Patient Registration

Date: / /	Chart Number:	Clinic

PATIENT MAILING INFO

LAST NAME	FIRST NAME	M.I.
MAILING ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	
WORK PHONE	EMAIL	

PATIENT PERSONAL

AGE	DATE OF BIRTH / /	SOCIAL SECURITY #
SEX MALE FEMALE	RELATIONSHIP STATUS MARRIED SINGLE WIDOW	

EMERGENCY CONTACT

NAME	HOME PHONE
RELATIONSHIP	CELL PHONE

SPOUSE OR GUARDIAN

LAST NAME	FIRST NAME	M.I.
EMPLOYER NAME		
WORK PHONE	DATE OF BIRTH / /	SOCIAL SECURITY #

PATIENT EMPLOYMENT

EMPLOYER NAME	OCCUPATION	
ADDRESS		
CITY	STATE	ZIP CODE

INSURANCE COVERAGE

TYPE OF INSURANCE

EMPLOYEE GROUP HEALTH PLAN PERSONAL HEALTH INSURANCE HEALTH SAVINGS ACCOUNT

PERSONAL INJURY MEDICARE

I UNDERSTAND AND AGREE THAT HEALTH ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS CHIROPRACTIC OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS CHIROPRACTIC OFFICE WILL BE CREDITED TO ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERIVCES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PLEASE PRESENT YOUR INSURANCE CARD SO THAT WE MAY PHOTOCOPY IT

SIGNATURE: _____ DATE: _____/_____/_____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for use and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Print Name: _____ Signature: _____ Date: _____/_____/_____

COMPLIANCE ASSURANCE NOTIFCATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability (HIPAA) with particular emphasis on the "Privacy Rule:. We strive to achieve the very highest of standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

OUR OFFICE POLICY
REGARDING INSURANCE ASSIGNMENT

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

However, it must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance company.

Office policy regarding insurance assignment:

- Since by taking your insurance on assignment, we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
- If you discontinue care without doctor's authorization, the balance of your account is due and payable in full immediately, even if your insurance has been filed. (If the insurance does pay, it will be refunded if you have a zero balance.)
- Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay balance due and be reimbursed by your insurance company when and if it pays.
- We will bill your insurance on 7 days cycles as long as you are receiving chiropractic care in this office.
- You may pay the percentage of your responsibility as you go along, if you choose. (e.g. If your insurance pays 80% of your care, you pay 20% on each office visit.)
- Or we will back bill your insurance company weekly, and when we receive an insurance check, we will bill you for any balance due at that time.
- You are required to sign an "Authorization to Pay Physician" form and any other assignment documents required by your insurance company on your first office visit.
- Our office does NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your insurance claim is denied you are responsible for the full amount of your bill
- Our office will NOT enter onto a dispute with your insurance company over your claim. This is your responsibility and obligation.

If you understand and agree with all of the above office policies, please sign your name below and we will accept your insurance.

_____ _____

SIGNATURE OF PATIENT DATE

Dr. Justin Bradish

We are glade that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

PATIENT INFORMATION		
LAST NAME	FIRST NAME	M.I.
DATE OF BIRTH / /	AGE	SEX MALE FEMALE

CHIEF COMPLANT

REASON FOR VISIT

_____

_____

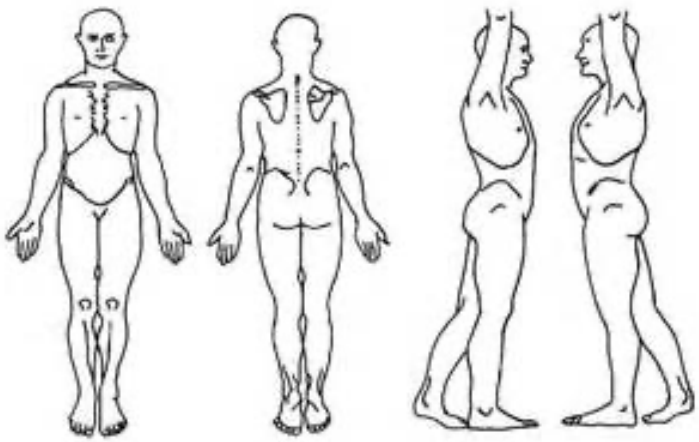
_____

USE THE SCALE BELOW FOR THE FOLLOWING QUESTIONS

1-NO SYMPTOMS	6- LIMITES MY WORK SCHEDULE
2 -SLIGHT DISCOMFORT	7- PREVENTS ALL WORKING ACITIVES
3 -DOES NOT AFFECT ACITIVTIES	8- PREVENTS ALL ACITIVES
4 -AFFECTS PERSONAL ACITIVES	9 -KEEPS ME BEDRIDDEN
5 -PREVENTS PERSONAL ACITIVES	10 -CAUSES THOUGHTS OF SUICIDE

