CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

Patient Name _____

_____

Address _____

City _____

State _____ Zip _____

Email _____

Social Security # _____ - _____ - _____

Sex ☐ M ☐ F Age _____

Birth date _____

Marital Status

☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Minor ☐ Single ☐ Partnered for _____ years

Occupation _____

Patient Employer/ School _____

Employer/ School Phone (_____)_____

Primary Doctor _____

Whom may we thank for referring you

☐ Walk-in ☐ Insurance ☐ Gift card ☐ Attorney

☐ Former Patient: _____

Internet: ☐ Google ☐ Yelp ☐ Website

☐ Other: _____

INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance Co. _____

Group # _____

Policy ID _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth date _____

Relationship to patient _____

ASSIGNMENT AND RELEASE

I certify that I, and my dependant(s), have insurance coverage with _____ and assign directly to Dr. Colaizzo all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to patient

PHONE NUMBERS

Home Phone (_____)_____

Cell Phone (_____)_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Phone (_____)_____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes, Date _____ ☐ No

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto insurance ☐ Employer ☐ Workers Comp. ☐ Other

Attorney name (if applicable): _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of the pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

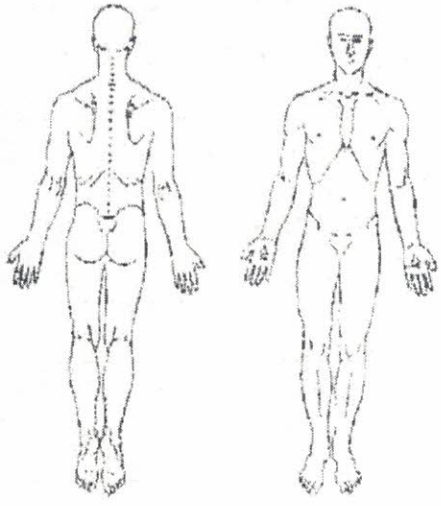
How often do you have this pain? _____

Is it constant of does it come and go? _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are difficult to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying down



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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and addresses of other doctor(s) who have treated you for your condition _____

Date of last: Physical exam _____ Spinal X-ray _____ Blood Test _____
Spinal Exam _____ Chest X-ray _____ Urine Test _____
Dental X-ray _____ MRI, CT-scan, Bone scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tyhhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated disc	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Prostate Problems	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking — Packs/ Day _____
☐ Alcohol — Drinks/ Week _____
☐ Coffee/ Caffeine drinks — Cups/ Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ No ☐ Yes, Due Date _____

Injuries/ Surgeries you have had

	Description	Date
Falls		
Head injuries		
Broken Bones		
Surgeries		

MEDICATIONS
_____
_____
_____
_____
_____

ALLERGIES
_____
_____
_____
_____
_____

VITAMINS/ HERBS/ MINERALS
_____
_____
_____
_____
_____

HIPPA 2022
Catherine Colaizzo, D.C.
1075 Easton Ave. Somerset, NJ 08873

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 here we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider 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, or your employer, if they are or may responsible for the payment of your services.

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related 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. Further, you have the right to inspect or obtain a copy of the information we will 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 provide 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 judgement we believe that you intend for us to provide care. *If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. 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 or about the status of your account. 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 and/or copy your health information for seven years from the date that the record was created or 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.

We are required by state and federal law to maintain the privacy of your patient file and the health 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: US DEPT of Health & Human Services.

This notice is effective as of Jan 1, 2014. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Printed) date	Signature	Parent or Guardian

Coronavirus (COVID_19) Screening Questionnaire

Patient Name:_____ Date:_____

DOB: _____ Age: _____

1) Have you traveled anywhere in the last 3 weeks (especially outside the USA)?

_____

_____

2) Have you been in contact with anybody that was sick in the last 3 weeks? NO____ Yes _____If yes please explain. (this could be a friend, family or co- worker).

_____

_____

3) Have you been to a region designated as an epicenter (AREAS OF HIGH CONTAGION)?

YES___ NO_____ If yes please explain.

_____

_____

4) Do you have symptoms of a cold or flu? Yes_____ NO___
5) Do you have a cough? YES___ NO_____
6) Do you have any difficulty breathing? YES___ NO____
7) Do you have a runny nose? YES____ NO____
8) Do you have a sore throat? YES____ NO____
9) DO you have any illness related body aches? YES_____ NO_____

I attest that I have fully and properly answered the above questions and the information complete.

Patient's/ Guardian's Signature: _____ Date:_____

Welcome to the Chiropractic & Therapy Center!
1075 Easton Avenue Somerset, NJ ♦ (P) 732-545-5999 ♦ (F) 732-545-3439 ♦ chirtherapy@yahoo.com
Catherine Colaizzo, DC

The insurance company, Medicare/_____, covers chiropractic services but on a very limited basis. You are allowed unlimited visits per calendar year. It does not cover services chiropractors are licensed and trained to perform such as:

X-rays, examinations, interferential electrical stimulation, ultrasound, ART (active release care), manual soft tissue therapy, massage, muscle work, neuromuscular re-education, stretching, active exercises, general nutritional counseling, and durable supplies such as cervical pillows and Biofreeze.

Note to Medicare Patients: even if you have AARP as additional insurance, these services will not be covered as AARP only covers charges approved by Medicare. However, coverage from a secondary insurance company may assume the costs.

In order to administer appropriate, quality chiropractic care some or all of the above services will be needed to be performed. This letter is to inform you of your benefits prior to receiving services. All non-billable services will be your responsibility. This is in addition to your co-pay/co-insurance of $30.00/_____% per visit.

Non-billable Exam Fee $_____ Non-billable X-rays $_____

Additional therapies $_____ Co-pay/Coinsurance $30.00/_____%

Total fee per visit $30.00

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. I hereby assign my insurance benefits to be paid directly to the Chiropractic & Therapy Center and acknowledge that I am financially responsible for any non-covered services. I hereby authorize my physician to release any information required to support my claim.

Print Name: _____

Signature: _____ **Date**: ____/____/____

☐ Adult Patient ☐ Parent/Guardian ☐ Spouse

Chiropractic & Therapy Center
Catherine Colaizzo, D.C.

Date: _____

Medical Release Form

I authorize the release and exchange of medical records including office notes, exam reports, and diagnostics tests between the entities listed below.

_____

_____

_____

Phone: _____

Fax: _____

Chiropractic and Therapy Center
Catherine Colaizzo, DC
1075 Easton Avenue Suite 9
Somerset, NJ 08873
P (732) 545-5999
Fax(732)545-3439

Patient name (printed) _____

Patient DOB: _____

Patient Signature: _____

Date of signature :_____