CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Social Security# _____

Address _____City _____State_____Zip _____
Primary # Secondary #
☐cell/☐home:_____ ☐cell/☐home: _____Email_____

Occupation_____Company _____Work Phone _____

Gender: M/F Age ____ DOB ___/___/____ Marital Status: M S W D Children(gender/age):_____

Spouse's Name_____ Spouse's Office #_____

Race: ☐Asian ☐African American ☐Caucasian ☐Hispanic ☐Native American ☐Other_____

Referred by_____ Nearest Relative & Phone #_____

HEALTH INFORMATION: Have you had previous chiropractic care? ☐No ☐Yes, by whom?_____

What is your major complaint?_____

Other Complaints:_____

Onset of complaints/condition:_____

How long have you had this condition?_____Have you had this or similar conditions in the past?_____

What activities aggravate your condition?_____

Is this condition getting progressively worse? Yes☐ No☐ Constant☐ Comes and goes ☐

Is this condition interfering with your: Work☐ Sleep☐ Daily Routine☐ Other_____

Do other family members have similar problems? Yes☐ No☐

Please list:_____

Other doctors who treated this condition:_____

List surgical operations and years:_____

_____

Current Medications (list dosage/frequency)_____

Allergies&Reactions:_____
Age of mattress_____ ☐Comfortable ☐Uncomfortable Are you a ☐smoker ☐non-smoker?
Are you wearing: ☐Heel lifts ☐Sole lifts ☐ Inner Soles ☐Arch supports? ☐Former? Quit Date_____

Have you been in an auto accident? ☐Past Year ☐Past 5 years ☐ Over 5 years ☐Never

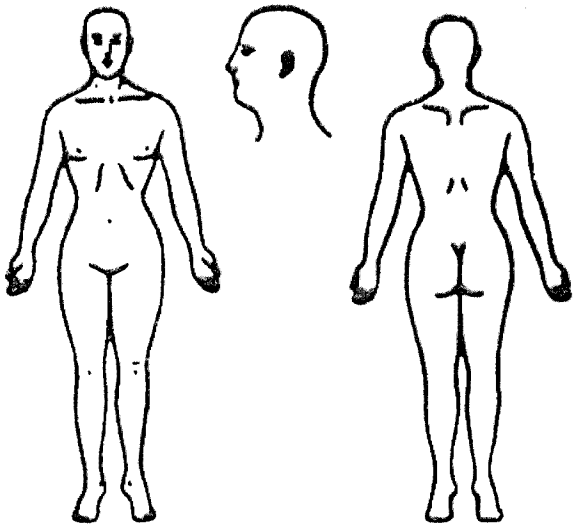
Describe:_____

Have you had any other personal injury, job related injury or accident? ☐Past Year ☐Past 5 yrs ☐Over 5 yrs ☐None

Describe:_____

Date of Last Physical Examination:_____

Please mark your areas of pain on the figures below.



Have you ever suffered from?

1. Dizziness_____
2. Backaches_____
3. Heart Trouble _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders _____
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____

Insurance information

Is your condition due to an auto accident or job related injury? ☐Yes ☐No

Do you have Health Insurance? ☐Yes ☐No If yes, Ins. Co:_____Policy#_____

Are you covered by Medicare? ☐Yes ☐No If yes, Health Insurance #_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all service rendered to 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 and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ Date_____

Guardian or Spouse's Signature:_____ S.S. #_____

In the case of emergency, I give permission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this form may be notified in in an emergency, as needed.

Primary Person to be notified in case of an emergency:

Name:_____Phone:_____Relationship:_____

Secondary Person to be notified in case of an emergency:

Name:_____Phone:_____Relationship:_____

Family health information. (Many health problems are the result of hereditary spinal weak-nesses; thus information about your family members gives us a better picture of your total health picture.)

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

If deceased please list year and cause

KAPLAN CHIROPRACTIC OFFICE

BENJAMIN S. KAPLAN, D.C.

2 Craftsman Lane
Amherst, NH 03031
Telephone: (603) 886-0886
www.kaplanchiro-nh.com

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____Insurance Company to pay by check made out and mailed directly to: Kaplan Chiropractic Office

2 Craftsman Lane
Amherst, N.H. 03031

The medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check payable to me and mail it as follows:

2 Craftsman Lane
Amherst, N.H. 03031

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this assignment will be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

DATE:_____

_____
Name of Policy Holder/Relationship

_____ _____
Signature of Claimant (Patient) **Witness**

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ASSIGNMENT, LIEN AND AUTHORIZATION

INSURANCE BENEFITS AND ATTORNEY

To whom it may concern:

I hereby authorize and direct you, my insurance company and/or my attorney to pay directly to Kaplan Chiropractic Office, 2 Craftsman Lane Amherst, N.H. 03031 such sums as may be due and owing this office for services rendered me, both by reason of accident benefits, workman's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement; judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's service provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for their services refuses to make such payment, upon demand by me or this office. I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the office to await payment and they may demand payments from me immediately upon rendering service at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjustor or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned office be given power of Attorney to endorse/sign my name on any and all check for payment of my doctor bill.

