FLEETWOOD CHIROPRACTIC & WELLNESS CENTER P.C.

8520 Allentown Pike #7, Blandon, PA 19510
(610) 916-2425

PATIENT REGISTRATION

NAME____

ADDRESS____

CITY__________________________ STATE_____ ZIP____________

DOB_________________ Age________ MARITAL STATUS__________

SS #__________________________ GENDER______________

Cell #________________________ Home #__________________

Work #________________________

Email____

If under 18 years old

GUARDIAN'S NAME_______________________________________

ADDRESS____

CITY__________________________ STATE_______ZIP____________

DOB_______________ Email ______________________________

INSURANCE PRIMARY_______________________________________
ID#__________________________ Group#____________________
Guarantor____________________ DOB ______________________
INSURANCE SECONDARY ____________________________________
ID#__________________________ Group# ____________________
Guarantor____________________ DOB ______________________

****Please present insurance card(s) and Photo ID to front desk person to copy for your file.**

Correspondence Consent: Detailed message on Phone____ Text ____ Email ____

How did you hear about us? _______________________________________

PRIVACY: Is there anyone who we can share your medical information with? If so, please list here:

Name	Phone#	Relationship

*****PLEASE PROVIDE YOUR PRIMARY CARE PHYSICIAN INFORMATION:**

PHYSICIAN'S NAME: _______________________________________

ADDRESS: _______________________________________

OFFICE TELEPHONE NUMBER: _______________________________________

NAME____ DATE_________________

Current Complaints/ Symptoms	**Complaint/ Symptom Associated with:** (e.g., accident, injury, medical condition, unknown) **Please Specify**	**Pain or discomfort Level:**	**Times or Situations at/in which pain is at its worst** (e.g., am., pm., during sleep, with activity, sitting, standing,)	**Areas of life impacted by Pain/Discomfort** (e.g., work, sleep, daily routine, recreation, exercise)
1.		0 1 2 3 4 5 6 7 8 9 10		
2.		0 1 2 3 4 5 6 7 8 9 10		
3.		0 1 2 3 4 5 6 7 8 9 10		

Are you Currently Pregnant? ____ Yes ____ No

If yes, Due Date______________ Any Complications? ________________________________

******List all Medications you are currently taking; or, you may provide a list to be copied – List to be signed and dated.**

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NAME____ DATE_________________

Your Medical History (check all that apply)

	No Medical Problems		Peripheral Vascular Disease
	DEXA scan or bone density scan		Hiatal Hernia/ Reflux Disease
	History of MRSA		Peptic Ulcer Disease
	Claustrophobic or fearful of enclosed spaces		Diverticulitis
	Diabetes, Insulin-Requiring		Urinary Tract Infections
	Diabetes, Non-Insulin Dependent		Kidney Disease
	Bleeding Disorder		High Cholesterol
	Pulmonary Embolism (Blood Clot- Lung)		Osteoporosis
	Deep Vein Thrombosis (Blood Clot- Leg)		Fibromyalgia
	Thyroid Disease		Seizure Disorder
	HIV or AIDS		Gout
	Leukemia or Lymphoma		Osteoarthritis
	Organ Transplant		Rheumatoid Disease
	Migraine Headaches		Cancer
	Heart Arrhythmia		Hepatitis
	Pacemaker		Liver Disease
	Heart Murmur		Psoriasis or other Skin Disease
	Stroke or Mini- Stroke		Poliomyelitis
	High Blood Pressure		Anxiety Disorder
	Asthma		Depression
	Emphysema or COPD		Alcoholism or Drug Addiction
	Pneumonia		Psychiatric Disorder
	Tuberculosis		Glaucoma
	Sexually Transmitted Disease		Eating Disorder
	Multiple Sclerosis		Parkinson's Disease
	Dementia (such as Alzheimer's Disease)		Prosthesis

