Glen M. Palmisano, DC, CCRD, FIAMA

Chiropractic Physician – Certified Chiropractic Rehabilitation Doctor

Fellow International Academy of Medical Acupuncture

162 South Street - Bristol, CT 06010

65 Memorial Road, Suite 435 – West Hartford, CT 06107

(860)585-9797 Fax:(860)589-9002 Email: Office@CTChiro.us

Thank you for reading and completing the enclosed paperwork prior to your scheduled visit in our office. We have found that completing the paperwork prior to your initial visit greatly reduces wait time for the patient, plus it gives you the opportunity to read the information more thoroughly. Please bring your completed paperwork, driver's license (or picture ID) and insurance card(s) with you to your initial appointment.

The attached documents are as follows:

1. WELCOME TO OUR OFFICE – please print patient name, read, sign and date
2. PATIENT INTRODUCTION CARD – please print and complete all lines
3. OFFICE FINANCIAL POLICY AND MEDICAL INSURANCE FORM (2pgs) please read, sign, print name and date
4. REQUEST FOR RELEASE OF MEDICAL RECORDS – please complete bottom of form only, this form gives authorization for our future use in accessing your medical records from hospitals, physicians and laboratories who's names you provide us
5. PATIENT SUBJECTIVE SYMPTOMOTOLOGY FORM – please print name, date, complete all sections beginning with top pain scale, checking all bubbles that apply to your symptoms and completing the body diagram with the pain symbols placed on the body diagram in accordance with your individual symptoms. Sign and date the form. Please note if you are experiencing pain in multiple areas ie. Neck and Back or any other combination of areas print off (2) of these forms and use one form for each separate area
6. PATIENT & FAMILY HEALTH HISTORY FORM – please print name, date and check off all that apply, write in surgeries, past hospitalizations, and medications with approximate dates and dosages where applicable
7. EHR (Electronic Health Records Intake Form) please complete all sections of this government form in compliance with the EHR incentive program, if you entered your medication information on the Patient History Form above then no need to duplicate just put see Patient Health History Form. Please list allergies on this form
8. HIPAA – The Health Insurance Portability and Accountability Act of 1996 establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, healthcare clearing houses and those healthcare providers that conduct certain healthcare transactions electronically. A full copy of our HIPAA available at office. Please sign and date our HIPAA receipt for our files

Again, thank you for scheduling an appointment with Dr. Palmisano, we look forward to providing you with the best possible care and individualized attention.

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WELCOME TO OUR OFFICE!

Patient Name:_____ Account #:_____

(Please print your name here) (Staff will complete this)

Dear Patient/Guarantor:

It is our pleasure to be of service to you. Dr. Palmisano's office is open for patients Monday through Friday. However, the doctor offers you twenty-four hour emergency care, seven days a week by calling our office telephone number.

After your initial examination, the doctor will decide whether he feels you will benefit from Chiropractic care. If he accepts your case, he will then set up the appropriate treatment schedule for your individual diagnosis. Please keep in mind it is important for you to follow your treatment schedule to obtain maximum results.

We have found it mutually beneficial for the patient to have a complete understanding of our office policies, insurance participation and financial policies at the beginning of treatment. Please see our attached Office Financial Policy and Medical Insurance Form which you are asked to sign as well.

CONSENT TO BASIC TREATMENT AND DIAGNOSTIC PROCEDURES: "This is to certify that I, the undersigned, consent to the administration of treatment to the above named patient at Dr. Palmisano's office. I consent to any x-ray, laboratory or other medical procedures or examinations and any other service rendered me under the general and specific instruction of my physician."

_____ _____ _____

Signature of Patient or Legal Representative (If guarantor, relationship to patient) Date

PATIENT INTRODUCTION CARD

(Please Print)

Date: ___/___/___

Name _____ ☐ Male ☐ Female

Date of Birth ___/___/_____ Soc. Sec. # _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed Spouse's Name_____ # of Children _____

Address _____

City _____ State _____ Zip Code _____ Home Phone # (_____)_____

Employer _____ Bus. Phone # (_____)_____

Occupation _____ Cell Phone # (_____)_____

E-Mail Address _____

Primary Care Physician _____ Referred By: _____

Do you have an attorney for this injury? ☐ Yes ☐ No If so, attorney's name:_____

In case of emergency:

Please contact _____ Relationship to patient _____

Phone # (_____)_____ Alternate Phone # (_____)_____

OFFICE FINANCIAL POLICY – DR. GLEN PALMISANO

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

IF YOU HAVE MEDICAL INSURANCE:

All co-pays are due at the time of visit. If you have a high deductible insurance, and your deductible has NOT been met, a required payment of $50 is due at the time of each visit.