Date: _____Signed:_____

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OFFICE POLICY

We believe that a clear definition of our office policies will allow both you, and our office to concentrate on the big issue-REGAINING AND MAINTAINING YOUR HEALTH.

- ***Appointment Policy***

Multiple appointments have been given for your convenience to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit.

When entering the office on any given visit, please go directly to the front desk and "**Sign-in.**" We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If there are any questions, please ask the receptionist.

- ***Financial Policy***

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreement, as well as billing and coding guidelines, we have adopted the following policies.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.
2. You may be entitled to a network or contractual discount under the following circumstances:
    a. We are a participating provider in your health plan.
    b. You are covered by a State of Federal program with a mandated fee schedule.
    c. As part of our compliance plan, our office will be unable to extend any type of discounts other than those listed above.

It is our office policy that all services rendered are charged directly to you, the patient, and that you are ultimately responsible for all payments, regardless of whether or not this office accepts your insurance assignment.

Patients with no insurance:

All payments are expected at the time of service. Patient balances may not exceed $100.00 at any time or professional care may be terminated.

Patients with insurance:

Deductibles and all co-payments are expected at the time of service. Your ***co-insurance*** balance may not exceed $50.00 or professional care may be terminated.

- ***Insurance Policy***

It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of- pocket expense and allows you to place your family under chiropractic care.

1. The privilege of insurance assignment ***begins*** when your insurance forms are ***received*** by our office.

2. Our office also ***DOES*** need your social security number for insurance reasons. From time to time it is necessary to use the social security number for policy information. We understand your concern and want to reassure you that this information is kept strictly confidential.

3. All deductible payments ***MUST*** be made prior to insurance submittal.

4. Our office will verify your insurance coverage in an effort to help you determine exactly what chiropractic coverage is available to you under your policy. However, you the patient are ultimately responsible of keeping record of your appointments to make sure it is within the allowable benefit and visit limits.

5. All co-payments are due when service is rendered. (Co-payment is the part of our service that is not paid for by your insurance.) A $50.00 co-payment balance must not be exceeded by any patient.

6. This office does not file for or accept co-payments for secondary insurance carriers, but will be happy to assist you in collecting from the secondary carrier. ***The only exception to this policy is Medigap.***

7. Since we do not own your policy and occasionally we experience difficulty in collecting from your insurance company. Insurance assignment is a privilege and may be terminated at any time. Of course we will give ample notice and ask that you act in your own behalf with your insurance company.

8. ***This office does not accept third party insurance assignment.***

9. This office does not await payment from auto accidents if payment is made from the Auto carrier to the patient and/or attorney. The bill must be paid by you, the patient. We will only honor the insurance assignment if payment is made directly to us from your auto carrier.

10. This office does not promise that an insurance company will pay for the usual and customary charges of this office, nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement.

11. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately due and payable in full by you, regardless of any claims submitted.

12. When making a health care decision, it is important to remember that you, the patient, are ultimately financially responsible for any service rendered.

13. **Cell Phone policy-PLEASE TURN OFF CELL PHONES WHILE HERE IN THE OFFICE**

    As the use of cell phones has grown, we have become aware how intrusive they are in a medical office. We realize that people do not want to miss important calls, but cell phones can interfere with communication between the patient and the doctor or our staff. This can cause delays, or worse can lead to distractions that may result in less than optimal medical care and attention. We kindly request that all cell phone be turned off or turned to silent mode after you arrive for your appointment, Thank you for your cooperation and understanding.

14. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions regarding your health care or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I, _____, have read the above policy statement and understand my obligations as outlined herein.

Signature _____Date_____

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THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Kaplan Chiropractic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another heath care provided or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party such as an insurance carrier, an HMO, a PPO, Attorney, or your employer if they are or may be responsible for the payment of your services.
- Your name, address, phone number, email, text messaging and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine or with fellow residents. Further, you have the right to inspect or obtain a copy of the information we use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances.

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use of disclosure of your protected health information, other than as outlined above, will only be made upon your written consent. The following would require your written consent.

