Hirsh Chiropractic Center

Patient Application Form

WELCOME and THANK YOU for applying as a patient at Hirsh Chiropractic Center! We are a unique team specializing in research-based spinal and posture rehabilitation. These methods have enabled our patients to achieve optimal health; even when other systems may have failed. Because of this approach, we may not accept you as a patient until we are certain we know the cause of you condition and are confident that we can help you recover your health. If we do not accept you as a patient, we will make specific recommendations based upon our understanding of your health.

_____

Patient Name

_____

Date Completed

Patient Information

Name: _____ Date of Birth: ___________

Address: _____ Cell: _____

City, State, Zip: _____ Home: _____

Email:_____ Marital Status: S M D W

Occupation: _____ Social Security: _____

Employer: _____ Gender: M F O

Spouse's Name: _____ Cell: _____

How were you referred to this office? Google Yelp Facebook PCP Insurance

Friend\ Family: _____

Purpose for This Visit

What is the MAIN reason for this visit? _____

What caused this condition? _____ Condition began: _________

Symptoms are: ___Constant ___ Frequent ___Occasional ___Intermittent

Do symptoms radiate to other areas, i.e. down arm or leg? _____

How has the complaint changed since onset? _____

The pain interferes with: ___Bending ___Sitting ___ Standing ___Walking

___Climbing Stairs ___Driving/Traveling ___Employment ___Exercising ___Lifting

___Getting in/ out of car ___Grocery Shopping ___Homemaking ___Making Love

___Personal Care ___Sleeping ___ Social Life ___ Yardwork

Have you had any previous episodes of this condition? _____

If yes, when? ___________ What treatment have you received until now for this condition?

_____

What aggravates this condition? _____

What improves this condition? _____

Have any healthcare providers performed any tests for this condition? _____

Experience with Chiropractic

Have you been treated by a Chiropractor before? Y N Who? _____

Did they take before and after x-rays? Y N What was the diagnosis? _____

Did they recommend a course of treatment? Y N Did they recommend Home Health Care? Y N

If yes, what? _____ How long were you treated? _____

Last treatment: ___________ How did you respond? _____

Are you aware of any poor posture habits? Y N Any family history of spinal problems? Y N

If yes, explain: _____

General Symptoms Chart

Name: _____ Date: ____________

Please list each of your present complaints from WORST to least.

Complaints List each complaint separate.	**Frequency** How often does it bother you? (Constant, Often, Occasionally, Rarely)	**Quality** Sharp, Dull, Achy, Stabbing, Numb, Tingling	**Scale** From 0-10 with 10 being the worst.
1)			
2)			
3)			
4)			
5)			
6)			
7)			

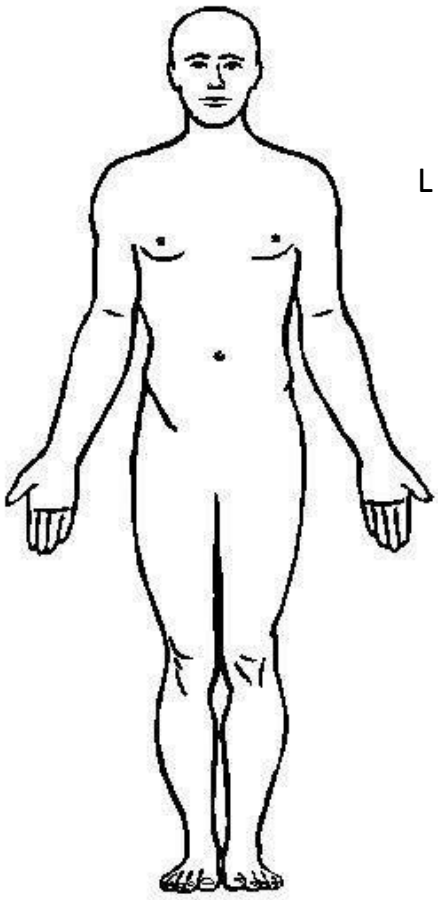
On the figures below please indicate where you are experiencing pain or discomfort by drawing on the area and then indicate the type of discomfort using this key.

