Balanced Body Chiropractic Center, LLC
Dr. Jacqueline D. Flynn
Dr. Jenny Bess Lennon
223 Meadow Street
Naugatuck, CT 06770
203-723-5715

You ought not to attempt to cure eyes without head, or head without body, so you should not treat body without soul
- Socrates

Patient History

Name_____Date_____

Address_____City_____

State_____Zip_____Home Phone_____

Work phone_____Cell Phone_____

Date of Birth_____Age____

Occupation_____Employer_____

Marital Status S M D W Number of Children and Ages_____

Social Security #_____E-Mail Address_____

Referred By_____and_____

Name of Emergency Contact_____Phone #_____

Insurance/Accident Information

Insurance Co._____Name of Insured_____
Ins. Co. Phone #_____ Name of Policy Holder_____
Policy Holder's SS# _____Relationship to Insured_____
Date/Birth_____ ID # _____ Group #_____
Insured's Employer _____

Is this condition/Pain the result of an accident? ___Yes ___ No ____Work ____Auto ____ Other
Date of Accident _____Nature of Accident _____

Medical Release/Assignment of Benefits

I authorize Balanced Body Chiropractic Center to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Balanced Body Chiropractic Center. I understand that I am fully responsible for any unpaid or unassigned portion of charges incurred at this office.

Regardless of insurance status, charges for services rendered at this office are ultimately the patient's responsibility. If your insurance requires a referral prior to treatment in our office, it is <u>your</u> responsibility to provide us with that referral.

I understand that Dr. Jacqueline Flynn or Dr. Jenny Bess Lennon requires 12 hours notice prior to canceling an appointment. A $25 charge will be applied to your bill otherwise. This charge is not covered by insurance and is your responsibility.

Patient's Signature _____Date_____
(Parent or guardian of minor)

Name: _____ Date: _____

General Health Information

Height_____ Weight_____ Left/Right Handed

Have you ever received chiropractic care before? Yes / No Drs. Name_____
Have you undergone previous chiropractic or physical therapy during this calendar year? _____
List any diseases or health conditions you now have, or have been treated for in the past. (Give a brief description):
_____

_____
List any known allergies:_____
List any other traumas or injuries: _____
List any hospitalizations or surgeries: _____
When was your last complete physical?_____ Blood Tests _____ X-rays _____
Other Tests (describe) _____ Results?_____
Who is your primary doctor?_____ Address_____ Phone_____
Date of last visit to primary doctor:_____ Reason for visit:_____
Please list **all** medications, including birth control pills, aspirin, cortisone or vitamins and herbs that you are presently taking._____

Women Only

Are you pregnant, or think you may be pregnant?_____

Date of last menstrual period _____

Do you have or have you suffered from any menstrual disorders? _____

If yes, please describe _____

_____

Men Only

Do you suffer from any bladder/urinating problems? _____

If yes please describe _____

_____

Date of last prostate exam_____

Name: _____ Date: _____

Family History - Check all that apply

	Stroke	Heart Disease	Arthritis	Cancer	Diabetes	Thyroid	Other
Mother's Side	___	___	___	___	___	___	____
Father's Side	___	___	___	___	___	___	____

Current Symptoms

Reason for consulting the doctor today: _____
When did this pain or condition begin?_____ Pain is: __Sharp __Dull __Constant __Intermittent
Rate your pain on a scale from 0 - 10 (0=No pain, 10=Severe Pain), please circle: **1 2 3 4 5 6 7 8 9 10**
Does your pain radiate or move? Describe: _____
What aggravates your condition/pain?_____
What relieves your condition/pain?_____
Is the condition worse at certain times of the day? When?_____
Activities limited due to your condition:_____
Is the condition getting progressively worse?_____
Previous doctors or treatments: _____
Any home remedies used?_____
Have you ever had same/similar condition before? Explain:_____

Check any of the following symptoms, which you have now or have had in the past. N=now **P=**past

