CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

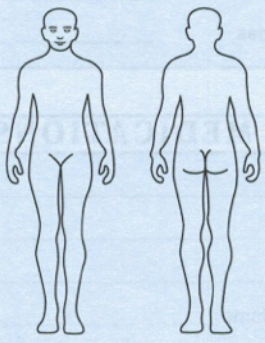
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Cape Chiropractic and Acupuncture

2 Davis Point Lane Suite 1B P: 207.799.9950
Cape Elizabeth, ME 04107 F: 207.799.9951

Zev J. Myerowitz Jr. D.C., Dipl. Ac. (NCCAOM), LAc.
Amber Smalley LAc. Dipl. Ac. (NCCAOM)

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays for myself (or on the patient named below for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Cape Chiropractic and Acupuncture Clinic and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with a staff member of Cape Chiropractic and Acupuncture about the aforementioned procedures and understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some very rare risks to treatment; including but not limited to: Fractures, disc injuries, strokes (CVA), dislocations and sprains. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at this time, based upon the fact then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my chiropractic physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s)for which I seek treatment at this facility.

To be completed by the patient:

_____
Print Patient's Name

_____
Print Name of Representative

_____
Signature of Patient

_____
Signature of Representative

_____/_____/_____
Date

_____/_____/_____
Date

_____
Staff Signature

_____/_____/_____
Date

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Zev J. Myerowitz Jr. D.C., Dipl. Ac. (NCCAOM), LAc. **Amber Smalley LAc.** Dipl. Ac. (NCCAOM)

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

Cape Chiropractic and Acupuncture is committed to your health and well being. All of us affiliated with the clinic believe that while Acupuncture and Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

WE, THE UNDERSIGNED, DO AFFIRM THAT _____ (patient)

HAS BEEN ADVISED BY Amber Smalley L.Ac., TO CONSULT A PHYSICIAN REGARDING THE CONDITION(S) FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____ _____

Patient Signature **Date**

_____ _____

Licensed Acupuncturist Signature **Date**

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with the practice of Acupuncture and traditional Oriental Medicine provided by members of Cape Chiropractic and Acupuncture clinical staff. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies such as Medical Massage, Tui Na (Chinese Massage) and Shiatsu.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. Bruising is a common side effect of cupping and gua sha. Rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (from plant, animal and mineral sources) which may be recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, diarrhea, rashes, hives and tingling of the tongue.

I will notify the clinical staff member who is caring for me if I am, or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment.

I understand the clinical and administrative staff may review my medical records and lab reports. All of my medical records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated):

_____ _____

Patient Name Date Representative Name Date

_____ _____

Signature of patient or representative Office Staff Witness

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Zev J. Myerowitz Jr. D.C., Dipl. Ac. (NCCAOM), LAc.
Amber Smalley LAc. Dipl. Ac. (NCCAOM)

Authorization and Assignment:

To: Dr. Zev J. Myerowitz Jr □ Amber Smalley □

In consideration of your undertaking to treat me, I agree to the following:

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, adjuster or employer in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

In consideration of the chiropractic and acupuncture services rendered and to be rendered, I authorize and direct the payment to the doctor named above of any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or him based in whole, or in part, upon charges made for his services.

I hereby acknowledge that I am receiving (or about to receive) health care services at the Cape Chiropractic and Acupuncture clinic, and that I have been advised that the professional providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined that either:

A) That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment of the doctor or make other provisions for the protection of the interest of the doctor;

B) If a liability claim exists, and my attorney refuses to protect the interest of the doctor, or if I have not engaged the services of an attorney;

then payment for services rendered by the professional at Cape Chiropractic and Acupuncture Clinic will be made on a current basis and my bill will be paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first. We reserve the right to charge 1.5% interest per month on any unpaid balance.

Date:_____

Patient's Name: _____ Witness (Printed): _____

Patient's Signature: _____ Witness (Signed): _____

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Your Health Information Rights:

This clinic has designated a Privacy Specialist to answer questions regarding our Privacy Practices as well as to respond to information requests or complaints. You may contact this Clinic's privacy Specialist by calling us at 207.799.9950. For inquiries that require a written request, please address them to: Cape Chiropractic and Acupuncture Clinic: 2 Davis Point Lane Suite 1B Cape Elizabeth, ME 04107. Attention: Privacy Officer

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO PHI ABOUT YOU:

OBTAIN A PAPER COPY OF THE NOTICE UPON REQUEST: You may request a paper copy of the Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy, you may request one in person or by contacting the Privacy Specialist.