- Uses and disclosures for marketing purposes. Examples: Website for our office, Facebook, Pinterest and Twitter.
- Uses and disclosures that constitute the sale of PHI;
- Other uses and disclosures not described in this notice such as individuals/family members you wish us to share and disclosed current treatment information to.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care, status of your account, or birthdays. If you would like to receive this information at an address other than your home or if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect, copy/ or access your health information in electronic format and/or hard copy for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in

writing. You have the right to restrict disclosures of protected health information (PHI) to health plans if you have paid for services out of pocket in full.

We are required by state and federal law to maintain the privacy of your patient file and protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to:

April Kaplan
Office Manager/Security Officer
2 Craftsman Lane
Amherst, NH 03031

If you would like further information about our privacy policies and practices, please contact:

April Kaplan
Office Manager/Security Officer
2 Craftsman Lane
Amherst, NH 03031

This notice is effective as of _____. This notice and any alterations or amendments made hereto will expire twenty-five years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed Please)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Personal Representative Printed	Personal Representative Signature	Date

Updated 03/2014

_____

Description of the authority to act on behalf of the patient

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Patient Authorization regarding chiropractic care being provided in an "open-door" adjusting environment

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and leaving doors between patient care areas open. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosure" of health information. It is our view that the kinds of matters related to an "open-door" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Benjamin Kaplan or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____

Name (Printed) Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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MASSAGE THERAPY CANCELLATION POLICY

Appointments scheduled with our massage therapists must be cancelled within twelve (12) hours before the scheduled appointment takes place. There will be a $30.00 broken appointment charge applied for any missed massage therapy appointments. This charge will be due immediately.

Even if you are not currently receiving massage therapy in this office, we request that you sign this form confirming you have been notified and are aware of our policy.

I have read and understand the above statement.

Patient Signature_____

Date_____

Witness _____

Kaplan Chiropractic Office
2 Craftsman Lane
Amherst, NH 03031
603-886-0886

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT

Patient Name: _____

Date of Birth: ____/____/____ **Maiden or Other Name** _____

Address: _____ **City:** _____ **State** _____ **Zip**_____

Day Phone: _____ **Evening Phone:** _____

With your permission, Kaplan Chiropractic Office may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, Kaplan Chiropractic Office may tell a family member when your next medical appointment is scheduled, the results of a laboratory test, treatment, or a procedure. By completing the top portion of this form, you are authorizing release of this information to these individuals. However, you are not authorizing Kaplan Chiropractic Office to provide extensive information about your medical history or copies of information from your medical record. If you wish to have this information disclosed, you must complete a separate authorization form. Please be aware that Kaplan Chiropractic Office may use its professional judgment in determining the amount of information it may disclose to any person besides yourself, and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care or the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name: _____ **Relationship:** _____ **phone#**_____

Name: _____ **Relationship:**_ _____ **phone#**_____

Name: _____ **Relationship:** _____ **phone#**_____

☐ Declined, only release to self

- By signing this form I am acknowledging that I have received a copy of Kaplan Chiropractic Office Notice of Privacy Practices as required by HIPAA.
- I understand that if I change my mind about any of the information in this form, I must contact Kaplan Chiropractic Office to revoke this form in its entirety or to complete a new form.

_____
Patient Name (Please Print)

_____ ____
Signature of Patient **Date**

_____
Parent/Legal Guardian/Authorized Person **Date**

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Patient Electronic Health Record Notification

As part of our commitment to provide our patients with integrated, high quality health care services, Dr. Kaplan and staff of Kaplan Chiropractic utilize an electronic health record (EHR) system. The EHR system allows our doctor and staff to consolidate, store, retrieve and share medical information about a patient's medical history. The EHR is endorsed by the Department of Health and Human Services of the US government as a way to increase accuracy, improve efficiency, and reduce medical errors.

Medical records are created when you receive treatment from a health professional, as you do from our office. Records may include your medical history, details about your lifestyle (such as smoking or involvement in high-risk sports), and family medical history. In addition, your medical records contain chart notes, consultation notes, medications prescribed, and reports that indicate the results of operations and other medical procedures. Information will be entered directly or scanned into a web based medical record system in the computer.

Our provider will upload a document or media information to an online patient portal. Using the link and login information provided via email, you may login and review the information uploaded by your doctor. The document is sent through the PracticeStudio online portal management system. www.patientwebportal.com

The EHR has levels of security to protect against inappropriate access or disclosure, and all users adhere to strict HIPAA criteria. Should you have any questions, please address them with our office manager or your personal physicians.

☐ Yes: I would like to receive copies of my care document(s), per encounter at the following: e-mail address:(please print clearly)_____

☐ No: I decline to receive copies and I understand my encounters will be uploaded

☐ No: I decline to receive copies and DO NOT want my encounters uploaded to the portal

Patient Name Printed:_____

Patient Signature: _____ Date:_____

Witness:_____