___ Headaches	___ Pins & Needles in Arms/Legs	___ Cold Hands/Feet
___ Neck Pain	___ Numbness in Fingers/Toes	___ Panic Attacks
___ Back Pain	___ Feeling of Anxiety	___ Stomach upset/Ulcers
___ Chest Pain	___ Irregular Heart Rate	___ Irritable bowel/Colitis
___ Neck Stiff	___ Shortness of Breath/Asthma	___ Leg/feet cramps at night
___ Ears Ring/Buzz	___ Tension/Irritability	___ Unexplained Fever
___ Sleeping Difficulties	___ High Blood Pressure	___ Eczema/Skin Rashes
___ Clench/Grind Teeth	___ Cold Sores/Fever Blisters	___ Severe Menstrual Cramps
___ Dizziness/Vertigo	___ Depression/S.A.D.	___ Chronic Fatigue
___ Roving muscle/joint Pain	___ Alcoholism/Addictions	___ Eyes very sensitive to light
___ Recent unexplained weight loss	___ Recent change in bowel/ or bladder function	

I certify that I have read and understand all the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Date Patient's Signature

Name: _____ Date: _____

About Holistic Health Care

Balanced Body Chiropractic Center strives to encompass all aspects of your being to bring whole health to your mind, body and spirit. One's optimum health potential will be reached only when a "balance" exists between these three components. Pain and disease are often "symptoms" which result from imbalance in our lives. This form will aid us in discovering symptoms and "dis-ease" which may be related to imbalances in your life. Be assured that immediate referral will be made with the discovery of any disease or symptom, which necessitates more immediate and specialized medical care. Those who are in need of more specialized medical intervention will often benefit from the addition of holistic chiropractic health care as well as other services offered at our center.

The Body

Comments

Yes / No Do you exercise regularly? In what way? _____
Yes / No Do you eat properly? What foods do you crave? _____
Yes / No Do you drink alcohol? Avg. daily intake? _____
Yes / No Do you consume caffeinated beverages? Avg. daily intake? _____
Yes / No Do you smoke? Average daily amount? _____
Yes / No Difficulty sleeping or falling asleep? Avg. hours of sleep? _____
Yes / No Are you taking any drugs? (Prescriptive or non-prescriptive) _____
Yes / No Do you take vitamins or natural remedies? Explain: _____

The Mind

Yes / No Do you often feel rushed? _____
Yes / No Do you easily lose your train of thought? _____
Yes / No Is it difficult to shut off or slow your thoughts? _____
Yes / No Are you intolerant of other's mistakes? _____
Yes / No Do you prefer to be in control of situations? _____
Yes / No Is it difficult to motivate yourself? _____

The Spirit

Yes / No Do you consider yourself spiritual? _____
Yes / No Do you feel a strong sense of purpose? _____
Yes / No Are you satisfied with your life? _____
Yes / No Do you pray or meditate regularly? _____

Life Events - Check any of the following that have occurred within the last 3 years

___Death of a Loved One	___Divorce/Separation	___Marriage/Family Additions
___Job/Career Change	___Personal injury/illness	___Illness of a Loved One
___Change of Residence	___Change in Financial Status	___A Difficult Relationship
___Starting/Finishing School	___Child Leaving Home	___Business Difficulties

List any major life events, (good or bad), which you anticipate within the next year:_____

_____

Balanced Body Chiropractic Center, LLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. (Large print copy available at office upon request.)

Balanced Body Chiropractic Center, LLC is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSURE OF YOUR HEALTH INFORMATION

Treatment – We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.
Payment – We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.
Workers Compensation – We may disclose your health information as necessary to comply with State Workers Compensation Laws.
Emergencies – We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may need to disclose your health information to coroners or medical examiners.

Organ Donation
We may need to disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may need to disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes. We may call you at home to remind you of appointments and may leave a message if there is no answer or you are not available. No health information will be disclosed other than the date and time of your next appointment. We may send a letter, postcard, or invitation, or call your home in order to participate in certain events. We may from time to time send you newsletters, birthday cards, reminder cards, holiday greeting cards, thank you cards, or office letters.

Change of Ownership
In the event that Balanced Body Chiropractic Center, LLC is sold or merges, your health information/record will become the property of the new owner.

Your Health Information Rights
You have the right to request restrictions on certain uses and disclosures of your health information. Balanced Body Chiropractic Center, LLC is not required to agree to the restriction. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location. You have the right to copy and inspect your health information. You have the right to request the office amend your protected health information. If your request is denied you will be provided an explanation and procedure for disagreeing with the denial. You have the right to receive an accounting of disclosures of your protected health information. You have the right to a copy of this Notice of Privacy Practices any time upon request.

Treatment
This office uses open room adjusting and therapy. Per request we will accommodate you with a closed room for adjusting and therapy.

