LoTurco Chiropractic PLLC

LoTurco Chiropractic
PATIENT INTAKE REGISTRATION QUESTIONNAIRE

Last Name_____ First Name_____ Initial_____

Street _____City_____ State___ Zip_____

Home Phone #(____)_____ Work Phone #(____)_____

Cell Phone # (____)_____ E-Mail_____

Date of Birth _____/_____/_____Sex _____ SS#_____-_____-_____ Marital Status_____

Employer_____Occupation_____

Street _____City_____ State____ Zip_____

How did you hear about our practice? _____

INSURANCE INFORMATION

To ensure all billing is submitted properly, please provide us with the following information. The front office will also need to make a copy of your insurance card for our records.

Insurance Company _____ Phone #_____
Street_____ City_____ State_____ Zip_____

Agent (Adjuster)_____ Phone #_____

Policy #_____Claim #_____ Group #_____

Name of Policy-holder_____ Your Relationship to holder_____

Is your current condition related to an Employment Incident? • NO •YES

Is your current condition related to an Automobile Accident? • NO • YES

Other Accidents?_____ If so, please describe_____

When did your present symptoms appear?_____

Have you ever had any complaints in the involved area before? •NO •YES

If yes, please explain:_____

Are your symptoms: Improving • Getting worse • Remaining the same •

Have you ever been Hospitalized for this condition? NO • YES • Name:_____

Street_____ City_____ State_____ Zip_____

In case of emergency, who should be notified? _____

Phone # ( ):_____ Relationship:_____

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Please check any boxes that apply to you NOW...

Symptoms	Symptoms
☐ Headaches	☐ Loss of Balance
☐ Neck Pain	☐ Fainting
☐ Back Pain	☐ Loss of Smell
☐ Trouble sleeping	☐ Loss of Taste
☐ Nervousness	☐ Diarrhea
☐ Tension	☐ Cold Hands
☐ Irritability	☐ Cold Feet
☐ Chest Pain	☐ Arthritis
☐ Dizziness	☐ Muscle Spasms
☐ Shoulder/Arm/Neck Pain	☐ Frequent Colds
☐ Pins & Needles in Arms	☐ Upset Stomach
☐ Pins & Needle in Legs	☐ Constipation
☐ Numbness in Fingers	☐ Cold Sweats
☐ Numbness in Toes	☐ Fever
☐ High Blood Pressure	☐ Sinus Problems
☐ Difficulty urinating	☐ Diabetes
☐ Allergies	☐ Hemorrhoids
☐ Weakness in the Arms	☐ Leg Cramps
☐ Weakness in the Legs	☐ Colitis
☐ Shortness of Breath	☐ Gall Bladder
☐ Fatigue	☐ Indigestion
☐ Depression	☐ Vomiting
☐ Light Bothers Eyes	☐ Shoulder Pain
☐ Loss of Memory	☐ Knee Pain
☐ Ringing in the Ears	☐ Hay Fever
☐ Face Flushing	☐ Menstrual Problems
☐ Buzzing in the Ears	☐ Positive for HIV or AIDS

Chiropractic health care stresses the treatment of the *WHOLE* person, not just your back and neck.
To help us understand your health history, we ask that you fill out this questionnaire.

Have you ever had chiropractic care before? Yes • No •

If so, when and with whom? _____

Do you have any Allergies? Yes • No • If so, to what are you allergic? _____

_____

_____

Have you ever broken any bones? Yes • No • If so, which ones and when?

_____

_____

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Medical History

Patient's Name: _____

Have you dislocated any Joints? Yes • No• If so, which joints? _____
_____

Please list any operations you have had:

1. **Year _____ Operation _____**
   _____
2. **Year _____ Operation _____**
   _____
3. **Year _____ Operation _____**
   _____
4. **Year _____ Operation _____**
   _____

Have you been treated by a physician for any other health conditions in the last year?
Yes • No • If so, for what condition?
_____
_____

Have you lost or gained weight in the last year? Yes • No •
Are you currently taking any medications? Yes • No •
If so, what medication? (Please list dosage) _____
_____
_____

Do you take vitamins or herbs? Yes • No •
If so, what type and how much? _____
_____
_____

Who is your Primary Care Physician? _____
Where are they located? _____ Phone: _____

When was your last:

	0-6 Months	6-12 Months	Over 12 Months	Never
Physical Exam:	☐	☐	☐	☐
Blood Test:	☐	☐	☐	☐
Urine Test:	☐	☐	☐	☐
X-rays:	☐	☐	☐	☐

Do you have any of the following habits?

