Patient Intake Information

Date: _____

_____ _____ _____ DOB: _____ Age

(Legal) First Name (Legal) MI (Legal) Last Name

Street _____ Apt. _____

City _____ State _____ Zip _____

Social Security #: _____ Marital Status: / / S / / M / / W / / D Spouse: _____

Language: _____English _____Spanish _____Indian _____Japanese _____Chinese _____Korean _____French _____German

_____Russian Other _____

Race/Ethnicity: _____White _____American Indian or Alaska Native _____Asian _____Native Hawaiian/Other Pacific Islander

_____Black or African American _____Hispanic or Latino _____Decline to Answer

Contact Info: Home Ph: _____ Work Ph: _____ Cell Ph: _____

Cell Carrier: _____ Email Hm: _____

Email Wk: _____

Contact Preference: ___Home Ph ___Work Ph ___Cell Ph ___Email Hm ___Email Wk ___Postal Mail

Emergency Contact: _____ Phone: _____

Who referred you to our office? _____ Phone: _____

Occupation: _____ Employer: _____

Employer Address: _____ _____ _____ _____

City Street State Zip

Insurance Information: *A copy of your insurance card[s] will be made. in addition, please complete the information requested below:*

Are you the policy holder? / / Y / / N If No, who is? ____Spouse ____Parent ____Employer Other _____

_____ _____ _____ DOB: _____

Policy Holder's First Name MI Last Name

Policy Holder's Social Security #: _____

Policy Holder's Employer: _____

Do you have secondary insurance? / / Y / / N If yes, please complete the following:

_____ _____ _____ DOB: _____

Policy Holder's First Name MI Last Name

Policy Holder's Social Security #: _____

Policy Holder's Employer: _____

Date: _____

First Name MI Last Name

Patient History

Please give a brief description of the problem[s] you are experiencing:

_____

_____

_____

Is/Are the problem[s] getting better? / / Y / / N or getting worse? / / Y / / N When did the problem[s] start? _____

_____

What appears to be the initial cause? _____

_____

Are you seeing any other providers for other problems or health conditions? / / Y / / N

Please list the problem[s], date problem[s] began and Provider[s] treating you for the condition[s]:

_____

_____

_____

Past History

Have you --- If yes, please list the date and the name of the treating provider.

ever been diagnosed with hypertension? / / Y / / N _____

been hospitalized in the last 5 years? / / Y / / N _____

been diagnosed with Diabetes? / / Y / / N _____

Type I_____Type II_____

Do you smoke? ____Never ____Former Smoker ____Current/Every Day Smoker ____Current Some Day[s] Smoker

Vitals (for office use only) Height _____ Weight _____ Blood Pressure _____

Medications

What medications are you currently taking? Please inclulde all non-prescription and over the counter vitamins, herbs, minerals, etc.:

List Date Started, Brand Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by:

Please be as specific as possible.

_____

_____

_____

_____

_____

Do you have allergies? / / Food / / Environmental / / Medication

List Type of Allergy and Reaction[s]

_____

_____

_____

Signature: _____

Thank you for your cooperation!

