

CULVER CHIROPRACTIC, P.C.

Dr. Thomas E. Culver – Palmer Graduate
1490 Springfield Ave., Ste 2 New Providence, NJ 07974
telephone: (908)508-1212 facsimile: (908)508-9211

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your care. Thank you.

Name: _____ **Social Security:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Birthdate: _____ **Age:** _____ **E-mail address:** _____

Home Telephone: (_____) _____ **Work Telephone:** (_____) _____

Cell Telephone: (_____) _____ **Fax:** (_____) _____

Marital Status: M / S / W / D **Number of Children:** _____

Spouse's Name and Phone Number: _____

Occupation: _____ **Company:** _____

College Student: Y / N **If yes, what school?** _____

Referred By: _____

Health Information: Have you had previous chiropractic care? _____

What is your major complaint? _____

Other complaints: _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

What aggravates your condition? _____

Is this condition progressively getting worse? Yes / No / Constant / Comes & Goes

Is this condition interfering with your: Work / Sleep / Daily Routine / Other _____

How long has it been since you felt really good? _____

List surgical operation and years: _____

Drugs you take now: Nerve Pills / Pain Killers / Muscle Relaxers / Pep Pills / Insulin / Birth Control
Others _____

Age of mattress: _____ Comfortable / Uncomfortable

Are you wearing: Heel lifts / Sole lifts / Lunar soles / Arch supports

Have you been in an accident? Past year / Past 5 years / Over 5 years / Never

Describe: _____

Any other personal injury or accidents? Past year / Past 5 years / Over 5 years / Never

Describe: _____

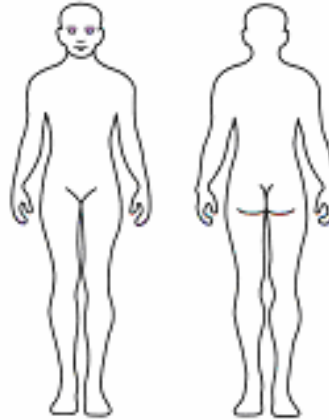
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Have you ever suffered from: (please check)

- Dizziness
- Backaches
- Heart trouble
- Diabetes
- Arthritis
- Headaches
- Asthma
- Hernias
- Digestive disorders
- Nervousness
- Sinus trouble
- Neck pain

Please mark your stress areas on the figure:



Date of last examination: _____

Is your condition due to an auto accident or job related injury? _____

Do you have health insurance? Y / N **Covered by Medicare?** Y / N **If yes, ID number?** _____

Family Health Information: (many health problems are the result of hereditary spinal weakness; thus information about your family members will give us a better picture of your total health picture.)

Name	Relation	Past and Present Health Problems

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If my insurance denies payment for any reason, I am responsible for that amount. Knowledge of my benefits is my responsibility. I understand that I am personally responsible for obtaining a referral from my PCP if my insurance requires it, and if I fail to obtain a referral, I will be responsible for the charges incurred at the time of visit. I also understand that if I suspend or terminate my care and treatment; any fees for professional services rendered to me will be immediately due and payable.

I will be paying today by: Cash / Check / Credit

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

Guardian or Spouse's Signature: _____ **Social Security#** _____

Doctor's Signature: _____

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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 read it carefully.

In the course of your care at **Culver Chiropractic**, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).
- Your name, address, phone number, and your healthcare records may be used to contact you regarding appointment reminders to provide information about alternatives to your personal care, or to 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 information we will use for these purposes. You have a 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 provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted to require using or disclosing your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare services to you based on the orders of another healthcare provider
- If we provide healthcare 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 judgment we believe that you intend for us to provide care.

- If we are ordered by the courts or another appropriate agency.

Any use of disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your healthcare to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare 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 for 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 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 or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have complaints regarding our privacy notice, practices, or any aspect of our privacy activities, you should direct your complaint to:

Thomas Culver (908)508-1212

If you would like further information about our privacy policies and practices please contact:

Thomas Culver (908)508-1212

This notice is effective as of **April 14, 2003**. 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)

Signature

Date

If you are a minor, or if you are being represented by another party:

Peronsal Representative (printed)

Signature

Date

Description of the authority to act on behalf of the patient

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Chiropractic Informed Consent for Diagnosis and Treatment

I hereby give my consent to the performance of diagnosis tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of manipulation. Like most healthcare procedures, the chiropractic adjustment carries with it some risks. Unlike many procedures, the serious risks associated with the chiropractic adjustment are extremely rare.

I have read or had read to me this informed consent document. *I have discussed or been given the opportunity to discuss any questions or concerns with my doctor and have had these answered to my satisfaction **prior to my signing this informed consent document.*** I have made my decision voluntarily and freely.

Signature of Patient or Guardian

Signature of Witness

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Hardship Agreement

To Whom It May Concern:

By my signature below, I am requesting that my doctor reduce normal and customary fees charged so as to allow my to receive chiropractic care. My financial circumstances are such that if I were to pay the customary fees charged I would be forced (due to economic reasons) to not receive care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship, I am only making partial payments.

Name (printed)

Signature

Date

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Cash Discount Plan

I understand that Dr. Culver is extending a cash discount to me due to the fact that I cannot afford the regular and customary office visit charge, and do not have any other means of payment. I understand and agree to the following conditions of this cash financial plan.

1. This discount can be given because of the bookkeeping savings we can extend as no insurance papers will be filled out, no itemized billings will be issued, and no diagnosis will be given.
2. No billings will be sent. I understand and agree to the following agreement and I take responsibility to meet the conditions of this agreement without billing reminders.
3. I understand that if and when insurance becomes available to me that I will notify the receptionist and the insurance will be billed only from that date on. This will void any cash discount agreements and regular fees will be charged from that day on.

Agreement

I have read, understood, and agree to the above stated conditions; I agree to pay Dr. Culver the following:

1. **\$75** for a new patient consultation.
2. **\$48** for a regular adjustment.
3. If x-rays are necessary, they will be charged at a reduced fee.
4. Only if necessary, an additional **\$25** charge will be added if you receive ultrasound and / or stim and heat.

I understand that in the case of default on my part, and it is necessary for this office to employ collection council on this bill, I am responsible for those collection charges. I further understand that in case I decide not to follow the care outlined, I waive this discount and the fees for services will be paid in full.

Signature of Patient or Guardian

Signature of Witness

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Patient Authorization for Referral Board and Patient Information Board

The purpose of a referral board in our waiting room is to express our thanks to those that have referred a patient to our office and to also encourage people to make referrals.

The purpose of a patient information board is to keep you informed on current health issues and to inform you of any of our patient involvement in the surrounding towns.

This authorizes your first and last name to be used on these boards in our office.

Name (printed)

Signature

Date