Please be considerate and help us serve you better by keeping scheduled appointments.

AGREED AND ACCEPTED

_____ Date_____

Signature of Patient/Guardian

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chiropractic + sports rehab

AGREE TO FORWARD PAYMENT

I, _____, am aware that my insurance may send me payments for services rendered by Velocity Chiropractic + Sports Rehab, which includes chiropractic, physical therapy and occupational therapy.

I agree that when I receive any payments from those services I will:

1. Sign the check and I WILL NOT DEPOSIT OR CASH IT. (Personal checks will only be excepted on multiple payer insurance checks)
2. Under my signature, I will print the following: "Make Payable Only to Velocity Chiropractic + Sports Rehab"
3. I will enclose the check with ALL OTHER PAGES ACCOMPANYING THE CHECK, such as explanation of benefits, etc.
4. Place all of the above in an envelope and mail immediately to:

   Velocity Chiropractic + Sports Rehab

   231 Maple Avenue

   Red Bank, NJ 07701

I also understand that in the event the check is not immediately sent to Velocity Chiropractic + Sports Rehab, I will be responsible to pay the full and entire fee for all services rendered. In the event that Velocity Chiropractic + Sports Rehab must retain a collection agency or law firm to collect past due balances owed to Velocity Chiropractic + Sports Rehab, I agree to pay any and all collection agency fees, court costs, attorney fees or incidental costs associated with collecting this debt.

I agree that Velocity Chiropractic + Sports Rehab, is hereby given the right to endorse/sign my name on any and all checks for payment of my bills; in connection with services provided by Velocity Chiropractic + Sports Rehab.

I will keep a copy of this agreement as a reminder as to what is required of me when I receive the payment from my insurance company.

Patient signature:_____ Date:_____

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Recurring Payment Authorization Form

Please complete the information below:

I _____ authorize **Velocity Chiropractic & Sports Rehab** to
(full name)
charge my credit card indicated below for _____ each time I have an office visit.
(insert $)

Billing Address: _____

City, State, Zip: _____

Phone#: _____ Email: _____@_____.com

CREDIT CARD INFORMATION

Cardholder Name: _____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____ Expiration Date: _____

Card Identification Number _____ (last 3 digits on the back of the credit card)

_____ Date: _____
(Cardholder Please Sign)

_____
(Patient Name if different from cardholder)

Address: 231 Maple Ave Red Bank NJ 07701 Phone: 732-530-1164

VELOCITY CHIROPRACTIC AND SPORTS REHAB
231 Maple Avenue, Red Bank, NJ 07701
p. 732.530.1164 f. 732.530.2172
Tax ID No. 03-0495413
Velocitychiro@hotmail.com

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which Velocity Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Signed_____Date_____

If Patient is a Minor

I am the parent or legal representative of _____who is a minor, _____years of age. I authorize the performance of diagnostic x-ray of this minor which Velocity Chiropractic may consider necessary or advisable.

Signed_____Date_____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Velocity Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed_____Date_____