Be Well Chiropractic
2299 Brodhead Road Ste A
Bethlehem, PA 18020
PH: (610)317-9355 Fax: (610)3179354
www.bewellchiropractic.com

WELCOME TO OUR OFFICE!

By completing this patient information form, you will help us to serve you more efficiently. Should you have any questions concerning our professional services or office procedures, please feel free to ask a member of our front office staff.

PLEASE PRINT - COMPLETE ALL INFORMATION

Patient and Insurance Information

Name: _____ Date: _____
First Middle Initial Last Suffix
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Email: _____ **D.O.B.:** _____ **Soc Sec #:** _____
Marital Status: M S D Sep Spouse Name: _____ # of Children: _____
Referred By: _____
Employer: _____ Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____
Emergency contact: Name_____ Address_____
Phone: (home) _____ (cell) _____ Relationship _____
Family Physician Name and Number: __ _____

Health Insurance Info
Carrier: _____ Ins Co. Phone: _____
Address: _____
Policy #: _____ Group #: _____
Patient Relationship to the Insured: Self Spouse Child Other
* If you are covered under another person's insurance, please complete.
Name of Insured: _____
Address of Insured: _____
Phone of Insured: _____Sex: _____ D.O.B. _____ SS #_____
Insured's Employer: _____
Address: _____
Phone: _____ Plan Name: _____

Auto Accident Insurance
Carrier: _____ Policy Number: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Person to Contact: _____ Claim #: _____
Date of Accident: _____ Patient Relationship to the Insured: Self Spouse Child Other

Assignment of Benefits/Authorization/Notice of Collection Practices	
I request payment of insurance benefits for all services rendered to me to be made on my behalf to Be Well Chiropractic, Health and Wellness. I authorize Be Well Chiropractic, Health and Wellness to release medical information to my insurance carrier and its entities to determine payment for services rendered. I further understand I am responsible to pay certain amounts due. These amounts may include annual deductibles, co payments, co-insurances and charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs.) I agree this authorization shall remain valid unless/until I rescind in writing.	
Print Name of Person Completing this form:	
Signature:	**Date:**

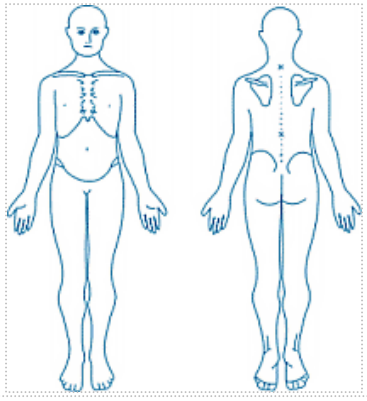
**** Please present your health Insurance cards and photo ID to the front desk****

HISTORY QUESTIONNAIRE

NAME: _____ D.O.B _____ DATE:_____ Patient ID# _____

Please answer the following questions accurately. If you are unsure about a certain question, please ask.

In your own words, what is your chief complaint? _____
What caused the pain to start? _____
When did it start? (date or month) _____
Did you receive any treatment? Yes/no What treatment? _____
Did it help? _____
Where do you feel the pain? _____
Did the pain/symptoms spread? _____
What makes the symptoms worse?
☐AM ☐PM ☐sitting ☐standing ☐walking ☐rising ☐lying ☐rest ☐on the move
Other: _____
What makes the symptoms better?
☐AM ☐PM ☐sitting ☐standing ☐walking ☐rising ☐lying ☐rest ☐on the move
Other: _____



Please shade area(s) of your pain

How would you describe your pain?

