Chiropractic Registration & History

Name_____ Social Security #_____

Address_____

City_____ State_____ Zip_____

Home Telephone ( )_____ Age_____ Birthdate_____ Marital Status: M S W D

Work Telephone ( )_____ # Children_____ Spouse's Name_____

Occupation_____ Whom may we thank for referring you?_____

HEALTH INFORMATION

Have you had previous chiropractic care? ☐ Yes ☐ No Date _____

Main Complaint_____

_____

Other Complaints_____

How long have you had this condition?_____

Have you had similar conditions in the past?_____

Does this condition affect your work? ☐ Yes ☐ No

Does this condition affect your family or social life? ☐ Yes ☐ No

What aggravates this condition?_____

_____

Other Doctors seen for this condition_____

_____

Are you taking any medication? ☐ Yes ☐ No If yes, please list:_____

_____

What helps your symptoms?_____

Have you had: Surgery? ☐ Yes ☐ No Falls? ☐ Yes ☐ No Accidents? ☐ Yes ☐ No

When? _____ Please describe_____

_____

Date of last physical examination_____

INSURANCE INFORMATION

Is this condition due to:

A work related injury? ☐ Yes ☐ No An automobile accident? ☐ Yes ☐ No

If you answer yes to either of the above questions, please complete other side of form.

Medicare# (If applicable) _____

Do you have Health Insurance? ☐ Yes ☐ No

Company_____

Address_____

Policyholder_____ Employer_____

Group#_____ ID#_____

Please check ☑ conditions or symptoms you currently have or have had in the past:

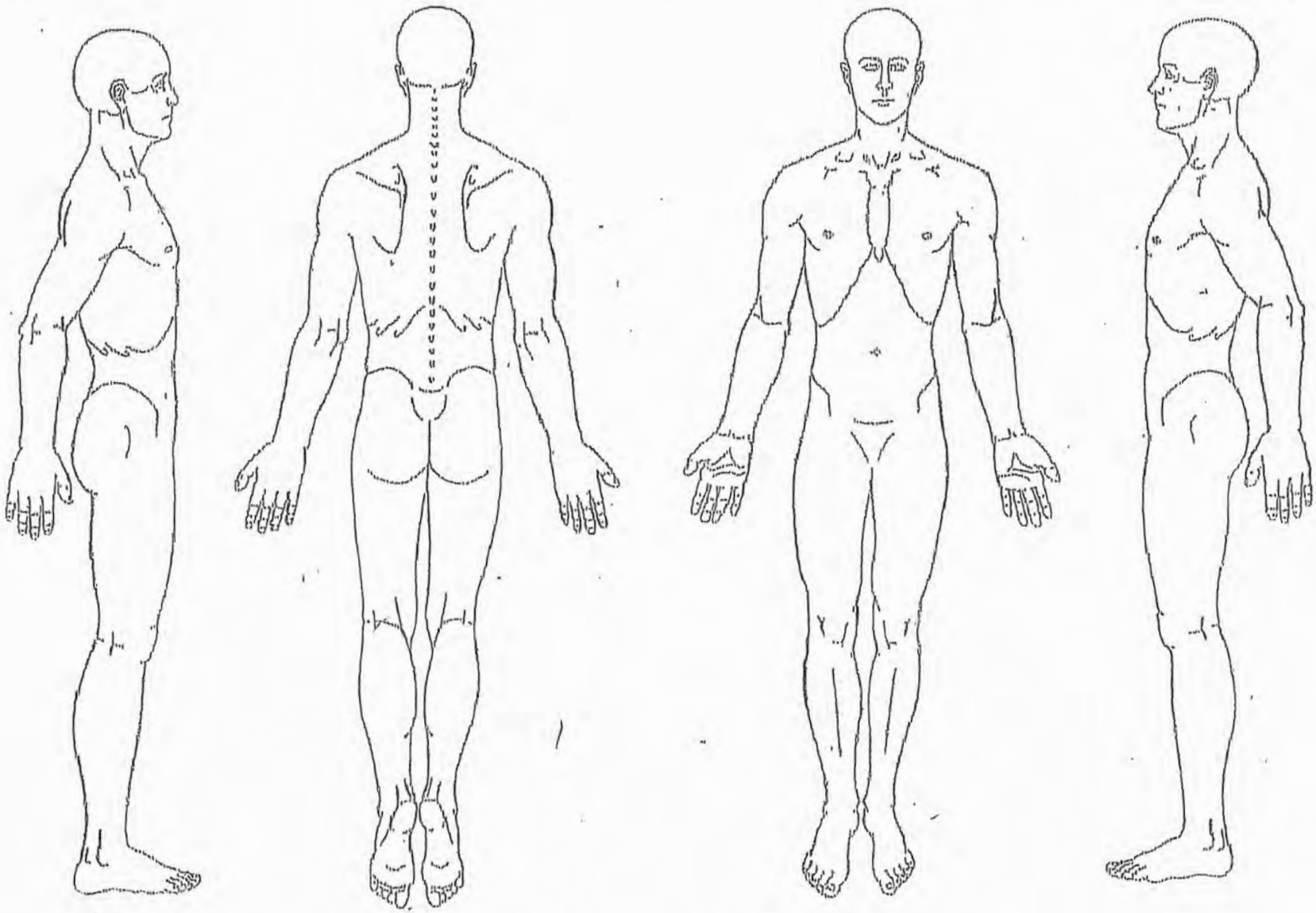
- ☐ Abdominal Pain
- ☐ Anemia
- ☐ Arm or Shoulder Pain
- ☐ Back Pain
- ☐ Bladder Problems
- ☐ Chest Pain
- ☐ Circulatory Problems
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Disorder
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headaches
- ☐ Heart Problems
- ☐ High or Low Blood Pressure
- ☐ Hip or Leg Pain
- ☐ Hot Flashes
- ☐ Insomnia
- ☐ Kidney Problems
- ☐ Loose Stool
- ☐ Lung or Bronchial Disorder
- ☐ Memory Problems
- ☐ Menstrual Problems
- ☐ Neck Pain
- ☐ Nervousness
- ☐ Numbness
- ☐ Palpitations
- ☐ Prostate Disorder
- ☐ Sinus Problems
- ☐ Swollen Joints