Height______________________________ **Weight**______________________

Allergies: Please list all meds, metals, dyes, latex, or food

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Occupational History;

__retired __working __unemployed __ homemaker __ paid leave __ unpaid leave __ disabled

Employer____

Occupation____**# of years**______________

If not working previous occupation ________________________________**# of years**______________

NAME______________________________________ **DATE**________________

Family History

	No Medical Problems		Peripheral Vascular Disease
	Asthma		Heart Disease
	Back Problems		High Blood Pressure
	Cancer		Diabetes
	Other: list		

	Your Surgical History		Date and Details
	No Previous Surgeries		
	Fracture without Surgery		
	Joint Replacement(s)		
	Fracture with Surgery		
	Shoulder Surgery		
	Hand Surgery		
	Spine Surgery		
	Total Hip Arthroplasty		
	Total Knee Arthroplasty		
	General Surgery		
	Appendectomy		
	C-Section		
	Gallbladder		
	Hernia Repair		
	Tonsillectomy/Adenoidectomy		
	Wisdom Teeth Extraction		
	Other		

Social History

	Marital Status		
	Number of Children		
	Tobacco use		
	Nicotine Vapor use		
	Alcohol use		
	Steroids		
	Caffeine		
	Recreational Drugs		
	Exercise		

****Please list any other medical information/conditions not listed in paperwork:**

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Fleetwood Chiropractic & Rehabilitation Center
8520 Allentown Pike, Suite #7
Blandon, PA 19510
Phone: 610-916-2425 Fax: 610-916-2431

OUR OFFICE POLICY

Thank you for choosing Fleetwood Chiropractic and Rehabilitation Center for your treatment. We are committed to providing you with the best possible care. If we cannot treat your condition, we will be sure to refer you to the proper physician. We believe that a clear definition of our office policies will allow both you, the patient, and the doctor, to concentrate on the more important issue – you regaining and maintaining your health.

Appointment Policy:

Multiple appointments may be recommended for your convenience, to minimize waiting, and to facilitate incorporating these appointments into your daily routine. Please arrive on time or call if you will be late. It is rare to wait over 15 minutes before your treatment begins.

Successful treatment of musculo-skeletal conditions is dependent upon your adherence to the recommended treatment plan. We request 24 hour notice for cancellation of any appointment. You must provide 24 hour cancellation notice for any massage appointments as well, lest you will be charged for the service.

If you have any questions, please feel free to ask the staff.

Financial Policy:

All services rendered are charged directly to you, the patient, and you are ultimately personally responsible for all payments, regardless of whether or not this office accepts your current insurance policy.

***Cash Patients**: All payments are expected at the time of service, or professional care will be terminated. We accept Cash or Credit Card payments.*

***Insured Patients**: Deductibles and coinsurance payments are expected at the time of service, or professional care will be terminated. The majority of your financial responsibility is typically greatest in the early stages of care. We accept cash and credit card payments. Please refer to our office manager/receptionist to discuss your questions.*

Missed appointments without a courtesy call may be charged a $30 fee.

We will submit claims to your primary insurance carrier, and attempt to contact your insurance company in order to get your claim processed. However, any insurance balances that are not paid within 120 days of claims submission will become patient responsibility.

Insurance Assignment/Financial Policy:

It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses, as your insurance company processes your claims.

The privilege of Insurance Assignment begins when you bring in your insurance information, we verify your insurance coverage, and you sign this form. Until then, you are considered a cash patient.

Please take time to consider, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR." "UCR" is an acronym for usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4. If your health insurance sends you the payment, you are required to remit the payment and all included paperwork to Fleetwood Chiropractic and Rehabilitation Center immediately. In some states, spending the money paid for a medical debt is a crime. Please be aware that if this payment is not immediately given to our office, legal action will unfortunately be implemented.

5. Deductible payments must be made prior to insurance submittal.

If your insurance company requires a referral, it is your responsibility to provide us with one. If a referral is not provided and you choose to receive care, you will be billed for this service.