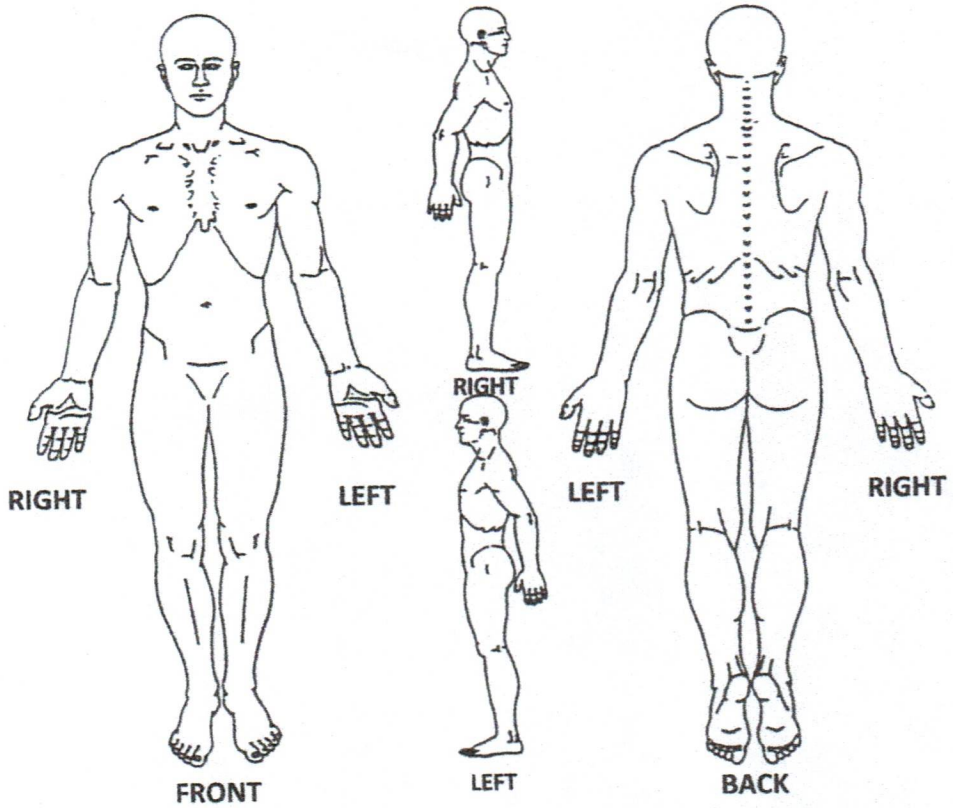
William DeMio, DC
1037 Preakness Ave.
Wayne, NJ 07470
Phone: (973)-595-8969
www.thehealthandwellnesscenter.net

Name: _____ Date: _____

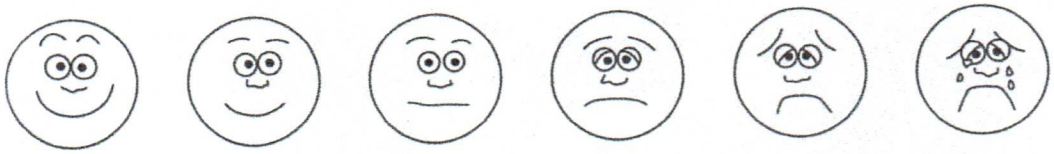
Please indicate the type and area of your pain on the drawings below, by using the abbreviations provided:

D = Dull Pain T = Tingling B = Burning

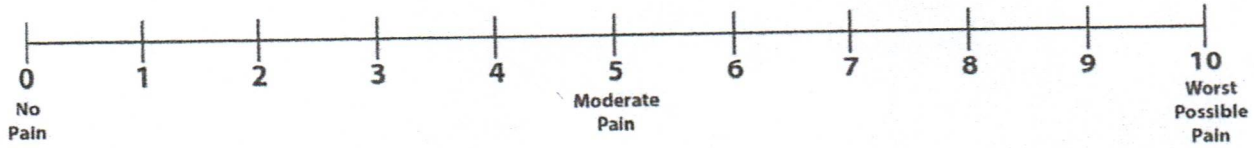
N = Numbness P = Sharp Pain S = Stiffness



Please check the face that most accurately depicts your pain.



Please give a numeric value to your pain on the pain scale below.



The HEALTH AND WELLNESS Center

Consent for Treatment

I, the undersigned, hereby authorize the providers of The Health and Wellness Center, LLC, to provide chiropractic treatment including procedures such as examination, diagnostic x-rays, spinal/extra-spinal adjustments and various ancillary modalities such as electronic muscle stimulation (EMS), cold-laser therapy, ultrasound and spinal traction. As with any other health care procedure, complications are possible following an adjustment, which may include muscular or ligamentous soreness. The risks of complication due to chiropractic treatment have been studied and determined to be rare; less than the complications that are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even future reduced by screening and examination procedures.