REQUEST A RESTRICTION ON CERTAIN USES AND DISCLOSURES OF YOU PHI. You have the right to request additional restrictions on our use or disclosure of PHI about you by sending a written request to our Privacy Specialist(address listen above). We are not request to agree to those restrictions.

INSPECT AND OBTAIN A COPY OF PHI. You have the right to access and copy PHI about you contained in a designated record set for a long as the Clinic maintains your PHI. The "designated record set" usually will include care and billing records. To inspect or copy PHI about you, you must send a written request to our Privacy Specialist (address listed above). We may charge you a reasonable fee for the costs of copying, mailing, or other supplies that are necessary to grand your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to PHI about you, you may request that the denial be reviewed.

REQUEST AND AMENDMENT OF PHI. if you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request and amendment, you must send a written request to the Privacy Specialist (address listed above). Forms for this are available. It is not necessary to use this form but it may aid you in providing adequate information for us to process your request. In addition, you must include a reason that supports your request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give you a rebuttal to your statement.

RECEIVE AN ACCOUNTING OF DISCLOSURE OF PHI. You have the right to receive an accounting of the disclosures we have made of PHI about you after MAY 21, 2012 for most purposes other that treatment, payment or health care operations. The accounting will exclude disclosures we have made directly to you, disclosures to friends or family members involved in your care, and disclosure for notification purposes. The right to receive an accounting is subjected to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit your request in writing to our Privacy Specialist (address listed above). Your request must specify the time period, but may not be longer than six years. THe first accounting you request within a 12 month period will be free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at any time.

REQUEST COMMUNICATIONS OF PHI BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATIONS. For instance, you may request that we contact you about Health matters only in writing or at a different residence or post office box. To request a confidential communication of PHI about you, you must submit your request to the Privacy Specialist (address listed above). You request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or would like additional information about the Clinic's Privacy Practices, you may contact our Privacy Specialist at 207.799.9950 or send an e-mail to info@capechiroacu.com. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Specialist or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

By signing below, I acknowledge that I have received a paper copy of this Notice of Privacy Practices. I have read this notice and had an opportunity to ask questions regarding all of the above listed Privacy Practices.

_____

Patient Signature Date

_____

Facility Witness Signature

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Notice of Health Information Practices

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Please feel free to ask any questions or request copies of any policy.

Understanding Your Health Care Record/Information

Each time you visit a specialist, hospital, or other health care provider complimentary and/or alternative, a record of your visit is made. Typically, the records contain your complaints, symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or visit record, serves as:

- Legal document describing the care that you received
- Basis for planning your care and treatment
- Means of communication between the many health professionals who contribute to your care.
- A tool in educating health professionals
- Means by which you or a third-party payer can verify that clinical services billed were actually provided.
- A source of data for health care research
- A source of data for facility planning and marketing
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- Understanding of what is in your record and how your health information is used to help you to:
  - Ensure its accuracy
  - Better understand who, what, when, where, and why others may access your health information
  - Make more informed decisions when authorizing disclosures to others

Your Health Information Rights:

Although you health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to copies at a reasonable fee to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Inspect and copy your health record as provided for in 54 CFR 164.524

- Amend you health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communication of your health information by alternative means or at alternative locations
- Revoke your authorization to use of disclosed health information except to the extent that action has already been taken

Our Responsibilities

This health care office is required to:
- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address that you have supplied us with. We will not disclose your health information without your prior authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information you may contact the office Compliance Officer for health information.

If you believe that your privacy rights have been violated, you can file a complaint with the office Compliance Offices for health information management or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint. Complaint forms are kept on file and will be used for educational and administrative purposes only. You may obtain a complaint for from the receptionist.

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Welcome to Our Office

When a patient seeks Chiropractic or Acupuncture care, and we accept a patient for such care, it is essential for both parties to be working toward the same objective.

Chiropractic and Acupuncture have only one goal. It is important that each patient understand both the objective and the method that will be used to attain that goal. This will prevent any confusion or disappointment.

Chiropractic: An ancient system of health care that involves adjustments to the spine to facilitate the body's correction of vertebral subluxation (vertebral misalignment). This correction is utilized for the sole purpose of removing nerve interference, which allows the body to heal itself.

Acupuncture: A 5000 year old system of health care that involves balancing the body's energetic system known as meridians. This correction takes place by treating specific points on the skin. This correction takes place by treating specific points on the skin. This system is utilized for the scale purpose of normalizing chi (aka: qi, energy), thereby allowing the body to heal itself.

Regardless of what the disease process is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate interference to the expression of the body's innate capability to repair and heal itself. Our only method is specific adjusting to correct vertebral subluxations and meridian balancing to normalize the body's energetic system.

I, _____, have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

_____ _____

Patient Signature Date