

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. 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: _____

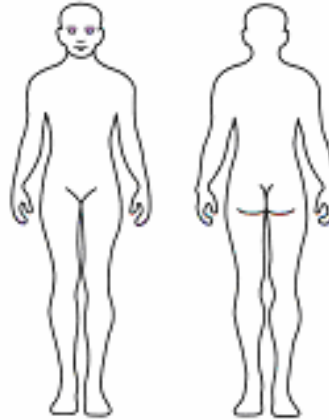
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Have you ever suffered from: (please check)

- 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:

Personal Representative (printed)

Signature

Date

Description of the authority to act on behalf of the patient

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Acknowledgement of Financial Responsibility

If your insurance denies payment for any reason you will be responsible for that amount. We will be happy to help you, but knowledge of your benefits is your responsibility. If we submit your treatment plan late, you will not be responsible for those charges. I acknowledge I have read and understand this form.

Name (printed)

Signature

Date

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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Signature on File

- I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.
- I authorize release of any information related to any claims to all my insurance companies or other relevant parties.
- I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
- I authorize payment of health benefits otherwise payable to me, directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- This "Signature on File" is valid for one year from the date indicated below.

Signature of Beneficiary, Guardian,
or Personal Representative

Medicare # (if applicable)

Date

Print name of Beneficiary, Guardian,
or Personal Representative

Relationship to Beneficiary

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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