☐ Cramping
☐ Dull
☐ Aching
☐ Sharp
☐ Lightning like
☐ Shooting
☐ Burning
☐ Pressure like
☐ Stinging
☐Deep
☐ Nagging
☐ Intermittent
☐ Throbbing
☐ Diffuse
☐ Constant
☐ Occasional
☐ Other_____

Do you experience any of the following symptoms, and <u>where</u>?
Numbness: _____Tingling: _____Weakness: _____

If you were involved in an accident, describe <u>when</u> and <u>how</u> it happened: _____
_____

Do you experience:
☐Neck Pain
☐Arm pain
☐ Headaches
☐Back Pain
☐Leg Pain (left or right)
☐Weakness of Extremity
☐Numbness in extremities
☐Feeling of pins and needles in extremities
☐Bowel or bladder incontinence
☐Blackouts
☐Memory difficulties
☐Vision changes
☐Speech difficulties
☐ Difficulty walking
☐Other

Do you have a history of:
☐ Heart disease/heart attack
☐ Heart murmur
☐Asthma
☐ Pulmonary disease
☐ Sleep apnea
☐ High blood pressure
☐ Diabetes
☐ Stomach Problems
☐ Reflux
☐ Thyroid Problems
☐ Kidney Problems
☐ Osteoporosis
☐ Arthritis
☐ Back Problems
☐ Stroke
☐ Stress test in the past
☐ Depression
☐ Psychiatric Problems
☐ Hepatitis
☐ High Cholesterol
☐ Cancer_____
☐ Other _____

Do you have problems with your:
☐ Ears
☐ Eyes
☐ Nose
☐ Throat
☐ Lungs
☐ Shortness of Breath
☐ Heart
☐ Circulation
☐ Heart Palpitations
☐ Recent unexplained weight loss
☐ Stomach or Intestines

Medications, dosages and Supplements: _____

Please list all surgeries (Type of surgery and date)
1. _____ 2. _____ 3. _____

Does anyone in your family have?
☐Diabetes ☐Asthma ☐Seizures ☐Stroke ☐Heart disease ☐Cancer_____ ☐High blood pressure
☐Aneurysm ☐ Back Problems ☐Arthritis ☐Other _____

Place of employment _____ **Currently working?** Yes No **Missed work** _____ **Last day of work**_____
Are you collecting disability? Yes No If yes, what type of disability? _____
Do you smoke? Yes No How much do you smoke per day? _____ **How often do you drink alcohol?** _____
Have you ever smoked in the past? Yes No When did you stop _____
Do you take any nutritional supplements? Yes No If so, what and how much_____
Do you have children? Yes No **If yes, how old?** _____

Be Well Chiropractic, Health and Wellness

Patient Authorization for Use, Disclosure and Request of Protected Health Information

This authorization permits Be Well Chiropractic, Health and Wellness to use, disclose and request the following individually identifiable health information about me.

Patient's first and last name _____ Date of birth _____

By signing this authorization, I authorize Be Well Chiropractic, Health and Wellness to use, disclose or request certain protected health information (PHI) about me to: **PLEASE LIST NAMES OF DOCTOR'S ATTORNEY, ECT. YOU APPROVE to receive medical information.**

_____

_____

_____

_____

_____

The information will be used or disclosed for the following purposes: Medical care, and reimbursement.
The purpose (s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will remain in place until otherwise rescinded in writing by me the patient.
Be Well Chiropractic, Health and Wellness will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Be Well Chiropractic, Health and Wellness. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re – disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Be Well Chiropractic, Health and Wellness
2299 Brodhead Road
Ste A
Bethlehem, PA 18020
(610) 317-9355

Signed by_____ _____
Patient Signature Date

PATIENT TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST

BE WELL CHIROPRACTIC, HEALTH AND WELLNESS
FINANCIAL POLICY

Be Well Chiropractic Health and Wellness believes that an important part of good healthcare practice is to establish and communicate our financial policy to our patients.

1. PAYMENT is expected at the time of your visit. We will accept cash, check, Visa, MasterCard, American Express, or Discover Network. Payment may include any unmet deductible, co-insurance, co-pay amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

2. INSURANCE – We are non-participating providers with some insurance plans. We will file all of these insurance claims for chiropractic treatment .Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.