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractor will prepare any necessary reports and forms to assist me in obtaining payment from the insurance company and that any amount authorized will be paid directly to the Chiropractor and be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature_____ Date_____

Guardian or Spouse's Signature_____ Date_____

Email _____



1. Mark the area(s) of pain with an "X" on the above diagrams.
2. Place an "X" on the line below to indicate the severity of your pain.

LEAST PAIN |——————————————————————————————| MOST PAIN

Patient Contact Information

Please print clearly.

Name:_____

Address:_____

_____

Email: _____

Cell: _____

Can we leave a detailed message at the number listed above? Yes No

Emergency Contact Information:_____

_____

Notice of Privacy Practices for Boro Chiropractic P.C.

Revised and effective March 10, 2020

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your protected health information (PHI) is generally any information that identifies you and is created, received, maintained, or transmitted by us in the course of providing health care items or services to you. We will obtain your written authorization for uses and disclosures of your PHI that are not identified in this Notice or are not otherwise permitted by applicable law. You may revoke an authorization at any time by sending us a written request; however we are not able to retract previous disclosures.

We May Use and Disclose Your PHI WITHOUT Your Written Authorization For The Purpose Of:

1. **Treatment**. We may use and disclose PHI for your treatment and to provide you with treatment- related health care services, for example, to doctors, nurses, technicians, or other personnel, including people outside our office who are involved in your medical cares.
2. **Payment**. We may use and disclose PHI so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. If you pay for service yourself without any third party contribution or billing, we will not disclose PHI to a health plan if you instruct us not to.
3. **Health Care Operations**. Examples include financial or billing audits, internal quality assurance including patient satisfaction surveys; personal decisions; participation in managed care plans; legal defense; business planning; and outside storage of our records.
4. **Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services**. We will not, however, send you communications about health-related or non health-related products or services that are subsidized by a third party without your authorization.
5. **Individuals Involved in Your Care or Payment for Your Care**. When appropriate, we may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
6. **Research.** Under certain circumstances, we may use and disclose HPI for research. Before doing this, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project as long as they do not remove or take a copy of any Health Information.
7. **Fundraising and Marketing**. PHI may be used for fundraising communications, but you have the right to opt out of receiving such communications. If we receive any financial remuneration from a third party in exchange for making the communication, we will require your authorization and we must advise you that we are receiving remuneration.

Special Situations:

1. We will disclose PHI when required to do so by federal, state, or local law.
2. Public Health Activities. For example, contagious disease reporting, investigation or surveillance, and notices to and from the FDA regarding drugs or medical devices.
3. Health Oversight Activities such as audits, medical licensing, investigations, inspections, or licensure.
4. Judicial and Administrative Proceedings such as in response to subpoenas or court orders.
5. Law Enforcement- such as disclosures about a suspected crime victim; to identify or locate a suspect, fugitive, material witness, or missing person; or about a crime committed in our office.
6. Coroners, Medical Examiners, and Funeral Directors: to identify a deceased person, to determine the cause of death or to allow funeral directors to carry out their duties.
7. Organ and Tissue Donation. Disclosures may be made to organizations that are involved in organs, eyes, or tissue donation or transplantation.
8. Public Health Risks. We may disclose PHI to prevent or control disease, injury, or disability; report births and deaths; report reactions to medications or problems with products; and report child abuse or neglect.
9. Specialized Government Functions- We may disclose PHI to authorized officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations. We may also release PHI to authorized federal officials for intelligence, counter- intelligence, or other national security activities.

10. Business Associates. We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
11. Workers' Compensation or similar programs.

Your Rights:

1. You have the right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. You must make your request, in writing, to our office.
2. You have the right to amend your PHI if you feel the information we have is incorrect or incomplete. You must make your request, in writing, to our office.
3. You have the right to request restrictions or limitations on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care such as a family member or friend. To request a restriction, you must make your request, in writing, to our office. We are not required to agree to all such requests.
4. You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment, or health care operations or for which you provided written authorization. You must make your request, in writing, to our office.
5. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communication, you must make your request, in writing, to our office. We will accommodate all reasonable requests.
6. You have a right to a paper copy of this Notice. You may obtain a copy of this Notice at our office.
7. You have the right to be notified if there is a breach of privacy such that your PHI was disclosed or used improperly or in an unsecured way.

Changes To This Notice:

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice in our office with the effective date on the first page.

Complaints:

If you believe your privacy rights have been violated, you may submit a written complaint to our office or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Please direct any questions or requests to:
borochirobuckstherapy@yahoo.com
76 South Main Street
Yardley, PA 19067
(215)321-6555

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_____ Yes, I have received a copy.

_____ I have declined a paper copy.

_____

Print Name Signature Date