

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance 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 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-named 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 (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker 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 your pain on a scale from 1 (least pain) to 10 (severe pain) _____

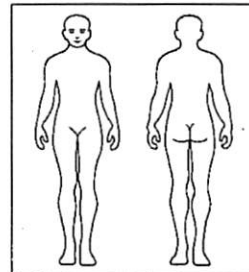
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

<p>EXERCISE</p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p>WORK ACTIVITY</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p>HABITS</p> <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
---	---	--

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____ Insurance Company to pay by check made out and directly mailed to:

***Hawthorne Pain and Spine Center
Dr. Peter J. Berger, DC
219 Lafayette Avenue
Hawthorne, NJ 07506***

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in current manner, any balance of said Professional Services charges over and above this insurance payment.

If my current policy prohibits direct payments to the doctor, then I hereby authorize you to make the check to me and mail it as follows:

***Hawthorne Pain and Spine Center
Dr. Peter J. Berger, DC
219 Lafayette Avenue
Hawthorne, NJ 07506***

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to any case to my insurance company, adjuster, or attorney involved in this case.

Date: _____ 20 _____

Signature of Policyholder

Signature of Witness

Signature of Parent/ Guardian

HAWTHORNE PAIN AND SPINE CENTER
PETER J. BERGER, DC
219 LAFAYETTE AVENUE
HAWTHORNE, NJ 07506
TEL: 973.423.9100
FAX: 973.423.1339

RELEASE OF RECORDS

DATE: _____

TO: _____

RE: _____

S.S #: _____

D.O.B: _____

All information, X-ray's, reports, and/or copies thereof relating to my examination, consultation, confirmation, or treatment and to permit them to inspect and make copies or abstracts thereof. You also authorize to send any psychiatric, drug and/ or alcoholic information if applicable.

Approximate date of admission to hospital, first examination, treatment, or consultation:

Signature of Patient

Hawthorne Pain and Spine Center
219 Lafayette Avenue
Hawthorne, NJ 07506
Dr. Peter J. Berger
PH: 973-423-9100
Fax: 973-423-1339

Informed Consent for Chiropractic Treatment

Patient Name: _____

******Please read document entirely before signing. Ask questions if there is anything you do not fully comprehend.**

The nature of chiropractic treatment: The primary treatment a chiropractor performs is a spinal manipulative adjustment. I will use that procedure to treat you. I may use my hands or mechanical instrument called an "activator" upon your body in such a way as to move your joints. That may cause an audible "pop" or click noise much like when you crack your knuckles. You may feel a sense of movement or some soreness if you have never experienced a spinal adjustment.

Treatment may include:

- | | | |
|--|--|---|
| <input type="checkbox"/> Spinal adjustment | <input type="checkbox"/> Extra Spinal adjustment | <input type="checkbox"/> Palpation |
| <input type="checkbox"/> Range of Motion testing | <input type="checkbox"/> Ortho Testing | <input type="checkbox"/> Basic Neurological testing |
| <input type="checkbox"/> Muscle strength testing | <input type="checkbox"/> Postural Analysis testing | <input type="checkbox"/> Hot/Cold Therapy |
| <input type="checkbox"/> EMS | <input type="checkbox"/> Other (please Explain) | |

Note: _____

Chiropractic adjustment is safe when it's performed by someone trained and licensed to deliver chiropractic care.

Serious complications associated with chiropractic adjustment are overall rare, but may include:

- Severe osteoporosis (metabolic bone fragility disease)
- Multiple myeloma (cancer affecting the body's plasma cells)
- Osteomyelitis (spinal bone infection)
- Bone tumors (benign or cancerous growths)
- Paget's disease (a disease that can cause bone deformities, fractures)

At examination the doctor is screening for any contraindications to manipulation if you the patient have any conditions that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor.

I _____, have read or have had read to me the above explanation to chiropractic adjustment and related treatment. I have discussed the treatment and any concerns. All my question have been answered to my satisfaction. I have been informed of any risks I have decided that it is in my best interest to undergo treatment. By signing I state that I hereby give consent to be treated.

Patient

Signature: _____ **Date:** _____

USES AND DISCLOSURES OF HEALTH INFORMATION FOR HIPAA

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY. The privacy of your health is important to us.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, and our legal duties and your rights concerning your health information to you. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect immediately and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in this Notice.

We use and disclose your health information about you for treatment, payment and healthcare operations. For example:

Treatment:

We may use or disclose your health information to a physician or other healthcare provider providing treatments to you.

Payment:

We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations:

We may use and disclose your information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization:

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health insurance information for any reason except those described in this Notice.

Patient Rights

Access:

You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed on this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request copies, we will charge you \$1.00 per page and \$15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

Disclosure Accounting:

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last 6 years but not before April 14, 2003. If you request this accounting than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Questions and Complaints

We support your right to the privacy of your health information. We will not retaliate in any ways if you choose to file a complaint with the Privacy officer or with the Office for Civil Rights. Their address follows:

Office for Civil Rights
US Department of Health and Human Services
200 Independence Ave. S. W.
Room 509F, HHH Building
Washington, DC 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read and received a copy of this office's Notice of Privacy Practice.

Print Name

Signature

Date

Financial Hardship Agreement

By virtue of my signature set forth below, I hereby request that my doctor and institutional provider reduce their usual and customary charges in order to allow me to receive care required by my current health care condition.

I represent and warrant that my financial status is such that I would be unable to receive diagnostic and treatment services if usual and customary charges were applied to the services required by my condition.

I recognize and acknowledge that this Agreement to reduce usual and customary charges is undertaken for my benefit, that this is dependent on my financial status as of the date of this Agreement, that it will result in a fee arrangement distinct from the one usually in place for the services in question and that the arrangement represents a confidential agreement entered into by the parties for the sole and exclusive benefit.

In light of the foregoing, I hereby agree to the following:

1. I will not seek reimbursement for the services rendered to me under this arrangement from any insurance company, employer, welfare program, government entitlement program (Medicare or Medicaid), Workers' Compensation program or other third-party payor.
2. If any third party payor responsible for all or part of the payment due as a result of services rendered under this Agreement contacts me, I will notify such payor of this arrangement and the reduced fees achieved as a result of the Agreement.
3. If the financial circumstances which cause me to qualify for financial hardship under this Agreement change, I will immediately notify my doctor and institutional provider in order to allow them to determine whether my financial status will then allow me to pay usual and customary charges for the services which I receive from that date forward.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Witness Signature: _____

Date Signed: _____