# WELCOME

one

## ABOUT YOU

Today's Date: ____/____/____ File #: _____

**Patient Name:** _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

**Employer:** _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two

## INSURANCE INFO

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

## REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ____/____/____

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

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom? _____ Phone#: _____

three

PLEASE CONTINUE ON BACK

four

## IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

## HEALTH HISTORY

five

**Are you taking any of the following medications?**

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

**Do you have or ever had any of the following diseases or conditions?**

| | | |
|---|---|---|
| **Y N** Heart Attack / Stroke | **Y N** Heart Surg./Pacemaker | **Y N** Heart Murmur |
| **Y N** Congenital Heart Defect | **Y N** Mitral Valve Prolapse | **Y N** Artificial Valves |
| **Y N** Alcohol / Drug Abuse | **Y N** Venereal Disease | **Y N** Hepatitis |
| **Y N** HIV+ / Aids | **Y N** Shingles | **Y N** Cancer |
| **Y N** Frequent Neck Pain | **Y N** Emphysema / Glaucoma | **Y N** Anemia |
| **Y N** High/Low Blood Pressure | **Y N** Psychiatric Problems | **Y N** Rheumatic Fever |
| **Y N** Severe/Frequent Headaches | **Y N** Kidney Problems | **Y N** Ulcers / Colitis |
| **Y N** Fainting/Seizures/Epilepsy | **Y N** Sinus Problems | **Y N** Asthma |
| **Y N** Diabetes / Tuberculosis | **Y N** Difficulty Breathing | **Y N** Chemotherapy |
| **Y N** Lower Back Problems | **Y N** Artificial Bones / Joints | **Y N** Arthritis |

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any **past** serious accidents with dates: _____

_____

Family Health History: _____

_____

**Do you:** Take Supplements or Vitamins? ❑Yes ❑ No / Exercise? ❑Yes ❑ No

Are you on a special diet: ❑ Yes ❑ No / Since: _____/_____/_____

Do you smoke? ❑ No ❑ Yes / How Much? _____ How Long? _____

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? _____ Is it comfortable? ❑ Yes ❑ No

**For women:** Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Nursing? ❑ Yes ❑ No

six

## ACCOUNT INFO

**Person ultimately responsible for account**

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SSN: _____

D.L.#: _____

Work Phone#: _____

**Payment method:** ❑ CASH ❑ Check

_____/____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

Wharfside
CHIROPRACTIC CENTER, INC.
Dr. Thomas C. McGillick, D.C.

2 Hollywood Blvd., Suite A
Forked River, NJ 08731
(609) 971-7722
Fax (609) 693-7623
(800) 447-1398

**Notice of Privacy Practices for Wharfside Chiropractic Center, Inc.**

Dear Patient,

Attached to this notice you will find our "7 page Notice of Privacy Practices".

This notice is to communicate to you, that Wharfside Chiropractic Center, Inc., and all employees are taking the Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously.

As you will also notice, our office provides this notice in plain view in our waiting room area so this is available for review at any time when patients enter our office.

Please read and review the attached notice. When finished reading and reviewing the Notice if you would like a copy for your own personal records please ask our front desk receptionist for a personal copy and one will be furnished for you. If you have any questions or concerns, please feel free to discuss these with our front desk receptionist. If you feel your concerns are private, please advise our receptionist that you would like to discuss this matter in a private setting. If you have a direct question and are in need to speak with our privacy officer, Dr. McGillick, please advise our receptionist that you would like to speak with Dr. McGillick personally.

If you are comfortable with our privacy practices, please sign and date where indicated at the bottom of this notice.

**I have been given Wharfside Chiropractic Center Inc.'s "Notice of Privacy Practices" and have had ample opportunity to read and review the notice as provided in Dr. McGillick's office. I have been offered a personal copy of this notice and am aware that this notice is available for review any time in the waiting room/receptionist area of Dr. McGillick's office. I have signed below indicating I have been informed of the HIPAA requirements as they pertain to Wharfside Chiropractic Center, Inc.**

X _____ _____

Patient Name Date

Wharfside
CHIROPRACTIC CENTER, INC.
Dr. Thomas C. McGillick, D.C.

