Ciarrocca Chiropractic Center
1101 South Avenue West
Westfield, NJ 07090

PATIENT INFORMATION & CONDITION

Date:_____

Patient Name: _____

Address_____

City_____ State_____ Zip code _____ Phone #_____

Date of birth: _____ Age _____ Gender ____M ____F

Marital Status (circle one) Married Separated Widowed Single How many children?_____

Weight _____ Height: ___ft. ___in. Do you smoke? Yes No How many packs per day? _____

Are you (circle one): Left Handed Right Handed

Skip this section of you are over 18 years old. If the patient is under 18 years of age, state the legal parents or guardian

Father _____ **Date of Birth**_____ **Cell Phone** _____

Mother_____ **Date of Birth** _____**Cell Phone**_____

Guardian_____ **Date of Birth** _____**Cell Phone**

Who do you live with?_____

Name of Spouse _____ Date of Birth_____

Spouse Employer _____ Work Phone _____

Spouse's work address_____

Who should we contact in case of an emergency?_____

Phone_____ How did you learn about us?_____

EMPLOYMENT INFORMATION

Your occupation _____ Employer_____

Work Address _____ Work Phone _____

Student at:_____ Full time _____ Part time_____

CONDITION

Did the condition or injury result from an automobile accident? Yes _____ No _____

Did the condition result from a work-related accident or cause? Yes_____ No _____

Approximately when did your injury or condition begin Date ___/___/___

Describe your condition, symptoms, or the purpose of this appointment:

_____

_____

Have you ever had the same or similar condition? Yes_____ No_____. If yes, when, and describe:

_____

_____

Please indicate any other healthcare providers you've seen for this injury or condition, and when you last saw them:

Name:_____ Specialty _____ Date_____

Name_____ Specialty_____ Date_____

Name_____ Specialty _____ Date_____

Date of last physical examination: _____

What surgeries have you had?_____ When? _____

Serious illnesses or conditions_____

Have you been treated for any health condition in the last year Yes_____ No _____

What medications are you taking?

_____

_____

_____

Have you ever suffered from:

_____ Dizziness	_____Arthritis	_____Digestive Disorders
_____Backaches	_____Headaches	_____Nervousness
_____Heart Trouble	_____Numbness	_____Sinus Trouble
_____Diabetes	_____Asthma	_____ Anemia
_____ Hernia	_____ Neuritis	_____ Cancer

WOMEN ONLY: Are you pregnant or is there ay possibility you may be pregnant?
_____Yes _____ No _____Uncertain

Do you have any
allergies_____
_____

Do you have health insurance? _____Yes _____No Insurance Carrier_____

Policy Holder Name _____Policy holder Date of Birth___/___/___

Does the policy holder have insurance through their employer ____Yes ____No

If yes, who is the employer?_____ Employer address _____

Policy holder relationship to patient_____

I understand and agree that health and accident insurance policies are an arrangement between me and my insurance company, not between my insurance company and Ciarrocca Chiropractic Center. I agree to pay my copayment, coinsurance and deducible as well as any uncovered medical expenses my insurance deems my responsibility. My insurance company will make that determination at the time of processing the claims.

I agree to keep a credit card on file in order for my bill to be finalized when my active treatment comes to an end, in the event of an outstanding balance due.

Card Number:_____ **Expiration:**_____

Security Code_____ **Card Holder Name:** _____ **Billing Zip Code**_____

Signature of Card Holder_____

I authorize this office to release any medical information, relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney wo may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assit in collecting from my insurance companies, attorney's or other payers.

I have read, understand and agree to the foregoing: The information which I have provided is true and complete to the best of my knowledge

Patient Signature: _____ Date ___/___/___

Ciarrocca Chiropractic Center
Kenneth J. Ciarrocca, D.C.

Patient Name _____ Date of Birth ___/___/___

PRIVACY POLICY

We keep a record of every healthcare service treatment provided to you within our office. You may ask for a copy of your records under the current laws. We will not disclose your record to others unless you have directly expressed us to do so in writing or unless legal authorities compel us to do so. If you are being represented by an attorney and would like our office to release your information to another business entity you must also state so in writing and your request will be honored based on our office policy timeline.

I have read ad acknowledge the privacy policy and agree.

