Patient Introduction Form

Name: _____ Date: _____

Address: _____City: _____ST._____ ZIP _____

Sex: M / F D.O.B. ____/_____/_____ Age: _____ Height: _____ Weight: _____

Home Phone: ( ) _____- _____ Cell: ( ) _____-_____ Work: ( ) _____-_____

E-mail Address: _____@_____. com Referred by _____

SS# _____-_____-_____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Employer Name/Address: _____

Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: ( ) _____- _____ Cell: ( ) _____-_____ Work: ( )_____-_____

Attorney Name: _____ Attorney Phone # ( ) _____-_____

Current Symptom #1: _____
Current Symptom #2: _____

Insurance Information

Insurance Co. _____ ID/Policy #: _____
Insurance Phone #: ( ) _____-_____
Policy Holder's Name: _____ D.O.B.: _____
Secondary Ins. Co. _____ ID/Policy#: _____
Phone #: ( )_____ - _____

EXERCISE:
□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY:
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS:
□ Smoking – Packs per day _____
□ Alcohol - Drinks per week _____
□ Coffee/Caffeine Drinks- Cups per day_____
□ High Stress Level - Reason_____

Medications and Conditions:	**Surgeries (Area):**	**Date:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check off all Medical Conditions that Apply:

AIDS/HIV		HEART DISEASE		PROSTATE PROBLEMS	
ALCOHOLISM		HEPATITIS		PSYCHIATRIC CARE	
ARTHRITIS		HERNIA		RHEUMATOID ARTHRITIS	
ASTHMA		HERNIATED DISC		STROKE	
CANCER		HIGH CHOLESTEROL		THYROID PROBLEMS	
FRACTURES		MIGRANE HEADACHES		VAGINAL INFECTIONS	
GOUT		OSTEOPOROSIS		OTHER:	
DIABETES		PINCHED NERVE		OTHER:	

I would like to use text message to make, confirm, reschedule, or cancel my appointments? □ Yes □No

I understand that standard text rates as determined by my cellular provider may apply.

Patient Signature: _____

Precision Chiropractic Health

Dr. Jennifer Carrasco • Dr. Alan Furman • Dr. Ross Ginsberg

Notice of Privacy for: Patient's Protected Health Information

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

This office abides by the terms described in this policy and we use and disclose your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Workers Compensation to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates when written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-In logs may be disclosed to verify office visits.
- We send birthday cards/postcards and newsletters to our patients.
- In this office we deliver care in an open-adjusting and open door adjusting environment. In the course of your care in these environments routine details of your condition and care may be disclosed to other patient's in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Any other uses or disclosures will only be made with your specific written prior authorization. Feel free to raise any concerns to the receptionist or to the doctor.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer, Dr. Jennifer Carrasco, in this office regarding privacy issues.
- Inspect, copy and amend your protected health information as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

_____
Patient Name

_____ _____
Patient Signature Date

Precision Chiropractic Health

Dr. Jennifer Carrasco • Dr. Alan Furman • Dr. Ross Ginsberg

Your signature below forms a binding agreement between Precision Chiropractic Health, P.C. and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We will bill your medical insurance as a service to you. As the Responsible Party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Present all current insurance cards prior to the first office visit.
- Present new insurance cards if insurance should change at any time.
- Pay any required copay at the time of the visit.
- Pay any additional amount owed within 30 days of receiving a statement from our office.

By signing below, you agree to accept full financial responsibility as a patient who is receiving chiropractic services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) ______________________________

Patient Signature ______________________________ Date ____________

Responsible Party Name (Please Print) ______________________________

Responsible Party Signature ______________________________ Date____________

~~~~~~

Name of Policy Holder______________________________

Insurance Company______________________________ ID#:____________________

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to this office for any service furnished by Jennifer Carrasco, D.C., Ross Ginsberg, D.C. or Alan Furman, D.C. I authorize any release of medical information to the insurance company regarding these charges.

Patient Name (Please Print) ______________________________

Patient Signature ______________________________ Date ____________

135 W Jericho Tpke Huntington Station, NY 11746 • Tel: (631) 423-1969 • Fax: (631) 423-2328
~~~~~~

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date: