

**Confidential Patient Health Record/ Cedar Chiropractic & Sports, 77 West Main St. Hopkinton MA**

**Today's Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**How did you hear about us?**  Family \_\_\_\_\_  Friend \_\_\_\_\_  Co-Worker \_\_\_\_\_  Close to home/work  
 Dr. \_\_\_\_\_  Yellow Pages  Drove By  Hospital  Insurance Plan  Website: \_\_\_\_\_

**Personal Information**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Sex: M / F SSN: \_\_\_\_\_ Marital Status:  S  M  W  D  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  R  L Handed  Glasses  Contact Lenses  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_  
Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_ Email Address: \_\_\_\_\_  
Spouses Name: \_\_\_\_\_ Children (Names & Ages): \_\_\_\_\_

**Emergency Contact**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_  
PRIMARY CARE PHYSICIAN: \_\_\_\_\_  
Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_  
Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_

**Employment Information**

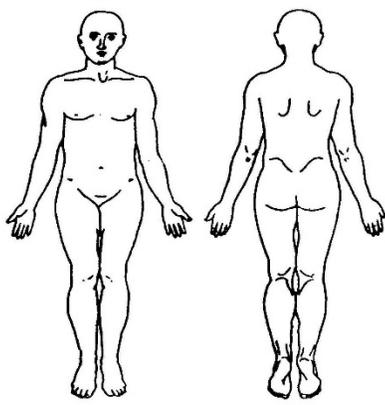
Business Name: \_\_\_\_\_  
Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ ext: \_\_\_\_ Fax #: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Occupation / Job Title / Description: \_\_\_\_\_

**Current Health Condition**

Unwanted Condition (Why are you here today?) \_\_\_\_\_

**PLEASE INDICATE ON THE DIAGRAM THE AREA OF DISCOMFORT:**

**Key:** A=Ache B= Burning N= Numbness P= Pins & Needles S= Stabbing



When did this Condition BEGIN? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Has it ever occurred before?  Yes  No. When? \_\_\_\_\_  
Is the Condition:  Auto Related  Job Related  Home Injury  Slip or Fall   
 Lifting  Slept Wrong  Unknown Cause  Other  
Explain: \_\_\_\_\_  
Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_ am/pm  
Condition / Pain STARTED on what DATE: \_\_\_\_\_  
Do you have any other health concern? \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Date:** \_\_\_\_\_

**REVIEW OF SYSTEMS** – Below is a list of symptoms that may be seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

<b>Constitutional:</b> <input type="checkbox"/> I <b>DENY</b> having or have had any of the symptoms or problems listed below.				
<input type="checkbox"/> chills	<input type="checkbox"/> fatigue	<input type="checkbox"/> night sweats	<input type="checkbox"/> weight loss	<input type="checkbox"/> daytime drowsiness
<input type="checkbox"/> fever	<input type="checkbox"/> weight gain	<input type="checkbox"/> other: _____		

<b>Eyes / Vision:</b> <input type="checkbox"/> I <b>DENY</b> having any of the symptoms or problems listed below.				
<input type="checkbox"/> spots	<input type="checkbox"/> change in vision	<input type="checkbox"/> trauma	<input type="checkbox"/> photophobia	<input type="checkbox"/> blurred vision
<input type="checkbox"/> glaucoma	<input type="checkbox"/> double vision	<input type="checkbox"/> tearing	<input type="checkbox"/> cataracts	<input type="checkbox"/> wear glasses/contacts
<input type="checkbox"/> itching	<input type="checkbox"/> eye pain	<input type="checkbox"/> other: _____		

<b>Ears, Nose and Throat:</b> <input type="checkbox"/> I <b>DENY</b> having any of the symptoms or problems listed below.				
<input type="checkbox"/> bleeding	<input type="checkbox"/> ear drainage	<input type="checkbox"/> hearing loss	<input type="checkbox"/> nosebleeds	<input type="checkbox"/> sore throat
<input type="checkbox"/> dentures	<input type="checkbox"/> ear pain	<input type="checkbox"/> history of head injury	<input type="checkbox"/> postnasal drip	<input type="checkbox"/> TMJ problems
<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> fainting	<input type="checkbox"/> hoarseness	<input type="checkbox"/> rhinorrhea (runny nose)	<input type="checkbox"/> tinnitus (ringing in ears)
<input type="checkbox"/> discharge	<input type="checkbox"/> frequent sore throat	<input type="checkbox"/> loss of sense of smell	<input type="checkbox"/> sinus infections	<input type="checkbox"/> other: _____
<input type="checkbox"/> dizziness	<input type="checkbox"/> headaches	<input type="checkbox"/> nasal congestion	<input type="checkbox"/> snoring	_____

<b>Respiration:</b> <input type="checkbox"/> I <b>DENY</b> having any of the symptoms or problems listed below.				
<input type="checkbox"/> asthma	<input type="checkbox"/> coughing up blood	<input type="checkbox"/> sputum production	<input type="checkbox"/> cough	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> wheezing <input type="checkbox"/> other: _____				

<b>Cardiovascular:</b> <input type="checkbox"/> I <b>DENY</b> having any of the symptoms or problems listed below.				
<input type="checkbox"/> angina (chest pain or discomfort)	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> low blood pressure		
<input type="checkbox"/> chest pain	<input type="checkbox"/> heart problems		<input type="checkbox"/> swelling of legs	
<input type="checkbox"/> claudication (leg pain/ache)	<input type="checkbox"/> ulcers	<input type="checkbox"/> orthopnea (difficulty breathing lying down)		
<input type="checkbox"/> heart murmur	<input type="checkbox"/> palpitations		<input type="checkbox"/> varicose veins	
<input type="checkbox"/> shortness of breath with exertion or exercise	<input type="checkbox"/> paroxysmal nocturnal dyspnea			<input type="checkbox"/> other: _____
<input type="checkbox"/> other: _____ (waking at night with shortness of breath)				

<b>Gastrointestinal:</b> <input type="checkbox"/> I <b>DENY</b> having any of the symptoms or problems listed below.				
<input type="checkbox"/> abdominal pain	<input type="checkbox"/> diarrhea	<input type="checkbox"/> indigestion	<input type="checkbox"/> vomiting blood	<input type="checkbox"/> abnormal stool consistency
<input type="checkbox"/> jaundice	<input type="checkbox"/> heartburn	<input type="checkbox"/> nausea	<input type="checkbox"/> constipation	<input type="checkbox"/> abnormal stool color
<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> vomiting	<input type="checkbox"/> rectal bleeding	<input type="checkbox"/> black tarry stools
<input type="checkbox"/> belching	<input type="checkbox"/> other: _____			

<b>Female:</b> <input type="checkbox"/> I <b>DENY</b> having any of the symptoms or problems listed below.				
<input type="checkbox"/> birth control	<input type="checkbox"/> cramps	<input type="checkbox"/> irregular menstruation	<input type="checkbox"/> vaginal bleeding	
<input type="checkbox"/> breast lumps / pain	<input type="checkbox"/> frequent urination	<input type="checkbox"/> pregnancy	<input type="checkbox"/> vaginal discharge	
<input type="checkbox"/> burning urination	<input type="checkbox"/> hormone therapy	<input type="checkbox"/> urine retention	<input type="checkbox"/> other: _____	

<b>Male:</b> <input type="checkbox"/> I <b>DENY</b> having any of the symptoms or problems listed below.				
<input type="checkbox"/> burning urination	<input type="checkbox"/> frequent urination	<input type="checkbox"/> prostate problems	<input type="checkbox"/> other: _____	
<input type="checkbox"/> erectile dysfunction	<input type="checkbox"/> hesitancy	<input type="checkbox"/> urine retention		

<b>Endocrine:</b> <input type="checkbox"/> I <b>DENY</b> having any of the symptoms or problems listed below.				
<input type="checkbox"/> cold / heat intolerance	<input type="checkbox"/> excessive hunger or thirst	<input type="checkbox"/> goiter	<input type="checkbox"/> unusual hair growth	<input type="checkbox"/> other: _____
<input type="checkbox"/> diabetes	<input type="checkbox"/> frequent urination	<input type="checkbox"/> hair loss	<input type="checkbox"/> loss / change in appetite	

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Date:** \_\_\_\_\_

**Skin:**  I DENY having any of the symptoms or problems listed below.

- changes in nail texture       hair loss       itching       skin lesions / ulcers
- changes in skin color       hives       tingling       varicosities
- hair growth       history of skin disorders  rash       other: \_\_\_\_\_

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- dizziness       limb weakness       numbness       slurred speech       tremor       other: \_\_\_\_\_
- facial weakness       loss of consciousness       seizure/convulsions       stress       unsteadiness of gait
- headache       loss of memory       sleep disturbance       strokes       loss of balance

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

- anxiety       behavioral change       depression       memory loss       other: \_\_\_\_\_
- confusion       bi-polar disorder       insomnia       mood change

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- anaphylaxis       itching       chronic nasal congestion       sneezing
- food intolerance       acute nasal congestion       rash       other: \_\_\_\_\_

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- anemia       blood clotting       bruising easily       lymph node swelling
- bleeding       blood transfusion       fatigue

**PAST HEALTH HISTORY**

**Previous Care for Same Condition:**  I have not seen a doctor for this condition **OR** Fill in the information BELOW.

Have you seen other doctors for THIS CONDITION?  Yes  No. If yes, Who? (Name) \_\_\_\_\_  
 Type of Treatment: \_\_\_\_\_ Was the treatment beneficial in resolving condition?  Yes  No  
 Explain: \_\_\_\_\_

**Previous Chiropractic Care:**  I have not previously seen a Chiropractor **OR** Fill in the information BELOW.

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Current Medication (s):** List ANY / ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

**Childhood Illness (es):** LIST all health conditions. CIRCLE all CURRENT conditions.

- ADD/HD       chicken pox       headaches       scoliosis
- eczema       Crohn's       hepatitis       seizure disorder
- allergies       depression       HIV       sickle cell anemia
- anemia       diabetes       measles       spina bifida
- asthma       ear infections       mumps       Lyme Disease
- bedwetting       fetal drug exposure       psoriasis       cerebral palsy
- other: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_\_

**Adult Illness(es):** LIST all health conditions. CIRCLE all CURRENT conditions.

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> ADD/HD            | <input type="checkbox"/> kidney disease         | <input type="checkbox"/> hypertension        | <input type="checkbox"/> vertigo                             |
| <input type="checkbox"/> Alzheimer's       | <input type="checkbox"/> neurological condition | <input type="checkbox"/> pneumonia           | <input type="checkbox"/> scoliosis                           |
| <input type="checkbox"/> anemia            | <input type="checkbox"/> diabetes               | <input type="checkbox"/> liver disease       | <input type="checkbox"/> seizures                            |
| <input type="checkbox"/> arthritis         | <input type="checkbox"/> heart disease          | <input type="checkbox"/> lung disease        | <input type="checkbox"/> shingles / chicken pox              |
| <input type="checkbox"/> asthma            | <input type="checkbox"/> eczema                 | <input type="checkbox"/> fibromyalgia        | <input type="checkbox"/> Rheumatoid / Inflammatory Arthritis |
| <input type="checkbox"/> cancer            | <input type="checkbox"/> emphysema              | <input type="checkbox"/> lupus erythema      | <input type="checkbox"/> Gout                                |
| <input type="checkbox"/> Crohn's / colitis | <input type="checkbox"/> CVS (stroke)           | <input type="checkbox"/> multiple sclerosis  | <input type="checkbox"/> thyroid problems                    |
| <input type="checkbox"/> Lyme Disease      | <input type="checkbox"/> collagen / vascular    | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> pneumonia                           |

