

Confidential Patient Health Record Cedar Chiropractic, 77 West Main St.,Hopk.,MA

Today's Date: / /

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan Website: _____

Personal Information

Last: _____ First: _____ Middle: _____

Birth Date: / / Age: Sex: M / F SSN: _____ Marital Status: S M W D

Height _____ Weight _____ R L Handed Glasses Contact Lenses

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ ext _____ Work Phone: (_____) _____ - _____ ext _____

Cell Phone: (_____) _____ - _____ ext _____ Email Address: _____

Spouses Name: _____ Children (Names and Ages): _____

Emergency Contact

Last: _____ First: _____ Relationship: Spouse Relative Friend Other

PRIMARY CARE PHYSICIAN: _____

Home Phone: (_____) _____ - _____ ext _____ Cell Phone: (_____) _____ - _____ ext _____

Work Phone: (_____) _____ - _____ ext _____

Employment Information

Business Name: _____

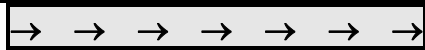
Phone: (_____) _____ - _____ Fax #: (_____) _____ - _____

Occupation/Job Title/Description: _____

Current Health Condition

Unwanted Condition (Why are you here today?) _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing

When did this Condition BEGIN? / /

Has it ever occurred before? Yes No. When? _____

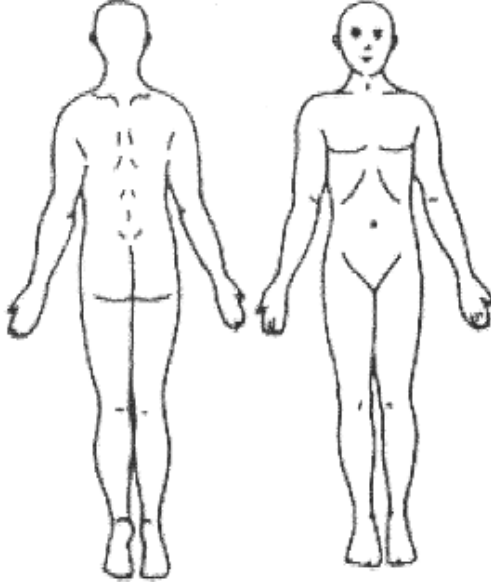
Is the Condition: Auto Related Job Related Home Injury
 Slip or Fall Lifting Slept Wrong Unknown Cause Other

Explain: _____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you have any other health concerns? _____



Patient Name: _____

Date: _____

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: I DENY having or have had any of the symptoms or problems listed below.

- chills fatigue night sweats weight loss
- daytime drowsiness fever weight gain

Eyes/Vision: I DENY having any of the symptoms or problems listed below.

- spots change in vision trauma photophobia
- blurred vision double vision glaucoma tearing
- cataracts eye pain itching wear glasses/contacts

Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

- bleeding ear drainage hearing loss nosebleeds sore throat
- dentures ear pain history of head injury postnasal drip TMJ problems
- difficulty swallowing fainting hoarseness rhinorrhea tinnitus
(runny nose) (ringing in ears)
- discharge frequent sore throat loss of sense of smell sinus infections
- dizziness headaches nasal congestion snoring

Respiration: I DENY having any of the symptoms or problems listed below.

- asthma coughing up blood sputum production
- cough shortness of breath wheezing

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- angina (chest pain or discomfort) high blood pressure low blood pressure
- chest pain heart problems swelling of legs
- claudication (leg pain/ache) orthopnea (difficulty breathing lying down) ulcers
- heart murmur palpitations varicose veins
- shortness of breath with exertion or exercise paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

- abdominal pain diarrhea indigestion vomiting blood
- belching difficulty swallowing jaundice abnormal stool color
- black - tarry stools heartburn nausea abnormal stool consistency
- constipation hemorrhoids rectal bleeding vomiting

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

- birth control cramps irregular menstruation vaginal bleeding
- breast lumps/pain frequent urination pregnancy vaginal discharge
- burning urination hormone therapy urine retention

Male: I DENY having any of the symptoms or problems listed below.

- burning urination frequent urination prostate problems
- erectile dysfunction hesitancy urine retention

Endocrine: I DENY having any of the symptoms or problems listed below.

- cold/heat intolerance excessive hunger or thirst goiter unusual hair growth
- diabetes frequent urination hair loss loss/change in appetite

Patient Name: _____

Date: _____

Skin: I DENY having any of the symptoms or problems listed below.

- changes in nail texture hair loss itching skin lesions / ulcers
- changes in skin color hives tingling varicosities
- hair growth history of skin disorders rash

Nervous System: I DENY having any of the symptoms or problems listed below.

