SIGNATURE HEALTH & WELLNESS CENTER

GETTING YOU HEALTHY FROM THE INSIDE OUT!

Confidential Patient History

Name: _____Age: _____Phone Number: _____

Address: _____ City: _____ Sate: _____Zip: _____

Phone Number: _____Birth Date: _____ Occupation: _____

Marital Status: M – S – W – D (please circle one)

Emergency Contact: _____Emergency Number: _____

Referred By: _____ How did you hear about our office? _____

Health Information:

Do you have: Pain Stiffness Tightness Discomfort Tension Stress Postural Concerns *(Please Circle One)*

What Regions: _____

List ANY other problems or concerns: _____

How long have you felt this way? _____ Have you had this or a similar condition in the past? _____

What is aggravating your condition? _____

Is this condition getting worse: YES – NO – CONSTANT – COMES AND GOES *(please circle one)*

Is this condition interfering with you WORK – SLEEP – DAILY ROUTINE – OTHER *(please circle one)*

Other doctors who have treated these conditions? _____

List ANY surgical procedures and year performed: _____

Date of last Physical Examination: _____

Drugs you take now *(Please Check)* ___Nerve Pills ___Pain Killers ___Muscle Relaxers ___Pep Pills

___Tranquilizers ___Insulin ___Birth Control ___Other

Are you wearing? ___Heel Lifts __Sole Lifts __Other

Have you ever been in an automobile accident? __Past Year ___ Past 5 year ___Over 5 Years ____ None

Have you had an personal injuries or accident? ___Past Year ___ Past 5 year ___Over 5 Years ____ None

Have you ever suffered from: __Dizziness __Backache ___Heart Trouble ___Diabetes ____Arthritis

___Headaches ___Asthma ___Neuritis __Digestive Issues ___Nervousness __Sinus Trouble ___Neck Pain

Assignment of Benefits

I hereby instruct and direct my insurance company to pay the following provider direct payment for services rendered:

Signature Health & Wellness Center
471 Cortlandt Street
Belleville NJ 07109

Of policy provisions prohibit direct payment to physician, I hereby request payment for services rendered per current policy provisions. Payment is for the profession or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward charges for profession services rendered.

THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE INSURANCE POLICY

This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment of Right and Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to nay insurance company, adjuster, or attorney involved in this case.

_____ _____

Patient / Guardian Signature **Date**

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this Health & Wellness Office will prepare any necessary reports and forms to assist me in making collection from the insurance company. Any amount authorized to be paid directly to this Health & Wellness Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment and fees for professionals services rendered me will be immediately due and payable.

_____ _____

Patient / Guardian Signature **Date**

Informed Consent For Chiropractor Care

When a patient seeks chiropractic health care and we accept a patient for such care. It is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science of art which concerns itself with the relationship between structure (primarily the spine) and the function (primarily the nervous system) as the relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebras in the spinal column become misaligned and / or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and / or reduced by an adjustment. An adjustment is the specific application of forces to correct and / or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instrument. In addition, ancillary procedures such as physiotherapy and / or rehabilitation procedures may be included.

If during the course of care we encounter non-chiropractic unusual findings and recommend that you seek the services of another health care provider.

All questions regarding the Doctors objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risk and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	**Patient/ Guardian Signature**	**Date**

I, _____ being the parent or legal guardian of _____ have read and fully understand the above informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last Menstrual Cycle _____

_____	_____
Signature	**Date**

Patient Consent for Use and Disclosure
Of Protected Health Information

Signature Health & Wellness Center
471 Cortlandt Street
Belleville NJ 07109

I herby give my consent for Chiropractic & Wellness Center at Signature Fitness. PC to use and disclose protected health information (PHI) about me to carry out treatment. Payment and healthcare operations (TPO)

Chiropractic & Wellness Center at Signature Fitness Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent Chiropractic & Wellness Center at Signature Fitness reserves the right to revise its Notice of Privacy at anytime. A Revised Notice of Privacy Practices may be obtained by forwarding a written request to Chiropractic & Wellness Center at Signature Fitness at 471 Cortlandt Street Belleville New Jersey 07109.

With this Consent, Chiropractic & Wellness Center at Signature Fitness may call my home or alternative location an leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, Insurance items and any call pertaining to my clinical laboratory results among others.

With this consent Chiropractic & Wellness Center at Signature Fitness may mail to my home or other alternative location any items that assist the practice in carrying out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consent in writing expect to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, Chiropractic & Wellness Center at Signature Fitness may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Patients Name

_____

Legal Guardians Name