

PATIENT INFORMATION

NAME: _____ DATE: _____
ADDRESS: _____ CITY/ST _____ ZIP _____
PHONE (H) _____ (C) _____ (W) _____
DATE OF BIRTH: _____ AGE: _____ SEX: M F SS# (OPTIONAL): _____
E-MAIL: _____ Ok to send you our newsletter? PRIMARY LANGUAGE: _____
EMPLOYER: _____ OCCUPATION: _____
RELATIONSHIP STATUS: MARRIED PARTNERED DIVORCED WIDOWED SINGLE
SPOUSE/PARTNER NAME: _____ PHONE: _____
EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____
WHOM MAY WE THANK FOR THE REFERRAL? _____

AUTHORIZATION TO TREAT A MINOR

If the patient is under the age of 18, or is otherwise unable to sign, please complete the following.

Patient is _____ years of age OR unable to sign because: _____

SIGNATURE: _____ DATE: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION

Please present your insurance card(s) to an Equilibrium front desk employee for photocopying.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I AGREE TO NOTIFY EQUILIBRIUM IMMEDIATELY WHENEVER I HAVE CHANGES IN MY PERSONAL INFORMATION LISTED ABOVE, INCLUDING MY INSURANCE STATUS. INITIAL HERE: _____

CANCELLATION POLICY *(Effective 02/02/15)*

Equilibrium requires a 24 hour advance cancellation for all appointments. If I am unable to give 24 hours advance notice the following fees will be charged: **\$76.50** for a chiropractic appointment, **\$75** for a massage appointment and **\$88** for an acupuncture treatment. I have read and understand the cancellation policy.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

- **Are you (or have you ever been) under the care of a primary care physician in the last year?**
 NO / YES (physician name, reason): _____
- **Do you or any of your immediate family members have any of the following inheritable conditions? NO / YES (circle and indicate whom below)**
 heart disease cancer diabetes strokes high blood pressure arthritis scoliosis other: _____
- **If you are working, please circle all of the following items that pertain to your job or jobs:**
 Full Time (>35 hrs/wk) Part Time (<35 hrs/week) Sitting Standing Heavy Lifting Air Travel
- **Have you taken a leave from work because of your injuries?**
 NO / YES (when? _____ restrictions? _____)
- **If you are currently exercising, please circle any of the following items that pertain:**
 Frequent (>5 times/week) Moderate (3-4 times/week) Infrequent (1-2 times/week)
 Aerobic Exercise (> 30 mins) Aerobic Exercise (<30 mins) Weight Lifting Yoga/Pilates
 Other: _____
- **Do you currently smoke/drink alcohol/use recreational drugs? (circle)**
 NO/YES (How much and how frequent? _____)
- **Please list any surgeries and/or hospitalizations you have had:**
 Procedure: _____ Year: _____ Result: _____
 Procedure: _____ Year: _____ Result: _____
 Procedure: _____ Year: _____ Result: _____
- **Please list any medications you are currently taking:**
 Name: _____ Dosage: _____ Date started taking: _____
 Name: _____ Dosage: _____ Date started taking: _____
 Name: _____ Dosage: _____ Date started taking: _____
- **Please circle any of the following symptoms/complaints you have experienced:**
 fever night sweats unexplained weight loss changes in bowel/bladder function headaches
 change in vision change in hearing difficulty swallowing chest pain poor circulation
 cough difficulty breathing nausea vomiting bruise easily swollen/painful joints
 dizziness allergies depression anxiety difficulty sleeping skin rashes/irritation

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by an Equilibrium chiropractic physician and/or other licensed doctors of chiropractic who now or in future will treat me while employed by, working for or associated with or serving as back-up for Dr. Bhalerao, including those working at the clinic or office listed herein or any other office or clinic.

I understand that the doctor will conduct a full exam with a complete report of findings. I have had or will have an opportunity to discuss with the doctor and/or other office or clinic, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon facts then known, to be in my best interest.

AUTHORIZATION FOR DIRECT PAYMENT OF INSURANCE BENEFITS TO THE HEALTHCARE PROVIDER AND CLINIC: I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering services during this visit or any insurance benefits payable to me.

AUTHORIZATION TO RELEASE INFORMATION: In obtaining payment for services, I authorize my healthcare provider and the clinic to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in the processing of the claim. If I have been referred by, or am being referred to another healthcare provider, I authorize the release of my clinical information to this provider for continuing care.

PROTECTED DIAGNOSIS: If my medical record contains information about drug or alcohol diagnosis or treatment, or HIV testing, I specifically authorize the release of this information for billing purposes ONLY. Any other release of such information may only be released with another specific consent form.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE CONSENT. I HAVE ALSO HAD OR WILL HAVE AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW I AGREE TO THE CONDITIONS STATED ABOVE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF TREATMENT FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

Patient name – PLEASE PRINT _____ DATE _____ Patient signature – PLEASE SIGN _____

PATIENT NAME: _____ DOB: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Equilibrium, we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, a collection agency, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you. Including information needed for independent collection agencies.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your voicemail or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care 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

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to

whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your 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 specific form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information 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 you with this notice of our privacy 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.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

Nicole Bhalerao, DC, Shireesh Bhalerao, DC, Lori Brown, DC or Melissa Miesen, LAc

If you would like further information about our privacy policies and practices please contact:

Nicole Bhalerao, DC, Shireesh Bhalerao, DC, Lori Brown, DC or Melissa Miesen, LAc

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of December 2, 2014

Your signature below acknowledges that you have read a copy of this notice. You have the right to a paper copy of this notice at any time. You may also find a copy of this notice on our web site.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that by signing below that I have received a copy of this office's Notice of Privacy Practices.

Patient name – PLEASE PRINT

DATE

Patient signature – PLEASE SIGN