

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 your 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

- | | | |
|--|---|--|
| <input type="checkbox"/> Death of a Loved One | <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Marriage/Family Additions |
| <input type="checkbox"/> Job/Career Change | <input type="checkbox"/> Personal injury/illness | <input type="checkbox"/> Illness of a Loved One |
| <input type="checkbox"/> Change of Residence | <input type="checkbox"/> Change in Financial Status | <input type="checkbox"/> A Difficult Relationship |
| <input type="checkbox"/> Starting/Finishing School | <input type="checkbox"/> Child Leaving Home | <input type="checkbox"/> Business Difficulties |

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

Balanced Body Chiropractic Center, LLC

Dr. Jacqueline Flynn
Dr. Jenny Bess Lennon

CANCELLATION POLICY

Cancelling an appointment with insufficient notice prevents us from scheduling another patient in your time slot. Any appointment not cancelled with 24 hours notice will be charged for an office visit under the following policy:

- » If you cancel or change your appointment with 24 hour notice there is NO charge.
- » Any appointments not cancelled with 24 hour notice will be charged \$25 for the time reserved. 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.
- » Not showing up for an appointment will be billed at \$25, since the time has been reserved specifically for you.

Please provide us with a valid credit card number in the event that you miss an appointment without cancellation.

I have read, understood, and agree to the terms of this policy as it is stated. I give Balanced Body Chiropractic Center, LLC permission to charge the card below if I do not cancel an appointment with proper notice.

Patient Name (please print)

Name on Card

Visa/MasterCard Account Number
(please circle which one)

CRV #

Expiration Date

Cardholder 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
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 _____

<u>FACILITY USE ONLY</u>
Authorized Facility Signature _____
Date _____