Alcohol ☐ **Yes** ☐ **No** **How Much?** **_____**

Coffee/Tea	Yes	No	How Much? _____
Tobacco	Yes	No	How Much? _____
Exercise	Yes	No	How Much? _____

Is there anything else about your health history that you think we should know?

_____

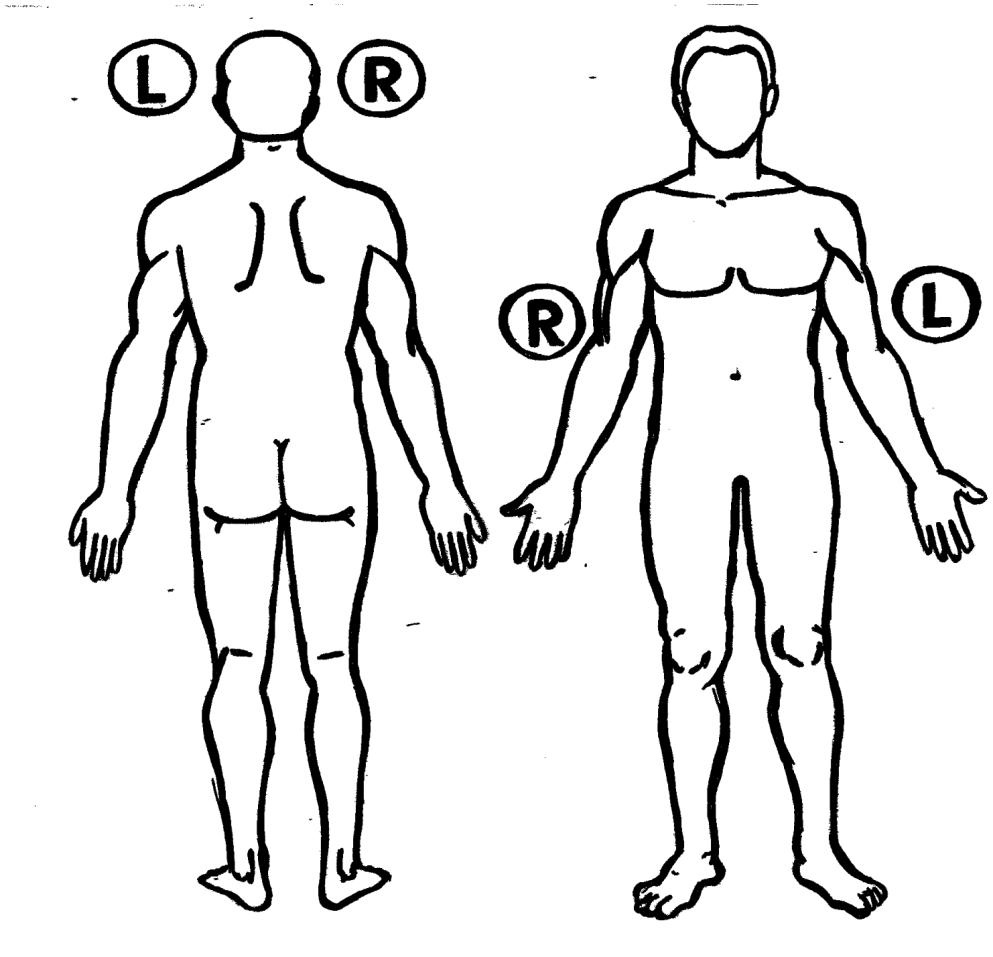
_____

Patient's Name: _____

Mark all the areas of your body where you feel pain <u>NOW</u>.
Use the symbols below to describe the type of pain in the area of pain.

