New Patient Application

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name:_______________________________ Today's Date:________________

Preferred Name: ______________________ Birthdate: ____/____/____ Age:______

Address:____

City/State/Zip:_____________________________ Email:____________________________________

Phone: Home:_________________ Work:__________________ Cell:___________________________

Status: Married / Widow / Divorced / Single Social Security #: ___________________

Who may we thank for referring you? ____

Occupation: _______________________________

Employers name: ______________________ Phone: _____________________

Spouse's name: ____________________________ Phone:______________________

Spouse's employer:________________________ Phone:______________________

Children's names & ages:____

Emergency Contact: ______________________ Phone: _________________ Other: ___________

Favorite hobbies or interests: ____

Your Prior Doctor of Chiropractic: ____

City, State: ___________ Approximate date of last Chiropractic treatment: ______________

Chiropractic adjusting techniques you've had success with: ____________________________

General Practitioner name: ____

Phone:___________________ City, State: _______

Please rate 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP:

____

Other Specialists you are currently under care with:

Name: ___________________________________ Phone:__________________________

Name: ___________________________________ Phone:__________________________

Name: ___________________________________ Phone:__________________________

Method of payment for first visit

____ Cash ____ Check ____ Credit Card

Person Responsible for payment:

Name: _________________________________

Phone Number:__________________________

Address: _______________________________

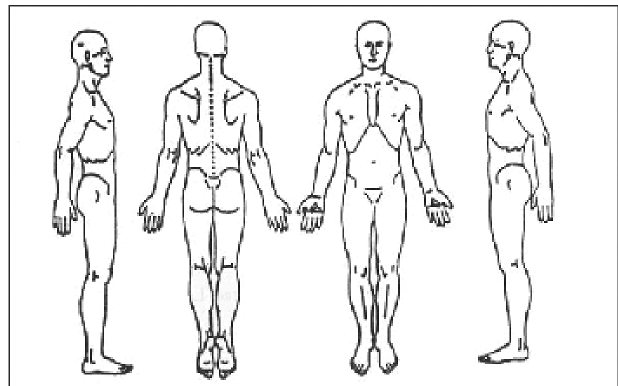
City:__________________________________

State/Zip:______________________________

Do you have Health (crisis) Insurance? Y N

Insurance Company: ____________________

Mark Area(s) of Health Concerns:



Health reasons for consulting our office:

1.____ 2. ____

3.____ 4. ____

Have you had same or similar problem(s) before? ___Yes ___No

How long?________________ Please explain:____

____

Does this condition interfere with your: ____work ______sleep ___ daily routine_________________
Father/Mother/Brother/Sister/Children, with similar problems?

____

Is this the result of an auto or work injury? _________ If so, when? _____________________________

If this is a work injury, is there a panel chiropractor that your company's Workmen's Compensation Insurances requires you to see in the first 90 Days? If so, who?____

Other doctors who have treated this problem: ____

What treatments did you receive: ____

Medication(s) you currently take: ____

____

Do you take supplements? Yes or No If yes, please list______________________________________

Is there any chance you are pregnant? Yes____ No ____

What do you understand chiropractic care to be?____

Do you know what a subluxation is? Yes or No If yes, please describe:

____

Do you play any sports or exercise regularly? Yes or No If yes please describe______________________

____

Do you smoke? Yes or No If yes how many cigarettes/packs a day?______________________________

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto Accidents: ___________________________ Motorcycle accidents: ___________________________

Falls or other injuries: ______________________ Spinal or neck injuries: __________________________

Broken Bones: _____________________________ Knocked unconscious: __________________________

Surgeries: _________________________________ Health problems of parents: ______________________

Do you or have you had any of the following? Please write *C* of current and *P* for Past

___Angina ___Arthritis ___Asthma ___Allergies ___Carpal Tunnel ___Cancer ___Diabetes ___Emphysema ___Gout ___Heart Disease ___High Blood Pressure ___Kidney Disease ___Low Blood Pressure ___Migraines ___Numbness/tingling ___ Sciatica ___Seizures ___Sinus Problems ___Spinal curvature ___Stroke ___Thyroid disorder ___Tuberculosis ___Ulcers

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Parent or Guardian Signature: ______________________________________
Date: __/__/__

Pregnancy Specific History

Prenatal history:

1) Is this your first pregnancy? ________

2) How many other births have you had? __________

3) How many weeks pregnant are you now? __________ Due Date:_____________

4) Have you experienced any traumas (accidents, falls) during this/past pregnancy? _______

Please describe: ____

6) Do you smoke or drink alcohol? ____

7) Have you had any evaluation procedures (ultrasound, amniocentesis, chorionic villus sampling)?

____

8) Please list dates, frequency and reason for these procedures:

____

9) How has your diet been during this pregnancy? ____

10) Have there been any stressful events in your life during this pregnancy? _____________________

____

11) What are your most significant fears associated with this birth? ____________________________

____

12) Who is your birth care provider? ____

13) Will you have someone with you at birth for support (other than birth care provider)?

Please specify who: ____

14) Where do you plan on delivering? ____

15) Have you put together a birth plan? ____

Previous Birth History:
Please print this page for each previous delivery

1) Place of birth: Hospital, Birthing Center, Home.