Signature_____ Date ___/___/___

Relationship to insured: _____

CONFIDENTIALITY POLICY

The Health Insurance Portability and Accountability Act (HIPAA) give the patient the right to request that we communicate financial and medical information to you in confidence. In order to protect your privacy and confidentiality of your information while abiding by the law please complete the information below. This will inform us how you wish to be contacted by the doctor or office staff and to whom we may discuss your health care.

You may contact me at the following phone numbers & email address (provide all that apply):

Home telephone:_____ **Work telephone:** _____

Personal email: _____

Work email: _____

___Yes, you may leave a confidential message at ____Home # ____Cell# _____Work#

___Yes, you may leave a message containing the necessary information on my voice vail or email listed above

I authorize Ciarrocca Chiropractic Center staff to disclose my Protected Health Information (PHI) to the designated person(s) listed below. Ciarrocca Chiropractic Center staff will disclose only information that is directly relevant to the person's involvement with my healthcare or payment, relating to my health care. Ciarrocca Chiropractic Center is not responsible if the person(s) listed below further disclose my protected PHI. I understand I am not required to list any person at all.

Name:_____ Relationship _____

Name: _____ Relationship_____

Name: _____ Relationship_____

Patient Signature_____ Date: ___/___/___

REFERRALS AND AUTHORIZATIONS

A "referral" is a document that may be required from your primary care physician before you can begin treatment with a specialist. Please check with your healthcare insurance carrier to see if a referral is required under the terms of your policy. **If your policy requires a referral and you do not get one prior to the beginning of your treatment, you will be responsible for the full cost of the treatment that will not be covered as a result. If the referral is for a specific number of treatments or dates of service, we will do our best to keep track of this, but ultimately it is your responsibility and if you treat on a date of service that was not approved you are responsible for paying for that date of service**

An "authorization" or "pre-authorization" is a status that is obtained by the doctor here at Ciarrocca Chiropractic Center. The doctor will send a report and request for treatment to your insurance carrier, and the carrier in turn will either approve or deny the request. The approval of the request generally comes in the form of a limited number of visits, or an approved period of time where treatment can occur. **Please note that if you receive treatment during a time when there is no active pre-authorization on file, and it is required under the contract you have with your insurance carrier, you must pay the full amount of the treatment for that day.**

I understand the policy on referrals and authorizations.

Patient Signature_____ Date ___/___/___

FINANCIAL POLICY

We are committed to providing you with the best possible Chiropractic care. If you have medical insurance, we are happy to help you receive the maximum allowable benefits under your contract.

In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. According to the Affordable Care Act and the State of New Jersey Insurance Laws, medical providers are required by law to collect all copayments, coinsurance and deductibles as spelled out in your individual contract with your provider. In order to receive a discounted rate, true hardship must be demonstrated and documented.

We accept cash, checks, all credit cards except Discover. Under the law, most insurance claims MUST be submitted electronically, and Ciarrocca Chiropractic Center is equipped to handle this. We will submit your insurance claims subject to verification of benefits. You, as policyholder are responsible for 100% of the claim, and if there is a problem with getting your insurance to pay their portion of the bill, it is up to you to compel the insurer to do their part.

Our fees are considered to be usual, customary and reasonable by all insurance carriers and therefore are covered up to the maximum allowance as determined by each carrier.

Continuity of Care: Your healing and improvement are the reason you sought out treatment at Ciarrocca Chiropractic Center. If we are required to obtain permission or authorization to provide care at any point in your treatment, we are committed and equipped to doing this in a timely fashion. We submit all medical records, reports and notes as requested I the required time frame. Often insurance carriers do not respond back in an equally timely fashion, and in the interest of continuity of your care, we will continue your treatment while the insurance company makes it's decision aout ongoing care. In the event further treatment is not approved you will e responsible for $60.00 per visit for each uncovered treatment rendered.

We must emphasize that as health are providers our relationship is with you, not your insurance company or your primary care physician. While the filing of insurance claims is a benefit we extend to all of our patients, all charges are your responsibility from the dates the services are rendered. All bills must be paid I full within 45 days of the conclusion of treatment

If you have any questions about our financial policy, or any uncertainty regarding your insurance coverage, please feel free to ask. We are here to help you.

Patient Signature _____ Date ___/___/___