Please understand that your insurance policy is a contract between you and your insurance company. Payment is accepted in the form of cash, check, Master Card or Visa at the time of visit. Returned checks and balances over 45 days may be subject to additional collection fees and charges. We participate in most insurance plans if your plan requires a referral please be sure to obtain one.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We know questions can arise on insurance and billing matters we encourage you to call our billing department at (860)585-9797 between 8:00am and 5:00pm with questions Monday – Friday and ask for our insurance specialist.

MISSED APPOINTMENTS:

Unless the office is given 24 hours' notice to cancel or reschedule an appointment, it is our policy to charge $30 for a missed appointment when the patient has incurred more than three "no-show" missed appointments or reschedules during the course of treatment. This charge is the patient's responsibility and cannot be charged to an insurance plan. Please help us to serve you and other patients by keeping your scheduled appointment! *A missed appointment affects 3 people: you, the patient we could have scheduled and the doctor. Thank you for keeping your appointments.*

ASSIGNMENT OF BENEFITS: "I authorize Dr. Glen Palmisano to release to my health plan and/or its agents information necessary to verify benefits, authorize services, and process medical/dental claims. Such information may include, but is not limited to, identification information, necessary medical information, services and charges. I authorize my health plan to pay benefits directly to Dr. Palmisano. I understand that I am responsible for payment of charges for services not covered by my health plan, or not covered under the terms of any agreement between my health plan and Dr. Palmisano, including but not limited to co-payments and deductibles, as well as charges which are considered by my health plan to be beyond usual, customary and reasonable."

NON ASSIGNMENT OF BENEFITS OR SELF-PAY: "I understand that if my health plan does not consider Dr. Glen Palmisano a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges rendered to the below named patient."

If you have any questions about the information stated or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Your signature below will authorize us to communicate effectively with your health plan and verify coverage as well as indicate that you understand our office policies financial policy and medical insurance form information.

X _____ / /

Patient Signature (or) Legal Guardian of Minor ... Date ...

_____

Printed patient name (or) Legal Guardian of Minor

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REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____ (to be completed by staff)

_____

_____

RE: _____ (to be completed by staff)

_____

_____

This will authorize you to permit Dr. Glen M. Palmisano, 162 South Street, Bristol, CT 06010 to obtain copies of any and all medical reports and medical records including: x-rays, MRI, CT, EMG/NCV, laboratory or other medical procedures and examinations.

A photocopy/fax of this authorization will be as effective as the original.

This authorization will be in effect for two years following the date of the signature. You may revoke your authorization to us at any time, as is detailed in our office privacy policy "Notice of Privacy Practices for Protected Health Information"; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already received the information requested. Your revocation request should be made to:

Dr. Glen M. Palmisano
162 South Street
Bristol, CT 06010
Fax: (860)589-9002

I give my authorization to release my medical records to Dr. Glen Palmisano.

Patient Name: _____

Patient Date of Birth: _____/_____/_____

Patient Signature: _____

Date of Authorization: _____/_____/_____

Patient's Name: Date:

Today's pain intensity can be ranked as a: (Circle one)

(NO PAIN) 0 ─┼─┼─┼─┼─┼─┼─┼─┼─┼─ 10 (EXTREME PAIN)

In each of the following sections, please check any and all boxes that apply

Severity: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderately Severe ☐ Severe

How Often: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

Movement: ☐ Inflexible ☐ Restricted Movement ☐ Stiffness

Sensation: ☐ Crawling ☐ Dead ☐ Numb ☐ Pins & Needles ☐ Prickly ☐ Tingly

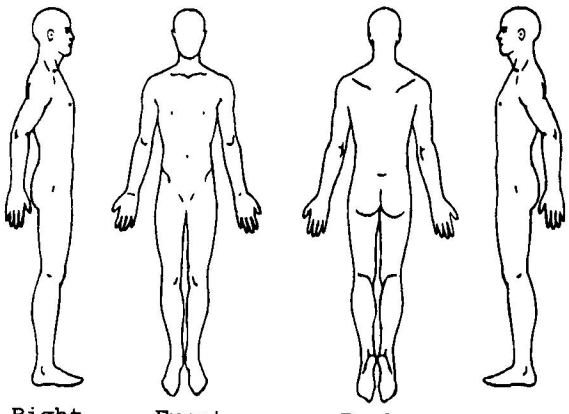
Pain Types: ☐ Achy ☐ Burning ☐ Dull ☐ Numb Ache ☐ Throbbing
☐ Sharp ☐ Shooting ☐ Stabbing ☐ Stinging ☐ Excruciating

