MANFORTI CHIROPRACTIC

We appreciate the opportunity to help you get back to the health. The more accurate and complete the information you give us, the better service we can give you.

Date:_____ Patient #_____ (assigned by office)

Name:_____ Social Security #_____ Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address: _____Fax # _____ Cell Phone:_____

Age:_____ Birth Date:_____ Marital Status: M S W D How many children?_____

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

In case of Emergency Contact:_____ Relationship: _____Phone:_____

How were you referred to our office?_____

Family Medical Doctor: _____When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

INSURANCE INFORMATION:

_____Major Medical _____Worker's Compensation _____ Medicaid _____Medicare _____Auto Accident

_____Medical Savings Account & Flex Plans _____Other

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

Insuredõs Name (as it appears on card):_____

Relationship to Patient: _____ Insuredõs Birth Date: _____Insuredõs SS#: _____

Insuredõs Employer:_____ Address:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Dr. Manforti. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.0

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint and/or Purpose of this appointment:_____
_

Date symptoms appeared or accident happened:_____ Is this due to: Auto___ Work____

Describe the injury/accident _____

Date of last physical examination:_____ Date of Last X-ray, MRI, CT Scan:_____

PAST MEDICAL HISTORY

Have you been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__High/Low Blood Pressure
__Circulatory Problems	__Stroke	__Alcoholism	__Coughing Blood
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__Excessive Bleeding
__Seizures/Convulsions	__Epilepsy	__HIV Positive	__Ulcers __Depression
__A Congenital Disease	__Hernias	__Gall Bladder	__Cancer_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? _____

_____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies of any kind? No / Yes Describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

SOCIAL HISTORY:
Do you drink alcoholic beverages?____ Drinks/Week_____
Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?____ Cups/Day_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____

FAMILY HISTORY:
Father: Current age if still living:_____ Cause of death and age at death if deceased:_____

Mother: Current age if still living:_____ Cause of death and age at death if deceased:_____

Do you have any family members who suffer from the same condition you do? If so, please list:_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):
Cancer____ Tuberculosis____ Mental Illness ____ Diabetes ____ Asthma____ Heart Disease ____
Stroke ____ Kidney Disease____ Lung Disease____ Arthritis_____ Liver Disease
Other_____

Patient Financial Policy

Thank you for choosing our office as your healthcare provider. We are committed to making your treatment successful. You are required to read and sign the following office financial policy prior to the commencement of any treatment.

1. If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Our payment plans make care an affordable part of your family budget.

2. If You Have Insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Our payment plans make care an affordable part of your family budget.

Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. You are responsible to know your policy. Your balance will become your responsibility if denied by your carrier for any reason. You reserve the right to appeal the reimbursement for services or lack of with your carrier pursuant to your health care insurance contract.

Please be aware that some and perhaps all services which we provide may be considered uncovered services, and therefore considered not medically necessary under the Medicare program and other insurance carriers.

You hereby authorize insurance payment directly to our office. Should payment be sent to you, it is your responsibility to return the check to our office, within seven (7) days of receipt. Failure to do so will result in civil collection proceedings wherein you agree to pay our reasonable attorneys fees and costs for collection as well as potential criminal liability for theft and conversion of funds. You further assign your rights to benefits under your contract of insurance or other third party payment to **Manforti Chiropractic**, and its employees, agents and/or contractors, all benefits payable to you under you insurance policies and health benefits plans.

If your insurance plan requires a referral prior to treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THIS AGREEMENT.

_____ _____

Patient Name, (Printed) Witness:

_____ _____

Signature Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

You may discuss my PHI with the following:

_____ _____

Name / Relationship Name / Relationship

_____ _____ _____

Name of Patient Signature Date

INFORMED CONSENT

PATIENT NAME _____

MANFORTI CHIROPRACTIC
Dr Alfonso Manforti J., D.C.
541 Lakehurst Rd
Toms River, NJ 08755
Phone: 732.244.3333

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

CONSULTATION QUESTIONNAIRE

PATIENT NAME _____

DATE _____ **Dr Alfonso Manforti D.C.**

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____
   _____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. Have you consulted another Physician?_____ If so, who._____
11. Diagnosis_____ Treatment_____
12. Did it help?_____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: _____
    _____
    _____

NO SYMPTOMS ——————————————— EXTREME SYMPTOMS

Please place an ñXò on the line above to indicate level of problem.

Doctorôs Signature _____ Date _____