3. OUTSTANDING BALANCES – Occasionally, a patient will accrue a large balance for services provided by our doctors. We will work with patients to establish an appropriate payment plan and obtain a signed financial agreement.

4. INSURANCE CHECKS – Your health plan may send directly to you the payment (check) for the Practice's services. If you receive such payment, please call the Practice Administrator immediately and mail or bring the check in to avoid duplication of bills and a delinquent account. The Practice always receives notification from your insurance company if a payment has been made and where the check was mailed.

5. RETURNED CHECKS – will incur a $30.00 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge.

6. ACCOUNTING PRINCIPLES – Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

7. COMPLETING INSURANCE FORMS AND COPYING MEDICAL RECORDS – require office staff time as well as the Doctor's time. We require $15.00 per form prepayment when completing forms with the exception of New Jersey State disability, copying medical records fee is $1.00 with a minimum of $10.00.

If you have any questions after reviewing our policy, please contact our office to avoid any misunderstandings.

I understand and agree to Be Well Chiropractic, Health and Wellness' Financial Policy.

Patient Name_____ Date of Birth_____

Signature_____ Date_____

Be Well Chiropractic, Health and Wellness

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIES THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws may be complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Be Well Chiropractic, Health and Wellness at 2299 Brodhead Rd. Ste A, Bethlehem, PA 18020 at (610) 317-9355

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice- including, but not limited to, our doctors and nurses – may use or disclose your IIHI in treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that your are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment. We may also use your IIHI to contact you to inform you of test results. We may leave the results of certain tests on your answering machine, but will do so only if your message identifies your name or telephone number.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect

- Preventing or controlling disease, injury, or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled; notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more that a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consist with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use of disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use or disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U>S> or foreign forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your IIHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you.

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to **Be Well Chiropractic, Health and Wellness, 2299 Brodhead Rd. Ste A, Bethlehem, PA 18020** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members or friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Be Well Chiropractic, Health and Wellness 2299 Brodhead Rd. Ste A, Bethlehem, PA 18020.** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Be Well Chiropractic, Health and Wellness 2299 Brodhead Rd. Ste A, Bethlehem, PA 18020** in order to inspect and/or obtain a copy of your IIHI. Our Practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Be Well Chiropractic, Health and Wellness 2299 Brodhead Rd. Ste A, Bethlehem, PA 18020.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-payment of non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented; for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Be Well Chiropractic, Health and Wellness 2299 Brodhead Rd. Ste A, Bethlehem, PA 18020.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure, and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Be Well Chiropractic, Health and Wellness 2299 Brodhead Rd. Ste A, Bethlehem, PA 18020.**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Be Well Chiropractic, Health and Wellness 2299 Brodhead Rd. Ste A, Bethlehem, PA 18020.** All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are not required to retain records of your care

Again, if you have any questions regarding this notice or out health information privacy policies, please contact **Be Well Chiropractic, Health and Wellness 2299 Brodhead Rd. Ste A, Bethlehem, PA 18020.**

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

_____ _____

Patient's Full Name Patient's Date of Birth

I, _____, have received a copy of Be Well Chiropractic, Health and Wellness Notice of Privacy Practices.

_____ _____

Patient's Signature Date

Be Well Chiropractic, Health and Wellness

Missed Appointment Policy

It is our wish that each and every one of our patients receive the very best care and service possible. **Your treatment program** consists of a specific series or treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist that you follow:

1. Meet all of your appointments. Arrange the activities in your life so that this can occur.

2. If you become ill, we still want you to come in, because **treatments** will help you recover.

3. If you are unable to make it due to an emergency, please call us and let us know so we can reschedule your appointment.

4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.

5. **All canceled or missed appoints must be rescheduled and made up within one week.**

6. There is a $20.00 charge for a no-call, no-show appointment.

I have read, understand, and agree to follow the above policy.

Patient's Name: _____

Signature: _____Date_____

Staff Witness: _____ Date _____