Changes to this Notice of Privacy practices
Balanced Body Chiropractic Center, LLC reserves the right to amend this Notice of Privacy Practices at any time and will make the new provisions effective for all information it maintains. If you have any questions about any part of this notice or if you want more information contact Jacqueline Flynn or Jenny Lennon (203) 723-5715. If Jacqueline Flynn or Jenny Lennon is not available you may make an appointment to meet with her in person or via telephone within two working days.

Complaints
Complaints about how Balanced Body Chiropractic Center, LLC has handled your health information should be directed to Jacqueline Flynn or Jenny Lennon (203) 723-5715. If you are not satisfied with the manner in which this office handles your complaint you may submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Ave., S.W., Room 509F, HHH Building, Washington D.C. 20201
This notice is effective as of July 28, 2008.

I have read this Notice of Privacy Practices and understand my rights contained in this notice. By way of my signature I provide Balanced Body Chiropractic Center, LLC with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations as described in this Notice. The staff of Balanced Body Chiropractic Center, LLC has explained the Notice of Privacy Practices to my satisfaction. I am aware that Balanced Body Chiropractic Center, LLC has the right to change the terms of its Notice and make any provisions effective for all the protected health information that it maintains.

Patient's name (PRINT) _____

Patient's Signature _____

Parent / Guardian Signature _____
(If Patient is a Minor)

Date _____

FACILITY USE ONLY

Authorized Facility Signature _____

Date _____

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Terms of Acceptance to Chiropractic Treatment and Connecticut Law

I have been informed of the nature of my disorder(s) and the nature and purpose of chiropractic procedures proposed as treatment. The availability of alternative treatment options has been explained to me. I have also been advised of all the possible consequences if I decide not to receive care. I understand that there is no guarantee or warranty for any specific cure or result.

Terms to understand before treatment:
Adjustment: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is made by specific adjustments to the spine or extremities.
Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

In the state of Connecticut, General statute chapter 327, section 20-24, Chiropractic is defined as such, "*The practice of chiropractic means the practice of that branch of healing arts consisting of the science of adjustment, manipulation and treatment of the human body in which vertebral subluxations and other malpositioned articulations and structures that may interfere with the normal generation, transmission and expression of nerve impulse between the brain, organs, and tissue cells of the body, which may be a cause of disease, are adjusted…*"

I have read the above statements. I have also had the opportunity to ask questions about its content. All questions about the doctor's care pertaining to me in this office have been answered. The best health services are based on a friendly, mutual understanding between provider and patient.

I _____have read and fully understand the above statements.
I therefore authorize chiropractic care and treatment on this basis.

Patient's signature: _____ Date: _____

Consent to evaluate and adjust a minor.

I, _____ being the parent or legal guardian of _____ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of authorized person: _____Relationship: _____

Date: _____

Balanced Body Chiropractic Center, LLC
OFFICE POLICY CHANGES 2023

PLEASE CHECK EACH PERTINENT BOX AND SIGN BELOW

☐ CARD ON FILE POLICY

In an effort to streamline the patient experience and with the increase in high deductible plans and HSA/FSA cards, as of June 1, 2023, we will be requiring a card to keep on file for each patient. Each card will be stored with our PayHub Credit Card Processing Company for on demand payments at check out or upon EOB receipt. Your credit card information will be shredded at the time of input. PayHub is FTC compliant for data and privacy storage to keep your mind at ease. By checking the box, you acknowledge that you have received a copy of the credit card policy.

☐ OPT OUT. By opting out of card on file policy we reserve the right to charge 6.5% per month on balances over 30 days.

☐ NO CALL/NO SHOW/CANCELLATION POLICY

As of May 1, 2023, there will be a $50 charge for each missed appointment that was a **no call/no show**. We appreciate 24 hour advance notice for all cancellations or rescheduling so we can make room for other patients. If you cancel or reschedule your appointment within 24 hours there will be no charge. Any appointments cancelled with less than 24 hour notice can be subject to a $25 charge. This fee may be waived if another patient schedules in the available slot or it is determined by the practitioner that an unavoidable emergency has occurred. Fee will be due at the time of next visit or subject to charge the card on file. We thank you for your understanding.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS TO SIGNATURE DATE

I agree that I will not dispute any charges with my credit card company unless I have first attempted to rectify the situation directly with BBCC.
Everything below this line will be shredded, as it is stored electronically.

Cardholder Name (please print)_____

Patient Name_____

Address _____Zip Code_____

Credit Card number (circle one) Amex/Mastercard/Visa/Discover

_____EXP_____CRV#_____