A = Ache B = Burning P = Pins & Needles G = Stabbing M = Spasm

F = Stiffness T = Tingling N = Numbness S = Sharp O = Other

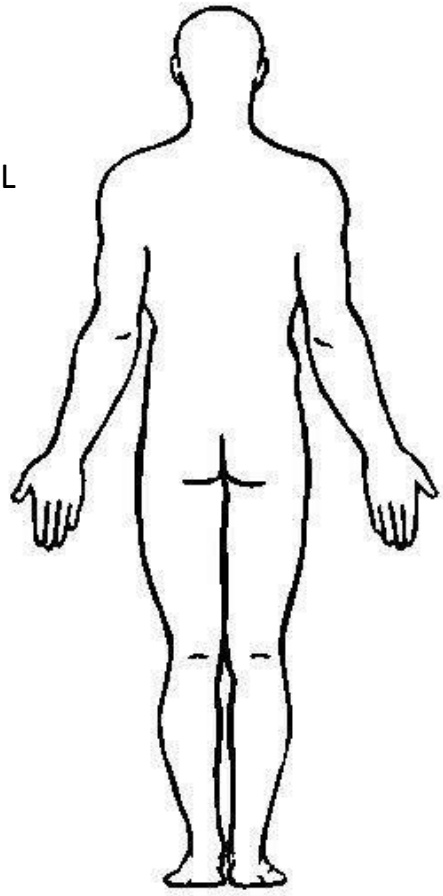
FRONT

R L



BACK

L R



Health & Lifestyle

Do you exercise? Y N How often? _____ day(s) per week.

What activities? Walking___ Running___ Weight Training___ Cycling___ Yoga____ Pilates___

Other: _____

Do you smoke? Y N How much? / How often? _____

Do you drink alcohol? Y N How much? / How often? _____

Do you drink coffee? Y N How much? / How often? _____

Do you take any supplements (vitamins, minerals, herbs)? _____

If yes, please list: _____

Please read the following and instructions of each section thoroughly:

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread, ultimately causing weakness and distortion to ALL areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease, and possibly a shortened life span. Please answer the following questions accurately so we may determine the FULL extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete **cervical curve** (neck) may result in many health conditions. Have you experienced any of these presently or in the past?

***Please indicate (N) = Now or (P) = Past** next to all conditions you've experienced or both if applicable.*

___Neck Pain ___Headaches ___Sinusitis

___Pain in shoulders/ arm/ hands ___Dizziness ___Allergies/ hay fever

___Numbness/ tingling in arms/ hands ___Visual disturbances ___Recurrent colds/ flu

___Hearing disturbances ___Coldness in hands ___Low energy/ fatigue

___Weakness in grip ___Thyroid conditions ___TMJ/ pain/ clicking

Please explain: _____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper **thoracic curve** (upper back) may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

***Please indicate (N) = Now or (P) = Past** next to all conditions you've experienced or both if applicable.*

___Pain in Upper Back ___Heart palpitations ___Recurrent lung infections/ bronchitis

___Heart murmurs ___Asthma/ wheezing

___Tachycardia ___Shortness of breath

___Heart attacks/ angina ___Pain on deep inspiration/ expiration

Please explain: _____

Health Conditions *continued…*

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid **thoracic curve** (mid back) may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now or (P) = Past *next to all conditions you've experienced or both if applicable.*

___Mid back pain ___Nausea ___Diabetes

___Pain in ribs/ chest ___Ulcers/ gastritis ___Hypoglycemia/ hyperglycemia

___Indigestion/ heartburn ___Reflux

___Tired/ irritable after eating or when not having eaten for a while

Please explain: _____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the **lumbar curve** (low back) may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now or (P) = Past *next to all conditions you've experienced or both if applicable.*

___Pain in hips/ legs/ feet ___Weakness/ injuries in hips/ knees/ ankles ___Low Back pain

___Numbness/ tingling in legs/ feet ___Recurrent bladder infections ___Coldness in legs/ feet

___Frequent/ difficulty urinating ___Muscle cramps in legs/ feet ___Sexual dysfunction

___Constipation/ Diarrhea ___Menstrual irregularities/cramping

Please explain: _____

OTHER

List any health conditions not mentioned above:

_____

_____

List any prior trauma, car accident, fall, sport injury or other injury:

_____

_____

_____

List any medications (include name, dose, condition, and how long you've been taking it):

_____

_____

_____

List any surgeries (include type of surgery and date it was performed):

_____

_____

Family Health History

Have you or any of your family members ever been diagnosed with the following?