**Doctor:** Are Child / Adult Illnesses listed contributory to the CURRENT Condition?  Yes  No

**Surgery (ies):** LIST all Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> angioplasty          | <input type="checkbox"/> cosmetic         | <input type="checkbox"/> hysterectomy         | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy         | <input type="checkbox"/> D & C            | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff        |
| <input type="checkbox"/> caesarian section    | <input type="checkbox"/> dental surgery   | <input type="checkbox"/> joint replacement    | <input type="checkbox"/> spinal fusion       |
| <input type="checkbox"/> cardiac              | <input type="checkbox"/> gall bladder     | <input type="checkbox"/> knee repair          | <input type="checkbox"/> tonsillectomy       |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy          | <input type="checkbox"/> other: _____        |
| <input type="checkbox"/> cardiac bypass       | <input type="checkbox"/> hernia repair    | <input type="checkbox"/> mastectomy           |  |

**Injury (ies):** Mark or List all Injuries. Write the DATE of the Injury immediately afterward.

- |                                      |  |   |                                       |
|--------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury         | <input type="checkbox"/> motor vehicle accident | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> fracture    | <input type="checkbox"/> concussion          | <input type="checkbox"/> fall (severe)          |                                       |
| <input type="checkbox"/> disability  | <input type="checkbox"/> industrial accident | <input type="checkbox"/> joint injury           |                                       |

**Family History:** Mark all that apply below. List any specific conditions past or present after has / had:

- |                      |                                |                                   |   |   |   |
|----------------------|--------------------------------|-----------------------------------|---|---|---|
| General family       | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Father               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Mother               | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Paternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Paternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Maternal grandfather | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Maternal grandmother | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Son (s)              | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Daughter(s)          | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Brother(s)           | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |
| Sister(s)            | <input type="checkbox"/> alive | <input type="checkbox"/> deceased | <input type="checkbox"/> normally developed | <input type="checkbox"/> no significant disease | <input type="checkbox"/> has / had: _____ |

**Social History:**

- Alcohol:  Never  Social consumption only  Frequent
- Diet (please mark all that apply)  High fat  High Fiber  High Protein  High Salt  High Sugar  
 Low Calorie  Low Carb  Low Fiber  Low Salt  Low Sugar
- Education: (please mark the highest level completed)  High School  Assoc/Technical  College  Graduate  Doctorate
- Drugs:  Deny any illegal drug use  Deny use of IV drugs  Have not used drugs since \_\_\_\_\_
- Tobacco:  Deny Tobacco use  Live with a smoker  Quit smoking  Chew  
 Smoke # \_\_\_\_\_ per  Day  Week  Month

**Insurance Information:**

- Who Is Responsible For Your Bill? YOU and ... (mark appropriate box(es))  Myself ONLY  
 Spouse  Worker's Comp  Auto Insurance  Medicare  Medicaid  Private  Self- Pay
- Personal Health Insurance Carrier: \_\_\_\_\_ Health ID Card #: \_\_\_\_\_
- Policy Holder's Name: \_\_\_\_\_ Group #: \_\_\_\_\_
- Policy Holder's Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Date:** \_\_\_\_\_

Dr. Binh Nguyen feels that it is very important we coordinate with your doctor(s) and keep them up to date on your treatment and progress here at our office. Please fill in **any** and **all** information.

**Primary Care Physician:** \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

**Dentist:** \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

**OB/ GYN:** \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

**Massage Therapist / Acupuncturist** \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

**Podiatrist / Optometrist / other Specialist(s) :** \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

I give authorization to Cedar Chiropractic & Sports P.C. to release my health care information to the above doctors.

Patient Signature \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_\_

## Cedar Chiropractic & Sports P.C.

77 West Main St. Suite 203B – Hopkinton, MA 01748

Phone: (508) 435 – 8182 | Fax: (508) 435 – 8183

### Procedure Request and Authorization to Release Medical Records

Date: \_\_\_\_\_

TO: \_\_\_\_\_

RE: \_\_\_\_\_

D/O/B: \_\_\_\_\_

#### CLINICAL INFORMATION:

\_\_\_\_\_  
\_\_\_\_\_

#### PROCEDURE REQUESTED:

\_\_\_\_\_ X-Ray with report:

\_\_\_\_\_ Standing Cervical (AP / Lateral / APOM / Flexion / Extension / Obliques)

\_\_\_\_\_ Standing Thoracic (AP / Lateral)

\_\_\_\_\_ Standing Lumbar (AP / Lateral / Flexion / Extension / Obliques)

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ MRI / CT scan:

\_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

Please send copies of my medical records including but not limited to diagnostic reports to Cedar Chiropractic & Sports P.C.

