A Therapeutic Effect

Personal Data

Patient's Name: ______________________ Today's Date: ______________________

Address: ______________________

______________________ Phone Number: daytime ______________________

email: ______________________ evening ______________________

Date of Birth: ____ / ____ / ____ (month / day / year)

Sex: ☐ Male ☐ Female

Occupation: ______________________ Referred by: ______________________

Emergency Contact: ______________________ Phone Number: daytime ______________________

Relationship: ______________________ evening ______________________

Are you currently under a Physician's care? Yes No

If yes, please explain: ______________________

Please list any past or present injuries, accidents, or medical treatment including surgeries:

____

____

Are you pregnant? Yes No ***If yes, some services may not be administered.***

Please list all known allergies: ______________________

Please list all medications and supplements you are taking: ______________________

____

CANCELLATION POLICY

If you are unable to keep your appointment - for any reason - please give us as much notice as possible. For appointments broken with less than 12 hours notice, we reserve the right to charge 50% of the standard fee. Appointments that no show will be charged in full to cover the therapist's time.

Chiropractic New Client Information **Client Name:** ____________________

What is your main complaint: ____________________

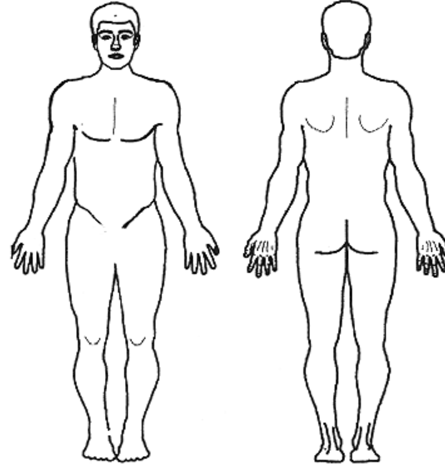
Date symptoms began: __________ **How symptoms began:** ____________________

Do you have: (please circle) Headaches Neck pain Mid-back pain Low back pain

Other (describe) ____________________

Is this: Work Related Auto Related N/A

Mark an X on the picture where you have pain or other symptoms



How do you feel today:

1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

- ☐ 0-25% (Intermittent)
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores?

1 2 3 4 5 6 7 8 9 10

No interference Unable to carry on any activities

Have you had spinal x-rays, MRI, CT Scan for your area(s) of complaint? Yes No

If yes, date(s) taken: __________ What areas were taken? neck mid back low back

Please circle all of the following that apply to you:

Recent Fever	Prostate Problems	Diabetes	Prescription birth control
High Blood Pressure	Urinary Problems	Pain at Night	Pain Unrelieved by Position or Rest
Abnormal Weight Gain	Abnormal Weight Loss	Epilepsy/Seizures	Marked Morning Pain/Stiffness
Dizziness/Fainting	Menstrual Problems	Osteoporosis	Numbness in Groin/Buttocks
Visual Disturbances	Stroke (date) __________	Corticosteroid Use (corisone, prednisone, etc.)	

Cancer / Tumor (please explain) ____________________ Currently Pregnant, # of weeks __________

Surgeries (explain) ____________________

Medications ____________________

Other Health Problems (explain) ____________________

Family History (please circle) Cancer Diabetes High Blood Pressure Rheumatoid Arthritis Heart Problems/Stroke

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendred and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ____________________ Date: __________

A Therapeutic Effect

Responsible Party Form

I ______________________________ give A Therapeutic Effect permission to bill my insurance(s).
print name

I ______________________________ will be responsible for any outstanding balance.
print name

Signature ____

Date ____

While we participate with most major insurance companies, individual insurance coverage and plans vary greatly. Until our office contacts your insurance company to verify coverage, we cannot guarantee that your services will be covered by your insurance. Please let us know if you have any questions or concerns. Thank you!

Medical Insurance Information

Primary Insurance: ______________________________

Name of Insurance: ______________________________

Policy or ID #: ______________________________ Group #: ______________

Claims Mailing Address: ______________________________ Phone Number: ______________
(on back of card)
____

Subscriber Name: ______________________________ Date of Birth: ______________
First Middle Last

SSN (optional): ______________

Relationship to Subscriber: Mother Father Spouse Child

Secondary Insurance: YES NO

Name of Insurance: ______________________________

Policy or ID # ______________________________ Group # ______________

Claims Mailing Address: ______________________________ Phone Number: ______________
(on back of card)
____
____

Subscriber Name: ______________________________ Date of Birth: ______________
First Middle Last

SSN (optional): ______________

Relationship to Subscriber: Mother Father Spouse Child

****** You will be contacted by our billing manager if you do not have this information with you******

Patient consent form

A Therapeutic Effect

Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for **A Therapeutic Effect** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **A Therapeutic Effect** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

A Therapeutic Effect reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **A Therapeutic Effect 313D Primrose Lane, Mountville, Pa 17554 (717) 285.9955.**

With this consent, **A Therapeutic Effect** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **A Therapeutic Effect** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, **A Therapeutic Effect** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **A Therapeutic Effect** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **A Therapeutic Effect** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **A Therapeutic Effect** may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

____

Print Patient’ Date

____

Print Name of Patient or Legal Guardian, if applicable

HIPPA Authorization form

A Therapeutic Effect

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **A Therapeutic Effect** to use and/or disclose certain protected health information (PHI) about me to _________________________.

This authorization permits **A Therapeutic Effect** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose: ______________________

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire ONE year to the date of authorization.

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **A Therapeutic Effect**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: **A Therapeutic Effect**

Signed by:

_______________________________ Signature of Patient or Legal Guardian

_______________________ Relationship to Patient

_______________________________ Print Patient's Name

_______________________ Date

_______________________________ Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.