Aggravating Factors: ☐ Coughing ☐ Carrying ☐ Getting in/out car ☐ Pulling ☐ Driving
☐ Throwing ☐ Anger ☐ Getting in/out bed ☐ Sneezing ☐ Climbing ladder
☐ Pushing ☐ Elevation ☐ Turning head left ☐ Depression ☐ Walking Uphill
☐ Lifting ☐ Reclining ☐ Turning head right ☐ Walking ☐ Ext. Rotation
☐ Straining at BM's ☐ Stooping ☐ Int. Rotation
☐ Arising from chair ☐ Bending ☐ Exercising
☐ Repetitious Mvmt. ☐ Standing ☐ Looking up
☐ Emotional Upset ☐ Sleeping ☐ Looking Down
☐ Flashing lights ☐ Stress ☐ Sitting

Use the following symbols to indicate your pain on the body below.

Aching XXXXX Stabbing ●●●● Numbness -----

Pins & Needles 00000 Burning ^^^^^



Relieving:

☐ Cold ☐ Resting ☐ Adjustment ☐ Sleeping
☐ Heat ☐ Hot Showers ☐ Reclining ☐ Sitting
☐ Advil ☐ Aspirin ☐ Tylenol ☐ Pain Pills
☐ Rubbing mineral ice ☐ Rubbing heat liniment ☐ Exercise

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date: _____

Patient Health History (check ones that apply)

O Abdominal Pain	O Cancer	O Heart Attacks	O Low Blood Pressure	O Scoliosis
O Allergies	O Colitis	O Heart Disease	O Lung Disease	O Sexually Transmitted Disease
O Angina	O Convulsions	O High Blood Pressure	O Multiple Sclerosis	
O Anorexia	O Diabetes	O HIV/AIDS	O Osteoporosis	O Sickle Cell Anemia
O Aortic Aneurysm	O Dislocated Joints	O Irregular Bowel Habits	O Painful Urination	O Sinus Trouble
O Arthritis	O Dizziness		O PMS	O Spinal Disc Disease
O Asthma	O Emphysema	O Irregular Menstrual	O Polio	O Stroke
O Blood Disorder	O Epilepsy	O Irritable Colon	O Profuse Menstrual	O Thyroid Trouble
O Breast Soreness	O Fainting	O Kidney Disease	O Prostate Problems	O Tuberculosis
O Breast Lumps	O Hay Fever	O Kidney Stones	O Rapid Heart Rate	O Ulcer
O Bulimia	O Headaches	O Liver Disease	O Rheumatic Fever	O Vaginal Discharge

Family Health History (check ones that apply)

O Abdominal Pain	O Cancer	O Heart Attacks	O Low Blood Pressure	O Scoliosis
O Allergies	O Colitis	O Heart Disease	O Lung Disease	O Sexually Transmitted Disease
O Angina	O Convulsions	O High Blood Pressure	O Multiple Sclerosis	
O Anorexia	O Diabetes	O HIV/AIDS	O Osteoporosis	O Sickle Cell Anemia
O Aortic Aneurysm	O Dislocated Joints	O Irregular Bowel Habits	O Painful Urination	O Sinus Trouble
O Arthritis	O Dizziness		O PMS	O Spinal Disc Disease
O Asthma	O Emphysema	O Irregular Menstrual	O Polio	O Stroke
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O Breast Lumps	O Hay Fever	O Kidney Stones	O Rapid Heart Rate	O Ulcer
O Bulimia	O Headaches	O Liver Disease	O Rheumatic Fever	O Vaginal Discharge

Lifestyle:

Patient Exercises:	O Regularly	O Moderately	O Rarely	O Never
Patient Smokes:	O2+ packs a day	O 2 packs a day	O 1+ pack a day	O 1 pack a day
	O ½ pack a day	O less than ½ pack/day	O Cigar or Pipe	O Never
Patient Uses Alcohol:	O Excessively	O Moderately	O Rarely	O Never
Dietary habits:	O Good	O Fair	O Poor	O Lacking

Prior Surgery(s)-

Past Hospitalization-

Medications-

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Date started smoking: __/__/____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

I have received a copy of Dr. Palmisano's Privacy Practices for Protected Health Information policy dated April 14, 2003. If I over have any questions or concerns regarding the policy I can contact the office's privacy manager, at 162 South Street., Bristol, CT 06010 or by phone at (860)585-9797. An additional copy of the Notice of Privacy Practices for Protected Health Information is posted in the waiting room for my convenience.

Printed Name

Authorized Provider Representative

Signature

Date

Date