Patient's Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

**Cedar Chiropractic & Sports** 77 West Main Street, Suite 203B • Hopkinton, MA 01748 p (508) 435-8182

### **ASSIGNMENT of BENEFITS / DIRECTION of PAYMENT / FINANCIAL POLICY**

1. I hereby authorize and direct Cedar Chiropractic & Sports P.C., and all its agents, to release all protected health and medical information necessary to my claims, as outlined in my *Patient Bill of Rights for Protected Health Information*.
2. I hereby authorize and direct my insurance carrier to pay all benefits, which may be due to me under my policy, directly to Cedar Chiropractic & Sports P.C.
3. I hereby give a lien to Cedar Chiropractic & Sports P.C. on any settlement, claim, judgment, or verdict as a result of said accident, and authorize and direct my insurance carrier or attorney to pay directly to Cedar Chiropractic & Sports P.C. such sums as may be due and owed to Cedar Chiropractic & Sports P.C. for services rendered to me, and to withhold such sums from any Personal Injury Protection, Med-Pay, or 3<sup>rd</sup> Party payments and/or any settlement, claim, judgment, or verdict as may be necessary to protect Cedar Chiropractic & Sports P.C. adequately.
4. I hereby authorize Cedar Chiropractic & Sports P.C. my permission to have on file a copy of my credit card. In the event that they will need to utilize this card, I understand they will notify me via phone or mail, that this transaction(s) occurred to settle any/all unpaid patient balances.
5. Effective January 1, 2009, patients will now be responsible for any non-covered chiropractic services that are performed during their visits. Please check your insurance company's plans as they vary significantly. You have the right to request a sample of out of pocket fees.
6. **All co-payments are due at the time of service**, and if I choose to discontinue care, I am still responsible for any and all unpaid balances. I fully understand that I am directly and fully responsible to Cedar Chiropractic & Sports P.C. for all medical bills incurred for services rendered to me, and that this agreement is made solely for the additional protection, and in consideration, of the risk Cedar Chiropractic & Sports P.C. takes in waiting for payment.

### **APPOINTMENT POLICY**

I understand there is a no show / no call policy. **I will be billed and be responsible for the \$45.00 fee.**

### **BILL OF RIGHTS ACKNOWLEDGEMENT**

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our *Patient Bill of Rights for Protected Health Information*. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

### **CONSENT AGREEMENTS (for protected health information (PHI))**

By signing, you grant authorization to Cedar Chiropractic & Sports P.C., and all its licensed physicians, to perform diagnostic testing and render Chiropractic care and treatment to yourself or said minor (as the parent or authorized legal guardian); you agree to and give consent to operate under those protocols as outlined. **WE RESERVE THE RIGHT TO:** change our privacy practices and you have the right to request that we do not disclose your health information to specific individuals, companies or organizations. You may also revoke your consent at any time, however this must be done in writing. By signing this consent, you authorize us to use telephone, text, mail or e-mail, as remainder for appointments. You may also revoke this authorization in writing.

WE ask that you sign this form as acknowledgement that our: AOB/DOP, FINANCIAL, APPOINTMENT POLICIES, CONSENT AGREEMENT AND BILL OF RIGHTS ACKNOWLEDGEMENT, were explained to you, that you understand it, and you accept full responsibility.

I, \_\_\_\_\_, HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS

DATED \_\_\_\_/\_\_\_\_/\_\_\_\_\_.

WITNESS: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

## Cedar Chiropractic & Sports P.C.

77 West Main St. Suite 203B – Hopkinton, MA 01748

Phone: (508) 435 – 8182 | Fax: (508) 435 – 8183

### **PATIENT BILL of RIGHTS for PROTECTED HEALTH INFORMATION (PHI)**

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

#### **III. A. Uses and Disclosures**

Here are some examples of how we might have to use or disclose your health care information:

Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.