Coinsurance payments are payable when service is rendered. Coinsurance is that part of our service that is not paid for by your insurance, and is your responsibility.

Our office will qualify your insurance coverage in an effort to help you determine what chiropractic coverage is available under your insurance plan. If you have questions regarding your coverage, please feel free to speak to our office manager. She will gladly provide you with the information we received from your insurance company. We typically have this information on the visit after you provide your insurance information. You must ask the staff to explain our coverage and responsibilities to you. However, you are required to call your insurance company and confirm this coverage. You should fully understand your benefits and your financial responsibilities to this office.

This office does not file for or accept coinsurance for secondary insurance carriers, but we will be happy to assist you in providing the necessary information.

We do not own your policy. We may experience difficulty in collecting from your insurance company. Since insurance assignment is a privilege, it may be terminated at any time. We ask that you act on your own behalf with your insurance company, to get the claims paid.

Patients whose visitation schedule is once per month or longer will no longer be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to assist you in providing the necessary information so you can be reimbursed.

This office does not guarantee that any insurance company will pay for the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement.

The adult accompanying a minor patient, be it the parent or guardian, is responsible for full payment. Parental consent is required in all cases, or treatment will be denied.

Should you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claims submitted.

If you are involved in litigation regarding your case (i.e. motor vehicle accident/liability case) you must sign this form as a letter of protection. This assigns payment to us when your case settles and prior to disbursement of any funds. Please keep a copy of this form and please forward a copy to your attorney.

When making a healthcare decision, it is important to remember that you, the patient, are ultimately financially responsible for any services rendered.

It is the goal of this office to provide you with the finest quality chiropractic care and rehabilitation available. We will incorporate the best of chiropractic and sports medicine/rehabilitation into your treatment plan. Unfortunately, many spinal conditions can be chronic. Optimum results are achieved when the patient follows our instructions, and continues the rehabilitation/exercise program after leaving our office. This is the best way to prevent your condition from returning and requiring more care in our office. Our goal is to help teach you to manage your condition on your own. We welcome your questions regarding your health care or any of our policies. We welcome your questions regarding your health care or any of our policies. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefits. We have built our practice by providing the best quality of care available. We do not solicit anyone. Our patients come from your referrals and from other physicians. We look forward to a caring, trusting doctor/patient relationship, and your return to a healthy, happy, pain-free lifestyle.

By signing below you agree that you have read and understand this Office Policy, submitting to all terms mentioned above. Thank you for your cooperation.

____

Signature of patient or responsibly party

____

Print name

____

Date

Fleetwood Chiropractic & Wellness Center, PC
8520 Allentown Pike, Suite #7
Blandon, PA 19510
PH# 610-916-2425 - FX# 610-916-2431

UPDATED HIPPA INFORMATION – EFFECTIVE IMMEDIATELY

We may disclose Health Information to our business associates that perform functions on our behalf. We may use other companies to perform billing and collection services on our behalf. Our business associates, including collection agencies, may disclose necessary Health Information to their vendors and business associates including but not limited to, third party mailing companies. All vendors and business associates are obligated to protect the privacy of your information.

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Patient Acknowledgment

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

____

Patient Signature

Date ______ / ______ / ______

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information is Important to Us

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.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Is your condition today related to:

- ☐ Motor Vehicle Accident
- ☐ Workers Compensation
- ☐ Personal Injury Case
- ☐ None of the Above

**Name____

**DOB______________________

Date of Injury________________ State MVA occurred__________

Insurance Information

Insurance Name____

Address____

Claims Address____

Contact Name____

Phone number____

Claim #____

Is your claim open and compensable? ________________________

Please be advised we will bill to your insurance company on your behalf for all treatments and services rendered at Fleetwood Chiropractic and Wellness Center, P.C. **You are responsible for all fees, including amounts not covered by your insurance.

**Signature__________________________ Date_____________