New Haven Chiropractic Group, LLC

Account Number____________________

How did this happen? □ Auto Accident □ Work Related □ Slip & Fall □ Other____________________

Today's Date__________________________

Name____

Address______________________________ City______________________ State_____ Zip________

Cell Phone________________________ Home phone ________________________

Email Address________________________________

Birthdate ______________________Age________ □ Male □ Female □ Other

If work related, employed by____

Date of Accident ___________________________

Attorney Name____

Do you have health insurance? □ Yes □ No Do you have auto insurance? □ Yes □ No
Did this accident happen in CT? □ Yes □ No
Have you lost days from work? □ Yes □ No If yes, Dates __________________________

IF INJURY IS A RESULT OF A MOTOR VEHICLE ACCIDENT, PLEASE ANSWER THE FOLLOWING:

Were you the: □ Driver □ Passenger
If passenger, were you in the: □ Front Seat □ Back Seat □ Other
If Passenger, name of driver ____

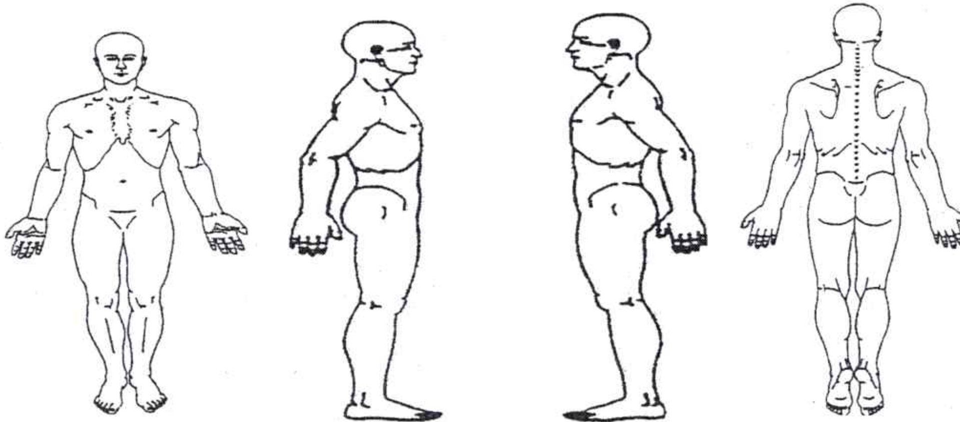
How were you hit? □ Rear-end □ Head-On □ Broad-sided on passenger side
□ Broad-sided on driver's side □ Other _______________

Were you wearing a seat belt? □ Yes □ No Did the airbag inflate? □ Yes □ No
Were you braced for impact? □ Yes □ No
Did you go to the Emergency Room? □ Yes □ No If yes, where ________________________
Did you go in an ambulance? □ Yes □ No
Have you had any imaging studies done (X-ray, CT scan, MRI etc.) □ Yes □ No
If Yes, where? ____

NEW HAVEN CHIROPRACTIC GROUP

Patient name ____

Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbols. Mark areas of radiating pain and include all affected areas.



Aches ᴧᴧᴧ Numbness **OOOO** Radiating ——→ Pins/needles • • • • •Burning **XXXX** Stabbing////

Please select your pain level

O 1 2 3 4 5 6 7 8 9 10 (Circle One)

Regarding your current injuries:

Where does it Hurt? ____

____

Have You Had This Type of Pain in The Past? ☐ Yes ☐ No If yes, Please describe.

____

____

FOR WOMEN: IS THERE ANY CHANCE YOU COULD BE PREGNANT? ☐Yes ☐No

Account Number ____________________________

Health History

Please check if you currently have any of the following?

□ **None**	□ Abdominal Pain	□ Easy Bruising
□ Fever	□ Dizzy Spells	□ Constipation
□ Night Sweats	□ Headaches	□ Tremors
□ Loss of Appetite	□ Numbness/Tingling	□ Lumps or Masses
□ Unexplained weight loss	□ Unsteady Gait	□ Skin Rash
□ Joint Swelling	□ Chest Pain	□ Difficulty Urinating
□ Pain with Walking	□ Swelling (Legs)	□ Loss of bowel control
□ Blurry Vision/Double Vision	□ Shortness of Breath	□ Loss of Urinary Control
□ Hearing Loss	□ Cough	□ Blood in stools

Prior History

Please check if you ever had any of the following?