2 Hollywood Blvd., Suite A
Forked River, NJ 08731
(609) 971-7722
Fax (609) 693-7623
(800) 447-1398

**Notice of Privacy Practices for Wharfside Chiropractic Center, Inc.**

Dear Patient,

Attached to this notice you will find our "7 page Notice of Privacy Practices".

This notice is to communicate to you, that Wharfside Chiropractic Center, Inc., and all employees are taking the Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously.

As you will also notice, our office provides this notice in plain view in our waiting room area so this is available for review at any time when patients enter our office.

Please read and review the attached notice. When finished reading and reviewing the Notice if you would like a copy for your own personal records please ask our front desk receptionist for a personal copy and one will be furnished for you. If you have any questions or concerns, please feel free to discuss these with our front desk receptionist. If you feel your concerns are private, please advise our receptionist that you would like to discuss this matter in a private setting. If you have a direct question and are in need to speak with our privacy officer, Dr. McGillick, please advise our receptionist that you would like to speak with Dr. McGillick personally.

If you are comfortable with our privacy practices, please sign and date where indicated at the bottom of this notice.

**I have been given Wharfside Chiropractic Center Inc.'s "Notice of Privacy Practices" and have had ample opportunity to read and review the notice as provided in Dr. McGillick's office. I have been offered a personal copy of this notice and am aware that this notice is available for review any time in the waiting room/receptionist area of Dr. McGillick's office. I have signed below indicating I have been informed of the HIPAA requirements as they pertain to Wharfside Chiropractic Center, Inc.**

X _____ _____

Patient Name Date

**WE WILL USE AND COMMUNICATE YOUR "HEALTH INFORMATION" ONLY FOR THE PURPOSES OF PROVIDING YOUR TREATMENT, OBTAINING PAYMENT AND CONDUCTING HEALTH CARE OPERATIONS. YOUR HEALTH INFORMATION WILL NOT BE USED FOR OTHER PURPOSES UNLESS WE HAVE ASKED FOR AND BEEN VOLUNTARILY GIVEN YOUR PERMISSION.**

**OUR LEGAL RESPONSIBILITY:**

**Law requires us to:**

1. **Keep your medical information private.**
2. **Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.**
3. **Follow the terms of the notice that is now in effect.**

**We have the right to:**

1. **Change our privacy practices and the terms of this notice at any time, provided that changes are permitted by law.**
2. **Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep.**

**To Provide Treatment:**

**We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician, assistant, covering physician, receptionist, and billing managers along with any other office staff. In addition, we may share your health information with referring physicians, clinical and pathological laboratories, pharmacies, and diagnostic testing centers or other health care personnel providing you treatment.**

**To Obtain Payment:**

**We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will ensure that we are working with other companies with a similar commitment to the security of your health care information.**

**To Conduct Health Care Operations:**

**Your health information may be used during performance evaluations of our staff. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.**

**Family, Friends and Caregivers:**
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgement when sharing your health information only when it will be important to those participating in providing our care.

**To Coroners, Funeral Directors, and Medical Examiners:**
We may be required by law to provide information to coroners, funeral directors and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

**Other use and Disclosure of Information:**
De-Identified Information allows Wharfside Chiropractic Center to use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you in any way.

**Business Associate:**
Wharfside Chiropractic Center may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists Wharfside Chiropractic Center in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

**Personal Representative:**
We may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

**Emergency Situations:**
We may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible.

**Medical Research:**
Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance requirements and approval of an Institutional Review Board.

