<u>Needham Chiropractic Assoc., P.C.</u>

1410 Highland Avenue Needham, MA 02492
2nd floor Suite 201

<u>From 128 South –</u>

Take Exit 19B Highland Ave – toward Needham

Go thru 5 traffic lights, at fifth light you will see Needham Service Station on your right. St. Joseph's school will be on your left.

We are located in the brick building between St. Josephs School and Babel's paint.

Parking is located behind the building. – 2nd floor – Suite 201

<u>From 128 North–</u>

Take Exit 17 toward Needham – At end of ramp take right.

At 3rd Traffic light you will see Santander Bank. Go straight thru light keeping the bank on your right.

Approx. 1/8 mile you will pass Walgreens on your right. At this point start to look for Fuji Steak House and Babel's paint, also on your right.

Take immediate right into the driveway after Babel's paint.

We are the brick building located next to Babel's paint – 2nd floor Suite 201.

If you see St. Joesph's school on your right, you have gone too far.

WE'D LIKE TO GET TO KNOW YOU BETTER!

Name:_______________________________________Birthdate:___________________________

Address:______________________________City/St.______________________Zip__________

Home Phone:________________________Cell:________________Work:___________________

Email:____
Single:_____ Married_____ Divorced_____ Widowed _____ Separated_____

Occupation:______________________________Employer:______________________________

Primary Care Doctor:____

Who shall we call in case of emergency?____
Their phone number:____

Who referred you to our office?____

Have you undergone chiropractic care before?____
When________________________Where____

PRIVACY NOTICE ACKNOWLEDGEMENT:
We are very 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 waive my right to privacy regarding the daily sign-in sheet for purposes of proof of attendance.

I acknowledge that I have been offered a copy of NEEDHAM CHIROPRACTIC ASSOCIATES' "Notice of Privacy Practices for Protected Health Information".

_________________________________ _________________________________
Patient Signature Date

_________________________________ _________________________________
Personal Representative Signature Authorized Provider Rep. Signature

HEALTH HISTORY

Please Print Name:____
Date*:*_______________________________________

1. My health goals are:
    ____correction/stabilization
    ____health maintenance
    ____pain relief

2. Please check area(s) of complaint:
    ____low back pain
    ____hip/buttock pain. __R__L
    ____leg pain. __R __L
    ____foot pain __R __L
    ____other___________________
    (Specify)
    _____neck pain
    _____shoulder pain. __R __L
    ____arm ____hand pain. __R __L
    ____mid-back pain.
    ____headache.

3. When did the pain begin? Approximate date:__________________________
    ____gradually, without incident.
    ____with specific incident.

4. Explain the accident/injury or how you think it occurred: ____________________________

____

5. What makes the symptoms worse?
    ____sitting
    ____getting out of a chair
    ____getting out of bed
    ____turning in bed
    ____backing up the car
    ____looking down
    ____sneezing
    ____coughing
    ____having a bowel movement
    ____other- please specify:
    ____

6. How does the pain feel?
    ____sharp
    ____dull
    ____throbbing
    ____cramping
    ____burning
    ____numbness
    ____tingling
    ____weak or lame
    ____other – please specify:
    ____
    ____

7. Does the pain or symptom travel from one site to another?
____No ____Yes Explain:____
____

8. How much does it hurt? **0 1 2 3 4 5 6 7 8 9 10** (0=no pain 10=severe and incapacitating pain)

9. Does your pain change with activity? ____No____Yes
Explain:____
____

PLEASE CHECK THE FOLLOWING:

1. Have you ever had cancer? ____Yes ____No
2. Does your pain ever awaken you from a sound sleep? ____Yes ____No
3. Are you losing weight now, without trying? ____Yes ____No
4. Are you coughing up blood or noticing it in your stools or urine? ____Yes ____No
5. Have you had any loss of bladder or bowel control? ____Yes ____No
6. Have you lost consciousness or had double vision recently? ___Yes ____No
7. Do you have a pace maker? ____Yes ____No
8. Are you seeing any other doctor now for any reason? ____Yes ____No
   Specify:____
9. Do you have any other symptoms or health problems? ____Yes ____No
   Specify:____
10. Are you taking any medications or over the counter drugs now, (i.e. anti-coagulants)?
    ____Yes ____No List them:____
11. Do you have any food or drug allergies (i.e. shellfish)? ____Yes ____No
    List them:____

PAST TREATMENT HISTORY:
____
____
____
____
____
____

NEEDHAM CHIROPRACTIC ASSOCIATES
Patient Informed Consent

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopathic, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advance notice of any risks, and/or complications. Informed consent information regarding any risks does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient, in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery and does not diagnose internal and/or medical conditions.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited, inherent risks. These seldom occur; not enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risks. With chiropractic adjustments the risk may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome, or stroke. The chances of these risks occurring have been estimated by experts to be approximately 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks and you will be notified in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based upon the facts then known. I have also had the opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions and I acknowledge that no guarantee of cure has been made to me concerning results and treatment.

______________________________	______________________________	
Patient Name (printed)	**Patient Signature**	**Date**
______________________________	______________________________	
Patient/Guardian Signature (if minor)	**Staff/Witness Signature**	**Date**

FINANCIAL AND APPOINTMENT POLICIES

PAYMENT IS DUE AS SERVICES ARE RENDERED

We gladly accept Cash, Checks, Visa and MasterCard.

INSURANCE: Health care policies of insurance companies with whom this office participates will be verified. Verification is not a guarantee of coverage or payment. We will accept assignment as specified for your particular plan. **Patients are responsible for all deductible amounts, co-payments and non-covered services. It is the patient's responsibility to keep track of how many visits are allowed and used on their insurance.** For all other insurance companies patients are required to pay at the time of service.

INSURANCE PROVIDER: ____________________________POLICY #:_______________________
SUBSCRIBER:_______________________SUBSCRIBER DOB:________________________________

I understand that Needham Chiropractic Associates are not providers of my insurance plan _______________________________, and understand I am responsible for all charges. I may request a receipt that I can submit to my insurance for reimbursement.

MISSED APPOINTMENTS: Please try to notify our office as soon as possible of an appointment change so that we can accommodate your needs as well as the needs of other patients. Patients may be charged a missed appointment fee of $45.00 without same day notice prior to a scheduled visit. This charge is a patient's responsibility and cannot be billed to insurance.

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility, due and payable at the time services are rendered. If you have a flex spending or employer contribution account, we will provide you with receipt for reimbursement. Payment is due at the time of service.

_________________________________ _________________________________

Patient Signature **Date**

ASSIGNMENT OF BENEFITS:

I hereby authorize and direct Needham Chiropractic Associates, P.C. to release medical information necessary to process my insurance claims. I also authorize and direct my insurance carrier to pay all benefits, which may be due to me according to my policy, to Needham Chiropractic Associates, P.C.

_________________________________ _________________________________

Patient Signature **Date**