

Chiropractic Registration and History

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____

Last Name

First Name

Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Phone Numbers

Home Phone (_____) _____ Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bedding Lying Down

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign liability to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

Accident Information

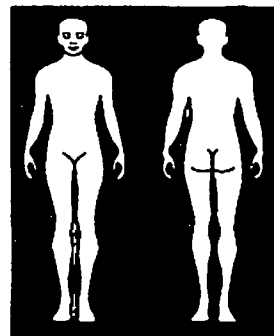
Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____



Health History

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None

Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam Spinal X-Ray Blood Test

Spinal Exam

Chest X-Ray

Urine Test

Dental X-Ray _____

MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turners, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Are you pregnant? Yes No

Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications

Allergies

Vitamins/Herbs/Minerals

Pharmacy Name _____

Pharmacy Phone (____) _____

To properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0 No pain 1 Mild pain 2 Moderate pain 3 Severe pain 4 Worst possible pain

2. Sleeping

0 Perfect sleep 1 Mildly disturbed sleep 2 Moderately disturbed sleep 3 Greatly disturbed sleep 4 Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0 No Pain; no restrictions 1 Mild Pain; no restrictions 2 Moderate Pain; need to go slowly 3 Moderate Pain; need some assistance 4 Severe Pain; need 100% assistance

4. Travel (driving, etc.)

0 No pain on long trips 1 Mild pain on long trips 2 Moderate pain on long trips 3 Moderate pain on short trips 4 Severe pain on short trips

5. Work

0 Can do usual work plus unlimited work 1 Can do usual work; no extra work 2 Can do 50% of usual work 3 Can do 25% of usual work 4 Cannot work

6. Recreation

0 Can do all work activities 1 Can do most activities 2 Can do some activities 3 Can do a few activities 4 Cannot do any activities

7. Frequency of pain

0 No pain 1 Occasional pain; 25% of the day 2 Intermittent pain; 50% of the day 3 Frequent pain; 75% of the day 4 Constant pain; 100% of the day

8. Lifting

0 No pain with heavy weight 1 Increased pain with heavy weight 2 Increased pain with moderate weight 3 Increased pain with light weight 4 Increased pain with any weight

9. Walking

0 No Pain; any distance 1 Increased pain after 1 mile 2 Increased pain after ½ mile 3 Increased pain after ¼ mile 4 Increased pain with all walking

10. Standing

0 No pain after several hours 1 Increased pain after several hours 2 Increased pain after 1 hour 3 Increased pain after ½ hour 4 Increased pain with any standing

Patient's Signature

Date

FINANCIAL POLICY

PATIENTS WITH INSURANCE COVERAGE:

We will be glad to help patients obtain the appropriate benefit information from their insurance carriers and bill them directly as a courtesy to the patient. However, we are not responsible for any misinformation that we may receive from insurance carriers regarding a patient's benefit coverage. Ultimately, the patient is responsible for the payments on the account.

We will be happy to request a pre-estimate of benefits from a patient's insurance carrier if requested. Routine treatment is generally performed without submitting a request for a pre-estimate of benefits. For managed-care plans (HMOs), referrals are required. Without a referral, the patient may be responsible for all of the cost of the visit.

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Sometimes, there is a co-payment or co-insurance amount required by the patient as part of their insurance agreement. Even if a patient has double coverage (this is possible if the patient is covered by their personal and spousal insurance), there may still be a portion that will be the patient's responsibility. **Please feel free to ask any questions you may have regarding your insurance policy and plan, or anything you may not understand.**

For patients who are receiving treatment over a period of time, we appreciate payment at the time of treatment. Our office assistants will be glad to help patients arrange a payment schedule if necessary.

PATIENTS WITHOUT INSURANCE COVERAGE:

Patients without insurance benefits are requested to pay for services rendered at the time of the visit. We accept cash, check, MasterCard, and Visa payments.

ADDITIONAL TERMS:

Checks returned by a patient's banks are subject to a **\$20.00** processing charge. Accounts unpaid after 30 days from the date of billing are subject to a finance charge at the rate of **1.25% per month**. If a patient's account is referred to collections, the patient will be responsible for collection costs in the amount of **30%** of the outstanding balance, together with court costs and reasonable attorney's fees.

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide the best care possible.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE OFFICE OF DR. BARRY L. SILVERMAN and THE HEALING ARTS CENTER OF PHILADELPHIA.

PATIENT/GUARDIAN SIGNATURE

DATE

PRINTED NAME OF THE PATIENT/GUARDIAN

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your information to another healthcare provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your information and billing records to another party if they are potentially responsible for the payment of services rendered.
- We may have to disclose your information within our practice for quality control or other operational purposes.

Your right to limit uses or disclosures

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review the notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in the notice. If we make a change to our privacy practices, we will notify you in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have read and received a copy of this notice.

Printed Name

Signature

Authorized Representative

Signature

Date Signed

The
Healing Arts Center
of PHILADELPHIA

123 Chestnut Street, Ste. 204 * Philadelphia, PA 19106
p: 215-627-3782 * f: 215-627-3695

Thank you for selecting the Healing Arts Center for your health and wellness needs. We look forward to treating you. In an effort to provide the best care and accommodation for our patients and providers, we ask that you review our cancellation policy listed below.

All providers kindly request **24-hour (one business day) notice** when canceling. If you need to cancel a Monday appointment, please contact our office by 2 p.m. Saturday.

Our fees for canceling without notice vary by provider due to their individual charge schedules. Please refer to your provider below:

Barry Silverman, DC	Chiropractic	\$35 flat fee
Steve Mavros, L.Ac.	Acupuncture & Herbal Medicine	50% of visit
Sheri McLellan-Krauss	Acupuncture	50% of visit
Julie Schwartz	Acupuncture	50% of visit
Matt Skahill	Acupuncture	50% of visit
Jerrold Friedman, MD	Physiatry/Medical Acupuncture	\$75 flat fee
Steven Rosenzweig, MD	Integrative Medicine	\$150/new patient \$75/established

If you have any questions about this policy, please feel free to ask a member of our staff. Due to the large number of clients we serve, exceptions to the policy will only be made under reasonable circumstances.

We do offer you the courtesy of a phone call or email one day prior to the visit to help remind you of your appointment. If you need to cancel and reschedule the appointment, you may do so at that time without incurring a charge.

By signing below, you are indicating that you have read and understood this policy.

Name

Date

**AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

Patient Health Information authorized to be disclosed:

For the specific purpose of (describe in detail)

Effective dates for this authorization: ____/____/____ through ____/____/____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected Patient Health Information.

Signature of Patient or Patient's Authorized Representative

Date

Authorized Signature of Facility

Date