- dizziness limb weakness numbness slurred speech tremor
- facial weakness loss of consciousness seizure/convulsions stress unsteadiness of gait
- headache loss of memory sleep disturbance strokes loss of balance

Psychologic: I DENY having any of the symptoms or problems listed below.

- anxiety behavioral change depression memory loss
- confusion bi-polar disorder insomnia mood change

Allergy: I DENY having any of the symptoms or problems listed below.

- anaphylaxis itching chronic nasal congestion sneezing
- food intolerance acute nasal congestion rash

Hematologic: I DENY having any of the symptoms or problems listed below.

- anemia blood clotting bruising easily lymph node swelling
- bleeding blood transfusion fatigue

PAST HEALTH HISTORY

Previous Care for Same Condition: I have not seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Was the treatment beneficial in resolving condition? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- AD/HD chicken pox headaches scoliosis
- eczema Crohn's hepatitis seizure disorder
- allergies depression HIV sickle cell anemia
- anemia diabetes measles spina bifida
- asthma ear infections mumps Lyme Disease
- bedwetting fetal drug exposure psoriasis cerebral palsy
- other: _____

Patient Name: _____

Date: _____

Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.

- AD/HD kidney disease hypertension vertigo
- Alzheimer's neurological condition pneumonia scoliosis
- anemia diabetes liver disease seizures
- arthritis heart disease lung disease shingles/chicken pox
- asthma eczema fibromyalgia Rheumatoid /Inflammatory Arthritis
- cancer emphysema lupus erythema Gout
- Crohn's/colitis CVA (stroke) multiple sclerosis thyroid problems
- Lyme Disease Collagen/Vascular Parkinson's disease pneumonia

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? yes or no.

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- angioplasty cosmetic hysterectomy pacemaker insertion
- appendectomy D & C joint reconstruction rotator cuff
- caesarian section dental surgery joint replacement spinal fusion
- cardiac gall bladder knee repair tonsillectomy
- carpal tunnel repair hemorrhoidectomy laminectomy other:
- cardiac bypass hernia repair mastectomy

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- back injury head injury motor vehicle accident
- fracture concussion fall (severe)
- disability industrial accident joint injury

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

- | | | | | | |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| general family | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| father | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| mother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| son (s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| daughter(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| brother(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |
| sister(s) | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has/had: _____ |

Social History

- Alcohol: Never Social Consumption only Frequent
- Diet (please mark all that apply): High Fat High Fiber High Protein High Salt High Sugar
- Low Calorie Low Carb Low Fiber Low Salt Low Sugar
- Education: (please mark the highest level completed): High School Assoc/Technical College Graduate Doctorate
- Drugs: Deny any illegal drug use Deny use of IV drugs Have not used drugs since _____
- Tobacco: Deny Tobacco Use Live with a smoker Quit smoking Chew
- Smoke; # _____ per Day Week Month

Insurance Information:

- Who Is Responsible For Your Bill? YOU and... (mark appropriate box(es)) Myself ONLY**
- Spouse Worker's Comp Auto Insurance Medicare Medicaid Private Self-pay
- Personal Health Insurance Carrier:** _____ **Health ID Card #:** _____
- Policy Holder's Name:** _____ **Group #:** _____
- Policy Holder's Date of Birth:** _____ - _____ - _____

Patient Name: _____

Date: _____

Cedar Chiropractic

77 West Main Street, Suite 211 - Hopkinton, MA 01748

p. (508)435-8182 f. (508) 435-8183

Procedure Request and Authorization to Release Medical Records

DATE: _____

TO: _____

RE: _____

D/O/B: _____

CLINICAL INFORMATION: _____

PROCEDURE REQUESTED:

_____ X-Ray with report:

_____ Standing Cervical (AP/Lateral/APOM/Flexion/Extension/Obliques)

_____ Standing Thoracic (AP/Lateral)

_____ Standing Lumbar (AP/Lateral/Obliques/Flexion/Extension)

_____ Other _____

_____ MRI/CT scan:

Please send copies of my medical records including but not limited to diagnostic reports to Cedar Chiropractic PC

Patient's Signature: _____

Witness: _____

Patient Name: _____

Date: _____

Cedar Chiropractic 77 West Main Street, Suite 211 • Hopkinton, MA 01748 p(508)435-8182