2) Delivering Practitioner: OB/Gyn, Certified Nurse Midwife, Certified Practicing Midwife, Lay Midwife____

3) Position of Delivery: Lithotomy position (on back with feet up), On Your Side, Kneeling, Squatting, Other? ______________________

4) Was labor induced? (Contractions were stimulated prior to the natural onset of labor) Yes No

f yes, specify type: Pitocin, Prostagland Gel (applied to your cervix), Unknown

5) Were your membranes ruptured by your care provider? Yes No Unknown

6) Were contractions stimulated intravenously with pitocin once labor started? Yes No

7) Did you receive any pain medications or anesthesia? Yes No Unknown Type________________

If you had an epidural, how many centimeters were you dilated when it was administered? ________

8) Did you experience back pain during labor? Yes No Unknown

9) Did you deliver vaginally? Yes No

10) Baby presentation at time of delivery: Normal, Posterior, Brow, Facial, Breech,

If breech, specify type: Footling, Frank, Complete, Kneeling

Was there any visible injury to your baby? Yes No Unknown

If so, where on your baby was the injury sustained?_________________________

11) Did your care provider assist delivery with his/her hands? Yes No Unknown

Was there any turning of the neck, or traction (pulling) applied to the neck? Yes No Unknown

12) Were operative devices used to facilitate the birth? Yes No Unknown

Which type? Forceps Vacuum Extraction

If yes, were there any visible signs of injury to your baby? Yes No Unknown

If yes, where was the injury sustained?_____________________________________

13) Was there a birthing coach present? Husband, Doula, Friend, Other

14) At what week of pregnancy was your baby born? __________________________

We believe that a clear definition of our policies will allow us both to concentrate on the big issue of regaining and maintaining your health…

APPOINTMENT POICY

In order to serve all our patients we ask that you call if you are unable to make your appointment. If you find yourself running late, please stop by the office and notify the receptionist and we will get you in for your visit as soon as possible. When you fail to notify our office, this leaves a time slot open that could otherwise be used to help someone else. Please help us help others. – Thank you

Payment Schedule

You have taken the first step on the path to optimal vibrant health. We take pride in delivering the finest in chiropractic care. The following payment options are available to help you handle your financial obligations.

- **Plan # 1 – CASH**
  Payment is due at the time of service, unless other payment arrangements have been made by the office.

- **Plan #2 – INSURANCE/MEDICARE**
  Please present your insurance card today. We will call your insurance company for you to verify your coverage. If you have coverage for your chiropractic care, our office will submit claims for you. After your insurance company has been reached for benefit information a financial payment plan will be presented on your following visit. Until we have the completed necessary insurance information, you will be required to pay for your care on a cash basis.

- **Plan #3 – PERSONAL INJURY**
  You need to provide us with the accident report, your auto insurance, health insurance, and attorney if applicable. If the claim is a possible their party liability, please provide us with the other parties' insurance carrier information. Although my insurance or lawsuit may eventually pay for services rendered, if insurance or lawsuit does not pay, I understand that I am responsible to pay my balance in full.

Assignment of Benefits

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and patient. Our policy requires payment in full for all services render at the time of visit, unless other arrangements have been made with the office. If all charges are not paid when due, the undersigned agrees to pay cost of collections. This includes 33 1/3% attorney's fee or other collection agency fees, plus interest at the rate currently applicable by Virginia statue to judgments. It is agreed that any legal action for collections of monies due may be properly instituted in the courts of Virginia and Virginia Law shall apply.

I QUALIFY AND UNDERSTAND THE REQUIRMENTS OF PLAN(s) # _______.

Patient's or Guardians Signature: ______________________________ Date: _________________

Please Print Patient Name: _____________________________________ CA Initials: _____________

Patient Authorization regarding chiropractic care provided in an "open adjusting" environment

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care care discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal-law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from our office or on your relationship with our staff.

Your signature indicates you authorization of this activity.

____

Name (Printed) Signature Date

Cancellation/No-Show Policy for Massage Therapy/Muscle Work

It is the policy of this office that if you find it necessary to cancel or change an appointment you must allow at least 24 hours prior notice. Missed and canceled appointments without proper notification will result in a $30.00 cancellation fee.

If you are late for an appointment, it is necessary to still end at the appointed hour, so not to effect the appointment following you.

____

Signature Date

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

In the course of your care as a patient at our office we may use or disclose personal and health related information about you in the flowing ways:

- Your personal health information including your clinical records, may be disclosed to another health provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing record may be disclosed to another part, such as an insurance carrier, an HMO or PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are proving health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for use to provide care.
- If we are order by the courts or another appropriate agency.

Any sue or disclosure of your protected health information, other then as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other then your home or, if you would like the information in a different form pleas advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was reacted or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to our office manager.

If you would like further information about our privacy poise and practices please contact our office manager.

This notice is effective as of _______. This notice and any alteration or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

____

Name (Print) Signature Date

If you are a minor, or if you are being represented by another party:

____

Person Responsible (Print) Signature Date

____

Description of the authority to act on behalf of the patient

Rosemont Chiropractic
397 Little Neck Rd
Building 3400 Suite 108
Virginia Beach, VA 23452

Patient Name: ______________________________ D.O.B.:________________ Date:____________

Privacy Notice Acknowledgement

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have been offered a copy of Rosemont Chiropractic *Notice of Privacy Practices for Protected Health Information.*

_________________________________ _________________________________
Patient Name Printed Date

_________________________________ _________________________________
Patient Signature Authorized Provider Rep.

_________________________________ _________________________________
Personal Representative Printed Personal Rep. Signature

____

Description of personal representative's authority to act for the patient