New Practice Member Application

Nazar Chiropractic Family Health and Wellness Center, P.C.

Date_____

Name: _____

Address: _____

_____

_____

Sex: M ___F ___ Age _____ Date of Birth: _____

___ Single ___ Married ___ Widowed ___ Divorced

Number of children? _____

Social Security Number _____

Occupation _____

Employer _____

Employer Phone _____

Spouse Name _____

Date of Birth _____ SS # _____

Occupation _____

Employer _____

Home Phone: _____Work Phone: _____

Email Address: _____

Cell/Mobil/Pager _____

In Case of Emergency, Contact:

Name: _____ Relationship _____

Home Phone: _____Work Phone: _____

Is this condition related to an accident __ yes ___ no
Date of accident: _____
Type of accident: __ Auto ___ Work ___ Home ___ other

Insurance Information
Who is financially responsible for this account? _____

Relationship to practice member? _____

Insurance Co. Name: _____

Group No. _____

Subscribers Name: _____

Subscribers ID No. _____

Is there additional insurance? Yes/No

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
And assign directly to Dr. Nazar 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered and non-covered. I also understand and agree to pay for all copays, coinsurance, deductibles and fees and non-covered services. I understand payment is due at the time of services or prepayment arrangements can be made. I understand that if I terminate my care any fees for services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond 30 days are subject to a 1.5% monthly finance charge. I understand that I am financially responsible for any and all fees including legal fees incurred to enforce payment of monies owed. I understand that there is a $35.00 return check fee and that I may be charged for missed appointments.

_____
Signature Date

_____
Printed Name and relationship

Please answer the following questions

How did you find out about Dr. Nazar? _____
_____

Why are you here today? _____
_____
_____
_____

Whom may I thank for referring you? _____
_____

Do you want Temporary Pain Relief, Permanent Relief or Total Health and Wellness? Please circle

When did your problem begin? _____

Please rate your *current pain level* on a scale of 1 to 10 with 10 being the greatest amount of pain. _____
What makes the pain worse? _____

What makes the *pain better*? Example positions, ice, heat, pain relievers etc. please be specific.

Activities or movements that are *painful to perform*: circle
Sitting, Standing, Walking, Bending, Lying down, lifting
Other: _____

Does your condition interfere with work, sleep, daily routine, recreation? Circle
Other: _____

Please circle the type(s) of pain: sharp dull ache

Throbbing numb shooting burning

Stiff swelling tingling other:

Do you have any numbness, tingling or pain in your arms, hands, legs and or feet? Yes/No

Please specify areas: Right arm/hand, Left arm, hand
Right leg/foot, Left leg/foot

How often do you have this pain? _____

Is it constant or does it come and go? _____

Is your problem getting better, staying the same or worse?

_____

Is your condition becoming more frequent? Yes/No

Can you do everything that you used to do? Yes/No

What would you like to improve about your health?

How long have you been ill or unable to live the way you want? _____

How much time have you spent trying to improve your health? _____

How much money have you spent trying to improve your health? _____

Rate the following questions by using the following
Scale: 1 = Little to 10 = Everything

What is your health worth to you? _____

How would you rate yourself on following recommendations for care? _____

Rate your commitment to getting rid of this problem. _____

How would you want to rate the Doctor on handling your care? _____

What have you heard about chiropractic? _____

Draw an x on the line at your current pain level

No pain ----------Worst Pain

What treatment have you already received for your problem?
Medications Surgery Physical Therapy Chiropractic None
Other?
_____

Name of your primary care Doctor?
_____

Have you ever had any spinal surgeries? _____

Other surgeries? List/Date: _____

Broken bones, fractures or dislocations? _____

Accidents or Falls? _____

Exercise: please indicate activity level
None, Moderate, Daily, Heavy

Work Activity Level:
Sitting, Standing, Light labor, Heavy labor

Habits

Smoking Y/N Packs/day _____
Alcohol Y/N Drinks/Week/Day _____

Coffee/Caffeine Y/N Cups Day _____

High Stress Level Y/N Reason _____

Medications? _____

Vitamins/Herbs/Minerals _____

Allergies? _____

Please indicate if you have ever had any of the following by drawing a **circle** around the word:

AID/HIV	Alcohol Addiction/Abuse
Allergy Shots	Anemia
Anorexia	Appendicitis
Arthritis	Asthma
Bleeding Disorder	Breast Lump/Cancer
Bronchitis	Bulimia
Cancer	Cataracts
Chemical Dependency	Chicken Pox
Diabetes	Emphysema
Epilepsy	Fractures
Glaucoma	Gonorrhea
Headaches	Gout
Heart Disease	Hepatitis
Hernia	Herniated Disk
Herpes	High Blood Pressure
High Cholesterol	
Kidney Disease	Liver Disease
Measles	Migraine Headache
Miscarriage	Mononucleosis
Multiple Sclerosis	Mumps
Osteoporosis	Pacemaker
Parkinson's Disease	Pinched Nerve
Pneumonia	Polio
Prostate Problem	Prosthesis
Psychiatric Care	Rheumatoid Arthritis
Rheumatic Fever	Scarlet Fever
Stroke	Thyroid Problems
Tonsillitis	Tuberculosis
Tumors/Growths	Ulcers
Vaginal Infections	Weight Problem
Whooping cough	Other: _____

_____

Recent weight loss without trying? Yes/No

Night Sweats Yes/No

Are you taking a blood thinner such as Coumadin? Yes/No

Change in bowel/bladder habits? Do you have full control of these functions? Yes/No

Family History of Cancer? Yes/No whom?

Is your problem increased with coughing, sneezing or having a bowel movement? Yes/No

Date of Last Physical Exam _____

Spinal Exam _____

Spinal X-ray _____

MRI/CT Scan/Bone Scan _____

Dental Exam/X-ray _____

Eye Exam _____

Are you right handed or left handed? Please circle

Are you currently under a doctor's care for any other conditions? Yes/No please explain yes

_____

Do you have a pacemaker or any other implanted device? Yes/No explain yes _____

Are you now or could you be pregnant? Yes No N/A

Date of your last menstrual period: _____ N/A

List below your five main physical complaints in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

NOTICE OF PRIVACY PRACTICES

Nazar Chiropractic Family Health Center, P.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgement form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make one you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractor's, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign/print your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share protected health information with third party "business associates" that perform various activities (e.g. billing transcription/newsletter services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose a protected health information to notify a family member, personal representative or any other person that is responsible for your care or of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain consent as soon as reasonably practicable after the delivery of treatment. If you chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization: **When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:**

Required Uses and Disclosures: Under law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. this right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Tana Nazar, D.C. (717) 564-1550, Fax: (717) 561-1744
4800 Derry Street, Harrisburg, PA 17111

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Nazar Chiropractic Family Health Center, P.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledged, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON DECEMBER 1, 2005.

Printed Patient Name _____ Date _____

Signature _____

Printed Name of Parent/Guardian_____

Signature of Parent/Guardian _____

ENTRANCE RECORD

The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and it's nerve roots. Misalignments of the spinal bones which interfere with the nervous system are called SUBLUXATIONS. Subluxations come from many causes and prevent various organs, glands, tissues and muscles from functioning properly.

The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the body to function properly and heal itself.

Chiropractic does not treat disease or symptoms. The doctor of chiropractic's only goal is to allow the body to function properly and her only means is the correction of vertebral subluxations.

Please understand that chiropractic is NOT a substitute for medical treatments of any kind. Also, NO statement of the chiropractor is intended as medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

When you take a drug or medication there is a risk of dangerous side effect. When any medical test or procedure is performed certain risk is involved. When you walk down stairs, drive in a car, or play sports, there is always risk. On that note, chiropractic adjustments, which are always extremely safe and effective (a typical chiropractor's malpractice insurance costs less than her car insurance and is about 1/10 of a medical doctor's), pose a very tiny degree of risk in certain situations. The most common side effects seen in a small percentage of people are post adjustment muscle soreness or mild headache. This is comparative to post exercise soreness. This typically subsides quickly. If you do have any questions concerning the safety of chiropractic in certain situations, please explain this to the doctor. The doctor will do her utmost to care for you in the safest and most effective manner, just as she would her own family.

Please PRINT OR WRITE CLEARLY

I, _____, have read the above, understand it fully and undertake Chiropractic care on this basis.

_____ Date _____