**In Patient Reminders:**
**Because we believe regular chiropractic care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and curative care modern chiropractic care provides. This may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as emails. This will be a part of our office practice with you unless you inform us that you do not want to receive these reminders. At no time will any protected health information (PHI) ever accompany any notice except that which is needed for legal purposes (ex: a diagnosis for patient billing, etc.).**

**Directory/Sign –In Log – Wharfside Chiropractic Center maintains a sign-in log at its reception desk for individuals seeking care and treatment in this office. The sign-in log is located in a position where staff can readily see who is seeking care in this office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.**

**Abuse or Neglect:**
**We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgement, when we believe we are specifically required or authorized by law or with the patient's agreement.**

**Public Health and National Security:**
**We may be required to disclose to Federal officials or military authorities, health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.**

**For Law Enforcement:**
**As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstance, if you are a victim of a crime or in order to report a crime.**

6. **REQUEST A COPY OF THIS NOTICE-** ***You have the Right*** **to obtain a free copy of this exact Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will hand you a direct copy in our office, mail you a copy or e-mail to you if you so request. We are required by law to maintain the privacy of your health information and to provide to you, or your representative, this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.**
7. **OPINIONS REGARDING PRIVACY CONCERNS:** ***You have the Right*** **to express complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express your concerns to us regarding the privacy of your information. Please let us know of any concern(s) in writing and we will respond to your concern(s) within three (3) business days.**
8. **PRIVACY OFFICER- Dr. Thomas C. McGillick is the acting Privacy Officer for Wharfside Chiropractic Center, Inc. as of April 14, 2003. Please direct your written comments, complaints or concerns regarding your privacy of your health information or about anything commented in this Privacy Notice. Written comments may be dropped off at our office or mailed directly to Dr. McGillick at 2 Hollywood Blvd. Suite A Forked River, NJ 08731 All comments, concerns, or complaints will be strictly held confidential and shall not become part of the patients health information folder.**
9. **You also have the right to complain to the Practice or to the Secretary of HHS (Health and Human Services) as provided by Privacy Rule Section 164.520(b)(1)(vi) if you believe your privacy rights have been violated. To file a complaint with the Practice, please contact our Practice's Privacy Officer in writing.**

**To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule) you may contact Wharfside Chiropractic's Privacy Officer, Dr. Thomas C. McGillick.**

**Wharfside Chiropractic Center is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI. In future considerations, we may be required by New Jersey State law to maintain greater restrictions on the use of release of your PHI than that which is provided for under federal law.**

**EFFECTIVE DATE: This notice is in effect as of 04/14/2003**

**Authorization to Use or Disclose Health Information:**
**Other than is stated above or where Federal, State or Local law requires us, we will NOT disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.**

# PATIENT RIGHTS:

**This new law is careful to describe that you have the following rights related to your health information.**

1. **RESTRICTIONS-** ***You have the Right*** **to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.**
2. **CONFIDENTIAL COMMUNICATIONS-** ***You have the Right*** **to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.**
3. **INSPECT AND COPY YOUR HEALTH INFORMATION-** ***You have the Right*** **to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. Our office charges a fee of $1.00 per page copy fee and $10.00 per copy of radiographs. A reasonable time should be allowed for proper review of records and copying.**
4. **AMENDMENTS TO RECORDS- If we have any information which needs amendments, updates or changes,** ***you have the Right*** **to request amendments to your records at no charge. Our office is happy to accommodate your request as long as our office maintains this information. In order to standardize this process, please provide us with your request in writing and describe your reason for a requested change. NOTE: Your request MAY be denied however if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.**
5. **DOCUMENTAION OF HEALTH INFORMATION-** ***You have the Right*** **to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations (TPO). Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We may again need to charge you a reasonable fee as noted in the records request. Health information is required to be on file and available for seven (7) years from date of service, after seven (7) years records are no longer available and are destroyed. An exception to the seven- (7) year rule is given to minors where records are kept for a minimum of seven (7) years and are also kept until the minor reaches the age of 21.**