

Health First
CHIROPRACTIC CENTER

Chiropractic Health Questionnaire

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

ABOUT YOU

Name: _____ SS#: _____ Today's Date: ____ / ____ / ____
Address: _____ City: _____ State: _____ Zip: _____
What you prefer to be called: _____ Age: _____ Birthdate: ____ / ____ / ____ Male Female
Home Phone: _____ Marital Status: S M D W Spouse: _____
Handedness: _____ Height: _____ Weight: _____ Number of Children: _____
Employer: _____ Occupation: _____
Work Phone: _____ E-mail address: _____ Referred by: _____

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? Yes No If yes, please explain: _____

The reason for this visit is a result of: work sports auto trauma chronic other _____

Explain what happened: _____

What is your major complaint? _____

When did condition begin? ____ / ____ / ____ Have you had this or similar conditions in the past? Yes No

Is this condition getting worse? Yes No Constant Comes and Goes

Is this condition interfering with your: work sleep daily routine If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No If so, where? _____

Name and address of primary physician _____

INSURANCE INFO

Ins. Company Name: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Policy and Group #'s: _____ Insured's SS #: _____
Insured's Name: _____ Relation: _____
Date of Birth: ____ / ____ / ____ Insured's Employer: _____

Please Inform front desk of 2nd Insurance source.

HEALTH HISTORY

Are you currently taking any medication? Muscle Relaxants Blood Thinners Insulin Stimulants
 Tranquilizers Pain Killers Other(s) _____

Have you ever had any of the following diseases or medical conditions?

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Allergies
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> High/Low BP
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Ulcer / Colitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Emotional Disorders	<input type="checkbox"/> Bone Fracture	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> HIV +	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> STD's	<input type="checkbox"/> Joint Pain

Please list any other notable conditions that you had / have _____

Family history of any of the previous or other? Yes (please note _____) No

What are your habits?

Smoking	<input type="checkbox"/> Never	<input type="checkbox"/> Occ	<input type="checkbox"/> Moderately	<input type="checkbox"/> Excessively
Alcohol	<input type="checkbox"/> Never	<input type="checkbox"/> Occ	<input type="checkbox"/> Moderately	<input type="checkbox"/> Excessively
Recreational Drugs	<input type="checkbox"/> Never	<input type="checkbox"/> Occ	<input type="checkbox"/> Moderately	<input type="checkbox"/> Excessively
Exercise	<input type="checkbox"/> Never	<input type="checkbox"/> Occ	<input type="checkbox"/> Moderately	<input type="checkbox"/> Excessively

List any previous surgeries/hospitalizations and dates _____

List any past serious accidents and dates _____

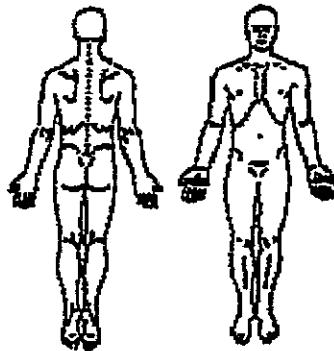
Are you wearing any: Heel lifts Inner soles Arch Supports What is the age of your mattress? _____

For Women: Are you taking birth control? Yes No Are you pregnant? Yes (How many mo. _____) No

Date of your last period? _____ Are you under the regular care of an OB/GYN? Yes No

CURRENT COMPLAINTS

Please mark the location of your pain on the following

**PAYMENT**

I will be paying today by:

Cash Check Credit Card

MasterCard Visa Discover AMEX

Acct. No. _____

Exp. Date _____

_____ (initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process any insurance claims.
- I understand and agree that health and accident 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 collection from the insurance company, and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____ / _____ / _____

Guardian or Spouse's Signature _____ Date _____ / _____ / _____

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468 HURFFVILLE - CROSS KEYS ROAD
SEWELL, NJ 08080

Medication List

Health First
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Assignment of Benefits Agreement

I hereby authorize my insurance company to make payment of medical benefits to Health First Chiropractic Center for medical services rendered to me. I also authorize the release of any medical or other information necessary to process this claim.

Signature _____ Date _____ / _____ / _____

MEDICARE PATIENTS

I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits either to myself or to Health First Chiropractic Center.

Signature _____ Date _____ / _____ / _____

Health First
CHIROPRACTIC CENTER

Medical Records Release

Date ____/____/____

To: _____

You are hereby requested and authorized to disclose, make available and furnish all information, records, x-rays, reports or copies thereof relating to my examination, consultation, confinement or treatment to:

Dr. Theodora C. Caraway
Health First Chiropractic Center, L
468 Hurfville - Cross Keys Road
Sewell, NJ 08080

And permit him to inspect and make copies or abstracts thereof.

Patient's Signature _____

Date _____

Patient's Name (please print) _____

Date(s) of Treatment: _____

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SEWELL, NJ 08080

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4-14-2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.25 for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Theodora C. Caraway, DC

Telephone: 856-218-2677

Fax: 856-218-2679

E-mail:

Address: 468 Hurffville-Cross Keys Road, Suite # 3, Sewell, NJ 08080

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment, activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue revised Notice Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting

Contact Person: Theodora C. Caraway, DC
Telephone: 856-218-2677 Fax 856-218-2679
Address: 468 Hurffville-Cross Keys Road, Suite # 3, Sewell, NJ 08080

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, Have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart

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Appointment Cancellation – No-Show Policy

Effective January 1, 2022

Thank you for trusting your chiropractic care to Health First Chiropractic Center, our job is to help you reach your goals and achieve your maximum potential in chiropractic treatment. In order for us to help you reach your goals when you schedule an appointment with Health First Chiropractic, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than **12 hours** prior to your scheduled appointment. This gives us time to schedule other patients who may be in pain and waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least **12 hours** notice will be considered a No Show and charged a **\$25.00** fee. This applies to **Healthcare, Self-pay and Personal Injury Patients** alike. If you are a Personal Injury Patient be aware that your attorney will be notified of all missed appointments, and repeated cancellations/no-shows without reschedules may result in termination of all treatment by your insurance carrier.
- Any established patient who fails to show or cancels/reschedules an appointment without **12 hours** notice a **second time** will be charged a **\$35.00** fee.
- Any established patient who fails to show or cancels/reschedules an appointment without **12 hours** notice a **third time** will be charged a **\$50** fee and may be dismissed from care.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, we provide reminder text messaging for appointments, however, this is just a courtesy, you are responsible for the appointment you have scheduled. Our office is not responsible for "glitches"/failures in software or communications. If you do not receive a reminder text message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office and we may be able to waive the No Show fee.

Show fee. You may contact Health First Chiropractic Center 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Thursday, or a weekend you may leave a message. Thank you for trusting your healthcare to Health First Chiropractic

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Patient Signature _____ Date _____

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DR. THEODORA C. CARAWAY

856.218.2677
856.218.2679