ACHE ####	**NUMBNESS ====**	**PINS& NEEDLES oooo**
BURNING xxxx	**STABBING ////**	**OTHER ^^^^ (please describe)**

Draw At The Location Of Your Pain



Rate Your Pain For <u>TODAY</u>

0 1 2 3 4 5 6 7 8 9 10

No Pain **Severe Pain**

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FINANCIAL POLICY

SCHEDULING - **All appointments during regular hours must be scheduled so as reduce waiting time for you and others.**
- **You are free to stop in at any time, but you will have to wait until all scheduled appointments are seen. You will be fit in as soon as possible**
- **Cancellations require 24 hour notice. THERE IS A $20.00 FEE OTHERWISE.**

PAYMENT
- **Payment is expected in full at the time services are rendered. This includes all co-payments.**
- **For your convenience we accept Cash, Checks, MasterCard and Visa.**
- **Payments on your deductible will be made by paying our per visit charge until it is met.**
- **Should you discontinue care for any reason other than discharge by the doctor, any outstanding balances will become immediately due and payable in full by you.**

INSURANCE
- **Our office will verify your insurance coverage in effort to help you determine exactly what chiropractic coverage is available under your policy.**
- **It is your responsibility to provide us with all the appropriate insurance forms, addresses, and information so that proper filing can be done.**
- **We are not obligated to accept your insurance payment on assignment although for your convenience, we may based on our experience with your insurance carrier.**
- **You are always responsible for the portion of your bill that the insurance may not cover and for your annual deductible.**
- **Remember that your insurance coverage is a contract between you, your employer and the insurance company. We do not bill any secondary insurance carriers.**
- **Does not apply to massage.**

FEES
- **Our fees generally fall between what is considered reasonable and customary for this area.**
- **Many insurers pay a percentage of the reasonable and customary rate, called the Co-Pay.**

LASTLY
- **You are responsible for all charges incurred as a patient of this office.**
- **We will do all we can with your insurance claims, but ultimately, you are responsible for payment.**
- **Past due statements for unpaid balances will be mailed. Statements unpaid for more than 30 days may be subject to an interest charge. In the effort to avoid expensive collection agency fees we hold the right to automatically bill any unpaid and outstanding balances, including interest payments to any credit card account on file in our office.**

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regards to your health 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, the undersigned, have read and agree to the guidelines of this financial/insurance policy. I also fully acknowledge that I have insurance coverage with _____ Insurance Company and assign directly to **(Dr. Jacob P. LoTurco)** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby, authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient's Signature:_____**Date:**_____

LoTurco Chiropractic PLLC

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Notice of Privacy Practices and Patient Rights

The use and Disclosure of Protected Health Information
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.

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a patient of ours, facts about you must be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and/or medical records;
- Diseases spread person to person, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);
- Drug and/or alcohol abuse;
- Psychiatric diagnosis and treatment records;
- Laboratory test results;
- Medical history;
- Treatment progress;
- Data from the OASIS data set (home health);
- Any other related facts.

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management;
- Any hospital, nursing home, or other health care facility where you may have done testing done or to which you may be admitted;
- Any assisted living or personal care facility where you live;
- Any doctor providing your care;
- Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.;
- State and/or Federal agencies acting on behalf of programs, Medicare and/or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc.;
- Other health care people to start treatment.

We may contact you to:

1. Provide appointment reminders or news about other health programs we provide;
2. Raise funds or donate items for our business.

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;
5. For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.;

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6. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to received abuse, neglect or domestic violence reports;
7. Health care oversight activities;
8. Certain legal administrative proceedings;
9. Certain law enforcement purposes;
10. To coroners, medical examiners and funeral directors in certain situations (home health, hospice, etc);
11. For organ, eye or tissue donation purposes (home health, hospice, etc.);
12. For certain research purposes;
13. To avoid a serous threat to health and safety;
14. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutional and custodial situations;
15. For Worker's Compensation purposes.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patients schedules);
2. To a family member, friend or other person you choose who may assist in your care or payment for care.

Other uses and disclosure will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

Patient Rights:

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you by filling out our Request form. However, we are not required to agree to the request restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our request form.
4. Amend protected health data by filling out our form.
5. Receive a list of disclosures made of your protected health data by filling out our request form.
6. Obtain a paper copy of this notice upon request, if you agreed to this notice by e-mail, fax, or website.

Complaints

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened and details of the incident.

By signing below, you are stating you understand and agree to all the above statements.

Print Name

Signature

Date