□ **None**	□ Blood Clotting problems	□ Diabetes
□ Osteoporosis (low bone density)	□ Seizures	□ Irregular Heartbeat
□ PRIOR Neck Pain	□ Excessive Thirst	□ Depression
□ PRIOR Back Pain	□ Temperature intolerance	□ Anxiety
□ Rheumatoid Arthritis	□ chronic fatigue syndrome	□ Heart Attack
□ COPD	□ Thyroid Disease	

Are you on blood thinners? □ Yes □ No

Do you have any Implanted metal □ Yes □ No If yes, please describe___________________

History of Cancer? □ Yes □ No If yes, please describe_______________________________

DO YOU HAVE A PACEMAKER? □ **Yes** □ **No** HISTORY OF STROKE □ **Yes** □ **No**

Do you have any other conditions we should know about that is not listed above? □ Yes □ No
If yes, please describe ____

Account Number ______________________________________

Informed Consent to Chiropractic Treatment

While rare, some patients may experience short-term aggravation of symptoms, rib fractures, muscle and ligament strained/sprained and dizziness as a result of manual therapy techniques. There are reported cases of stroke associated with many common neck movements, including adjustments of the upper cervical spine. The apparent association is noted infrequently, however, you are being warned of this possible association because stroke can cause serious neurological impairment and may rare occasions result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is rare; however, possible there are rare, reported cases of disc injuries following cervical and lumbar spinal adjustment of chiropractic treatment. Chiropractic treatment, including spinal adjustment, has been the subject of government reports in multidisciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many back and neck conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. I acknowledge I have discussed, or I had the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general in my treatment in particular (including spinal adjustment) as well as all the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient name ______________________________ Date________________

Patient or Guardian signature ______________________________

Account number ________________________________

New Haven Chiropractic Group

951 State Street

New Haven, CT 06511

p. 203.787.1331 f. 203.787.1595

At New Haven Chiropractic Group maintaining our patients trust and confidence is especially important to us. That is why we have made it our policy to keep the information you provide to us safe and confidential. Our employees are educated on the importance of maintaining the confidentiality of your health information. The privacy notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and necessary for the practice to obtain payment for that treatment and to carry out healthcare operations.

The practice explained to me that the privacy notice is available to me now, or in the future at my request. The practice reserves the right to change its privacy practices that are prescribed in its privacy notice in accordance with applicable law. I understand that, and to consent to, the following appointment reminders that may be used by the practice. This will be done using your text, voicemail, email, or mailing address.

The practice may use and/or disclose my PHI (which includes information about my health or condition and treatment provided to me) for the practice to treat me and obtain payment for that treatment and as necessary for the practice to conduct its specific healthcare operations. I understand I have a right to request an accounting of the disclosure of my PHI other than for treatment, payment and/or healthcare operations. I understand I may restrict access or a disclosure of my PHI. However, the practice is not required to agree to any restrictions that I have requested. If the practice agrees to the requested restriction, then the restriction is binding on the practice. I understand that the practice may share my PHI with the Connecticut chiropractic Association in the event advocacy is needed for insurance claims or utilization disputes. I acknowledge that I have received the privacy statement from New Haven Chiropractic Group.

_______________________________ _______________________________

Name of Patient Signature of Patient or Guardian

____

Relationship if Guardian

Date: _______________________________

Account number # _______________________________

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________________ ______________________________

Name of Patient Signature of Patient or Guardian

______________________________ ______________________________

Name of Legal Parent or Guardian Relationship to Patient or Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes stepparents, grandparents and any care takers who can have access to this patient's records):

Name: ____________________ Relationship: ______________________

Name: ____________________ Relationship: ______________________

☐ I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA: Cell, Home, Work phone Confirmation, Email Confirmation, and/or Text Message to my Cell Phone

☐ I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA: Cell, Home, Work phone Confirmation, Email Confirmation, and/or Text Message to my Cell Phone

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As a Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

____
Signature

Acct#______________________________________

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New Haven Chiropractic Group
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New Haven, CT 06511
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James Cianciolo D.C. Sarah Levin D.C. Virginia McKenna D.C.

URGENT

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To Provider: ____
(NAME OF DOCTOR, CLINIC, HOSPITAL, ETC.)

Patients Name: ______________________________

Date of birth ______________________

Date of Accident / Injury ________________

You are hereby requested to furnish the following information checked below:

☐ **DIAGNOSTIC IMAGING REPORTS ONLY**

☐ **X-rays** ☐ **History** ☐ **Diagnosis** ☐ **Treatment** ☐ **Reports**

Concerning my: ☐ **Accident** ☐ **Injury** ☐ **Other**________________

Re Requester:

____
(NAME OF INSURANCE CO., ATTORNEY, DOCTOR, HOSPITAL, EMPLOYER, NEXT OF KIN, ETC.)

For the purpose of: ______________________________________
(Specify above: Review, Investigation or Evaluation of an application, or the processing of any claim, or any purpose reasonably related to the above enumerated activities.)
This authorization shall become effective immediately and remain in effect only as long as necessary for the Requester to complete the required activities undertaken.

I understand that I have a right to receive a copy of this authorization upon my Request.

Date:____

Signature ____
of Patient or Guardian

Account# ______________________________________