The probability of adverse reactions due to ancillary procedures is also described as "rare". Other treatment options which you may consider instead, include, over-the-counter and prescription medications, injections, or surgery, which may all include a multitude of side effects to the stomach, liver and kidney organs. The risks to remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. This may complicate treatment making it less effective the longer it is postponed.

I understand the importance of informing the doctor in writing about any new factors which may change or affect the treatment of my condition. I have had the opportunity to discuss with the doctor the nature of my condition, the intended result of proposed treatment and the risks of chiropractic adjustments and other recommended procedures. I also understand and agree to accept my responsibilities as a patient seeking care, understanding that results are not guaranteed. ***By signing below, I state that I have read the explanation of treatment in and outside of The Health and Wellness Center, LLC.***

I have decided that it is in my best interest to undergo the course of chiropractic care recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment/care. I, the undersigned understand that I am responsible for payment for services received, including any balances not covered if using a medical insurance plan to pay a portion of your care depending on benefits of the policy.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Patient/Guardian(print): _____ Doctor's Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

HIPPA FORM

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During your care a patient at The Health and Wellness Center, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment, including electronic health records (EHR).
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they are responsible for the payment of your services.
- Your name, address, phone number, email, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.
Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic treatment from us. We may also mail information to you regarding your health care or the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form please advise us in writing.

You have the right to inspect and/or copy your health information for seven years from the date that the information was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your healthy related information should be provided to us in writing.

_____

Patients Name Date

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

The Health and Wellness Center also utilizes other forms of communication, which you may have the right to refuse including:

- (EHR) Electronic Health Records
- Healthy e-mail topics
- Birthday e-mails
- Treatment information in our wellness semi-open area

This notice is effective as of May 1, 2024. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____

Patients Name (Printed Please) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____

Personal Representative (Printed) Personal Representative (Signature)

_____

Date

_____

Description of the authority to act on behalf of the patient

The HEALTH AND WELLNESS Center

Financial Policy

Please review our financial policy *thoroughly*.
We want you to know what to expect before you receive care, so that we may move comfortably forward and focus on what is most important –YOUR HEALTH.

Horizon Policies

We are a participating provider in the Horizon Traditional and Managed Care networks.
All co-payments and deductibles are payable at time of service.
Computerized re-scans are not covered and are $30.

Medicare

Our office is a participating provider with Medicare.
Chiropractic adjustments are usually covered for acute care, but therapy, x-rays, and exams are not. Medicare will not cover maintenance or preventative services. Medicare requires that all patients sign specific forms (i.e. ABN, NEMB). Medicare requires us to collect annual deductibles if not covered by a secondary policy. Medicare allows 18-30 visits depending on your condition.
Computerized re-scans are not covered and are $30.

Major Medical Policies: Aetna/Cigna/United Healthcare/Oxford/Health Net…

We are an out-of-network provider with these companies. Payment is due at the time of service. Payments from your insurance carrier will be reimbursed to you upon satisfaction of your policy's deductible. Reimbursement on these policies can vary in coverage and cannot be guaranteed. Our office will provide completed forms and the guidance necessary to enable you to receive reimbursement from your insurance company.

All Patients

Should you interrupt or discontinue your care all balances are immediately due. You are financially responsible for any services rendered.
All expenses incurred involving a collection agency is the patient's responsibility, *including an additional 30% fee.*

Missed Appointments

Missed appointments will incur a $20.00 charge.
No charge will be made if 24 hrs. notice is given for missed appointments.

Returned Checks

A handling fee of $20.00 will be charged on any returned checks.

Patient/Parent/Guardian(print): _____

Signature: _____ Date:_____