***Please indicate (Y) = You or (O) = Other family member** or both next to all conditions applicable.*

___Diabetes	___ Varicose veins	___Neurological problems	___Lung disease
___Rheumatic	___Circulatory problems	___Stroke	___Hear murmur
___High blood pressure	___Heart disease	___Cancer	___Osteoporosis
___Kidney disease	___Paralysis	___Migraine headaches	___Arthritis
___Liver disease	___Metal implants	___Infectious disease	___Gall bladder
___Broken bones/ fractures	___Appendectomy	___Tonsillectomy	___Hernia
___Pneumonia/bronchitis	___Polio	___Tuberculosis	___Anemia
___Whooping cough	___Chicken pox\ shingles	___Mumps	___Measles
___Thyroid problems	___Small pox	___Influenza	___Pleurisy
___Blood sugar problems	___Epilepsy/ seizures	___Eczema/ psoriasis	___Lumbago

___Other: _____

Authorization of Care

I authorize and agree to allow the doctors/ staff to take **X-RAYS** and work with my spine, or the spine of the charge I represent, though the use of spinal **adjustments and rehabilitative exercises** for the sole purpose of pastoral and structural restoration of normal bio-mechanical and neurological function.

Initial___

I understand that I am responsible for ALL fees incurring for the services provided and agree to ensure full payment of all charges.

Initial: ___

The doctors and their staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this office.

Initial: ___

I also clearly understand that if I do not follow the doctors and/ or staff's specific recommendations at this office that I will not receive the full benefit from these programs and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Initial: ___

Patients signature: _____ Patient name printed: _____ Date: ____________

PARENT OR LEGAL GUARDIAN RELEASE:

Relationship to patient: _____ If legal guardian, please complete the following:

Date guardianship awarded: Date: ____________ County & State of guardianship: _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Parent or Guardian signature: _____Date: ____________

PREGNANCY RELEASE (females only):

This is to certify that to the best of my knowledge I am not pregnant and above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____________ Patients signature: _____Date: ____________

Emergency Contact

Name: _____ Relationship: _____
Cell: _____ Home: _____ Work: _____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this office. In cases where benefits are not assignable or in any case where your benefit is processed directly to you, regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this office within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation of payment of services received.

Your insurance plan is a contract between you and your insurance company. This practice is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive in this office is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this office and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits, we require that you provide a credit card with authorization to bill the account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company is not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will automatically be transferred to your credit card or extended payment plan.

ITEMIZED RECEIPTS, aka "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. If this office does not participate with your insurance provider, patient are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred to as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal record.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier, they are performing these services strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover; if that is the case I agree to pay for these services.
Initial: ___

Patients signature: _____ Date: __________

Signature of person authorizing care: _____ Date: _________ Relationship to insured: _____

Primary Insurance Company: _____ Policy ID: _____

Insurance Address & Phone: _____

Insured's Name: _____ Insured's Employer: _____

Insured's date of birth: __________ Insured's last 4 of SS #: _____ Relationship to insured: _____

HIPPA Notice of Privacy Practices

Hirsh Chiropractic Center 301-490-7785
14440 Cherry Lane Court Suite 100 Laurel, MD 20707

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your PHI may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to a medical school student that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contract you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Requires By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensations: Inmates: required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in in reasonable anticipation of, or use in, a civil, criminal, or administrative, actions or proceedings, and PHI, that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even, if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment you have the right, you may file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint.

We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices;

_____ _____ _____

Signature Print Date