THE SEVERITY OF YOUR CHIEF COMPLAINT AS IT IS RIGHT NOW	1 2 3 4 5 6 7 8 9 10
THE SEVERITY OF YOUR CHIEF COMPLAINT AS IT IS ON AVERAGE	1 2 3 4 5 6 7 8 9 10
THE SEVERITY OF YOUR CHIEF COMPLAINT AS IT IS AS ITS BEST	1 2 3 4 5 6 7 8 9 10
THE SEVERITY OF YOUR CHIEF COMPLAINT AS IT IS AS ITS WORST	1 2 3 4 5 6 7 8 9 10

MARK THE AREAS OF YOUR CHIEF COMPLAINT ON THE DIAGRAMS BELOW. INCLUDE ANY DESCRIPTORS OR COMMENTS THAT YOU FEEL ARE IMPORTANT. IF YOUR SYMPTOMS TRAVEL TO OTHER AREAS OF YOUR BODY, MARK THE DIAGRAMS TO REFLECT HOW THE SYMPTOMS SEEM TO MOVE.



REVIEW SYSTEMS (COMPLETE)		MARK ALL OF THE CONDITIONS THAT YOU CURRENTLY HAVE.		
CONSTITUIONAL	**MUSCULOSKELETAL**	**NEUROLOGICAL**	**CARDIOVASCULAR**	**RESPIRATORY**
FEVER	BACK PAIN	SUDDEN NUMBESS	HIGH BLOOD PRESSURE	ASTHMA
WEIGHT LOSS	HEADACHES	SUDDEN HEADACHE	HEART DISEASE	COPD
OBESITY	EXTREMITY PAIN	LOSS OF SENSATION	ARTERIAL ANEURYSUM	COMMON COLD
LOSS OF APPETITE	BONE DEMINERALIZATION	CONFUSION	ANGINE	EMPHYSEMA
FATIGUE		DIZZINES	IRREGULAR HEART	PNEUMONIA
ANXIETY		SLURRED SPEECH	BEAT	CANCER
ALLERGIES		LOSS OF BALANCE	BLEEDING DISORDER	PNEUMOTHRAX
			HEART ATTACK	
EYES	**E,N,M,T**	**GENTOURINARY**	**GASTROINTESTINAL**	**DISEASE HISTORY**
VISION TROUBLE	HEARING LOSS	KIDNEY INFECTION	DIARRHEA	STROKE
DOUBLE VISION	TINNITUS	LOSE BLADER	BLOOD IN STOOL	HEART ATTACK
NIGHT BLINDNESS	VERTIGO	CONTROL	ABDOMIINAL PAIN	DIABATES
GLAUCOMA	NOSE BLEEDS	URINE COLOR CHANGE	LIVER/ GALL	CANCER
CATARACTS	DRY MOUTH	PAINFUL URINATION	CONDITION	HIV/ AIDS
DISCHARGE	CHANGE IN TASTE	URINE LEAKAGE	NAUSEA/ HEARTBURN	
DROPPY EYELIDS	BLEEDING GUMS	URGENCY	LOSS BOWEL CONTROL	
		BLOOD IN URINE	PROSTATE PROBLEMS	

PAST FAMILY AND SOCIAL HISTORY					
HOW OFTEN DO YOU EXERCISE?	NEVER	1X/WEEK	2X/WEEK	3/WEEKS	4X/WEEK
HOW OFTEN DO YOU USE TABACOO?	NEVER	DAILY	WEEKLY	MONTHLY	YEARLY
HOW MANY ALCOHOLIC BEVERAGES DO YOU DRINK EACH WEEK?	0	1-2	3-4	5-6	>7
HOW MANY COFFEE BEVERAGES DO YOU DRINK EACH WEEK?	0	1-2	3-4	5-6	>7
HOW MANY SODAS OR SUGAR BEVERAGES DO YOU DRINK EACH WEEK?	0	1-2	3-4	5-6	>7
LIST ALL PRESCRIPTION YOU ARE TAKING?					
LIST ALL OVER THE COUNTER MEDICATIONS OR NUTRITIONAL SUPPLEMENTS YOU ARE TAKING					
LIST ALL SURGICAL PROCEDURES THAT YOU HAVE HAD					
LIST ALL OF THE TIMES YOU HAVE BEEN HOSPITALIZED					
LIST ALL PAST SIGNIFICANT PAST TRAUMAS THAT YOU HAVE HAD					
MARK THE FOLLOWING THAT WE IN YOUR FAMILY HISTORY		HEART DISEASE	STROKE/TIA	DIABETES	CANCER

_____ _____ _____/_____/_____

PRINT PATIENT NAME PATIENT OR GURDIAN SIGNATURE DATE