Your chiropractor and members of the staff may need to use our health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently run our practice.

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder, a message will be left on your answering machine. If you prefer, a text will be sent to your phone as an alternative.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

#### **B. Our Privacy Pledge**

We have an always will respect your privacy. Other than the uses and disclosures we described above, **we will not sell or provide any of your health information to any outside marketing organization.**

#### **C. Permitted uses and disclosures without your consent or authorization**

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

We are permitted to use or disclose our health information if we are providing health care services to you based on the orders of another health care provider.

We are permitted to use or disclose your health information if we provide health care services to you as an inmate.

We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.

We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples and under the *Uses and Disclosures* section above, any other use or disclosure of your health information will only be made with your written authorization.

#### **D. Your right to revoke your authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

If we have already released your health information before we receive your request to revoke your authorization.

If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

If you wish to revoke your authorization please write to us at:

**Cedar Chiropractic & Sports P.C.**  
77 West Main St. Suite 203B  
Hopkinton, MA 01748

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Date:** \_\_\_\_\_

**E. Your right to limit uses or disclosures**

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

**F. Your right to receive confidential communication regarding your health information**

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding our health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

**G. Your right to inspect and copy your health information**

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

**H. Your right to amend your health information**

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

**I. Your right to receive an accounting of the disclosures we have made of your records**

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except those disclosures:

- required for your treatment, to obtain payment for your services, or to run our practice.
- to individuals involved with your care.
- for national security or intelligence purposes.
- made to correctional officers or law enforcement officers.
- that were made prior to the effective date of the HIPAA privacy law, April 1, 2003.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

**J. Our duties**

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will pally for all of your health information in our files.

**K. Re-disclosure**

Information that we use or disclose 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 roles.

**L. Your right to complain**

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

**Dept. of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201  
Tel: (877) 696-6775**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Cedar Chiropractic & Sports PC Financial Policy**

We strive to provide the highest quality health care, all the while maintaining affordability for you, the patient. We understand that even with insurance, most patients will experience at least some out of pocket expense.

### **Participating Insurances**

Our office will accept your insurance on assignment and do participate as preferred providers for many insurance plans. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or insurance policy issue. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery. We cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is our policy and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays.

### **Non-Participating Insurances**

We will gladly bill your insurance for you, and will call to determine your chiropractic benefits. Payment is due at the time of service for all deductibles, co-pays, and non-covered therapies unless arrangements are with the office staff.

### **Patients without Insurance**

We request that 100% of the examination and treatment be paid at the time of the visit, unless other arrangements have been made. To qualify for our Time of Service Reduction in fees, you must pay on the day the service was performed. We are happy to accept cash, check, MasterCard, Visa, Discover or American Express. No insurance will be billed.

### **Medicare**

Our office accepts assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will ONLY cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

### **Secondary Insurance**

Please inform us of any secondary insurance you may have. We will file and collect from your secondary insurance for services covered by the secondary payer.

### **Flex Plans/Medical Savings Accounts**

Please inform us if you have a medical savings account, or a 'flex spending plan'. We will be happy to provide you with a statement of your charges for reimbursement.

### **Health Saving Accounts (HSA)/High Deductible Health Plan**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ **Date:** \_\_\_\_\_

Please inform us if you have an H.S.A. As Chiropractic is a qualified expense and this can be paid through your H.S.A. and billed to your high deductible health plan. Please read the following office policy regarding assignments:

1. At the beginning of your treatment in our office we will verify your policy benefit. However, phone or fax verification of coverage is never a guarantee of payment.
2. Returned checks and balances over 90 days may be subject to additional collection fees and interest charges of 4% per month. Charges may also be made for missed appointments and those canceled without 24 hours notice.
3. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis.
4. You will be responsible for your full deductible and co-payment or co-insurance. Payment is due when services are rendered. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.
5. If you pay the full amount for services rendered each visit, you may qualify for our Time of Service (TOS) discount. You may then submit the bill to your insurance company for reimbursement.
6. If your insurance company has not paid a claim within sixty (60) days of submission, you agree to take an active part in the resolution of your claim. If your insurance company has not paid within ninety (90) days of submission, you are responsible for payment of any outstanding balance.
7. Our fees are considered usual and customary by most insurance companies, and therefore are covered up to the maximum allowance determined by each insurance company. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current Standard of care in this area.