ASSIGNMENT of BENEFITS/DIRECTION of PAYMENT/FINANCIAL POLICY

- 1. I hereby authorize and direct Cedar Chiropractic, and all its agents, to release all protected health and medical information necessary to process my claims, as outlined in my *Patient Bill of Rights for Protected Health Information*.
- 2. I hereby authorize and direct my insurance carrier to pay all benefits, which may be due to me under my policy, directly to Cedar Chiropractic.
- 3. I hereby give a lien to Cedar Chiropractic on any settlement, claim, judgment, or verdict as a result of said accident, and authorize and direct my insurance carrier or attorney to pay directly to Cedar Chiropractic such sums as may be due and owed to Cedar Chiropractic for services rendered to me, and to withhold such sums from any Personal Injury Protection, Med-Pay, or 3rd Party payments and/or any settlement, claim, judgment, or verdict as may be necessary to protect Cedar Chiropractic adequately.
- 4. I hereby authorize Cedar Chiropractic my permission to have on file a copy of my credit card. In the event that they will need to utilize this card, I understand they will notify me via phone or mail, that this transaction(s) occurred to settle any/all unpaid patient balances.
- 5. Effective January 1, 2009, patients will now be responsible for any non-covered chiropractic services that are performed during their visits. Please check your insurance company's plans as they vary significantly. You have the right to request a sample of out of pocket fees.
- 6. **All co-payments are due at the time of service**, and if I choose to discontinue care, I am still responsible for any and all unpaid balances. I fully understand that I am directly and fully responsible to Cedar Chiropractic for all medical bills incurred for services rendered to me, and that this agreement is made solely for the additional protection, and in consideration, of the risk Cedar Chiropractic takes in waiting for payment.

APPOINTMENT POLICY

I understand there is a no show/no call policy. I will be billed and be responsible for the \$45.00 fee.

BILL OF RIGHTS 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 *Patient Bill of Rights for Protected Health Information*. 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.

CONSENT AGREEMENTS (for protected health information (PHI))

By signing, you grant authorization to Cedar Chiropractic, Inc., and all its licensed physicians, to perform diagnostic testing and render Chiropractic care and treatment to yourself or said minor (as the parent or authorized legal guardian); you agree to and give consent to operate under those protocols as outlined. **WE RESERVE THE RIGHT TO:** change our privacy practices and you have the right to request that we do not disclose you health information to specific individuals, companies or organizations. You may also revoke your consent at any time, however this must be done in writing. By signing this consent, you authorize us to use telephone, mail or e-mail, as a reminder for appointments. You may also revoke this authorization in writing.

WE ask that you sign this form as acknowledgement that our: AOB/DOP, FINANCIAL, APPOINTMENT POLICIES, CONSENT AGREEMENT AND BILL OF RIGHTS ACKNOWLEDGEMENT, were explained to you, that you understand it, and you accept full responsibility.

I, _____, HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS dated _____.

WITNESS: _____

Patient Name: _____

Date: _____

Cedar Chiropractic

77 West Main Street, Suite 211 • Hopkinton, MA 01748
p. (508)435-8182 f. (508)435-8183

PATIENT BILL of RIGHTS for PROTECTED HEALTH INFORMATION (PHI)

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.

III.A. Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.

Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

B. Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, **we will not sell or provide any of your health information to any outside marketing organization.**

C. Permitted uses and disclosures without your consent or authorization

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:

We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.

We are permitted to use or disclose your health information if we provide health care services to you as an inmate.

We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.

We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples and under the *Uses and Disclosures* section above, any other use or disclosure of your health information will only be made with your written authorization.

D. Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

If we have already released your health information before we receive your request to revoke your authorization.

If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

If you wish to revoke your authorization please write to us at:

**Cedar Chiropractic
77 West Main St., Suite 211
Hopkinton, MA 01748**

Patient Name: _____

Date: _____

E. Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

F. Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

G. Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

H. Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

I. Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except those disclosures:

- required for your treatment, to obtain payment for your services, or to run our practice.
- made to you.
- to individuals involved with your care.
- for national security or intelligence purposes.
- made to correctional officers or law enforcement officers.
- that were made prior to the effective date of the HIPAA privacy law, April 1, 2003.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

J. Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

K. Re-disclosure

Information that we use or disclose 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.

L. Your right to complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

**Dept. of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Tel: (877)696-6775**

Patient Name: _____

Date: _____

Dr. Jennifer Belesi and Dr. Jason Mavor feel that it is very important we coordinate with your doctor(s) and keep them up to date on your treatment and progress here at our office. Please fill in **any** and **all** information.

Primary Care Physician: _____ **Phone#:** _____

Address: _____

Dentist: _____ **Phone#:** _____

Address: _____

OB/GYN: _____ **Phone#:** _____

Address: _____

Massage Therapist / Acupuncturist: _____ **Phone#:** _____

Address: _____

Podiatrist / Other: _____ **Phone#:** _____

Address: _____

I give authorization to Cedar Chiropractic Wellness Center in Hopkinton to release my health care information to the above doctors.

Patient Signature _____