### **Personal Injury (PI) or Automobile Accidents**

Please present your auto insurance card, your health insurance card, and inform us if you have retained an attorney. If you need an attorney we will refer you to an attorney.

There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill and accept assignment from the portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney.
4. Account balances 90 days past the release date of treatment will incur a 4% monthly charge.
4. We will bill your standard health insurance plan if your auto insurance policy medical coverage is exhausted and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 (six) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ **Date:** \_\_\_\_\_

I have read and understand this financial policy. I realize that I am responsible for all charges incurred by me at Cedar Chiropractic & Sports PC.

WE ask that you sign this form as acknowledgement of our financial policy agreement: **Cedar Chiropractic & Sports PC Financial Policy**, were explained to you, that you understand it, and you accept full responsibility.

I, \_\_\_\_\_, HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS

DATED \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_.

WITNESS: \_\_\_\_\_



**CEDAR CHIROPRACTIC & SPORTS**

**77 West Main Street Lower Level Suite LL103 Hopkinton MA 01748**

**Telephone: (508)435-8182 Fax: (508)435-8182**

**Informed Consent for Chiropractic & Medical Treatment**

**\*\*Patient Name:\*\*** \_\_\_\_\_

**\*\*Date:\*\*** \_\_\_\_\_

I, the undersigned, acknowledge that I have been informed about my medical condition and the proposed course of treatment involving chiropractic adjustments (manual, drop technique, Activator, Arthostim machine adjusting) and various other services that is offered at Cedar Chiropractic & Sports. These services may include: IASTM, Active Release Technique, Flexion Distraction mobilization, Dry Needling, Radiofrequency, Cold Laser, Shockwave Therapy, Non-surgical spinal decompression, therapeutic exercises and manual therapy or any other services that may be rendered at the time. I understand that this treatment may include cervical adjustments and other related procedures.

I have been made aware of the potential risks and side effects associated with chiropractic treatment, which may include but are not limited to:

- Muscle soreness or aches, Increased in pain from the treatment, Bruising, Scars, Skin Burn, Frostbites, Bleeding, Strain or sprain, Disc injury, Fracture or dislocation, Stroke

I understand that while the provider will exercise professional judgment and take all necessary precautions during my treatment, there are inherent risks involved in any medical procedure. I acknowledge that no treatment can be guaranteed to be free of risk.

I have had the opportunity to ask questions about my condition and the treatment options available to me. All of my questions have been answered to my satisfaction, and I consent to the proposed chiropractic treatment.

By signing below, I confirm that I understand the information presented to me and voluntarily consent to receive chiropractic care.

**\*\*Patient Signature:\*\*** \_\_\_\_\_

**\*\*Date:\*\*** \_\_\_\_\_

**\*\*Provider Signature:\*\*** \_\_\_\_\_

**\*\*Date:\*\*** \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

### Credit Card on File Agreement

We have implemented a policy which enables you to maintain your credit card information securely on file with Cedar Chiropractic & Sports, PC. **In providing us with your credit card information, you are giving Cedar Chiropractic & Sports, PC permission to automatically charge your credit card on file for your (or any other patient(s) you have listed on this form) co-pay/s, outstanding balance/s, service/s, missed appointment/s without cancellation and /or product/s**

**Co-pays:** Co-pays are due at time of the office visit.

**Outstanding Balance:** If your insurance provider has paid their portion of your bill (or any other patient(s) you have listed on this form) and there is still an outstanding balance owned, Cedar Chiropractic & Sports, PC will notify you via phone and/or mail. If by the final billing notice from Cedar Chiropractic & Sports, PC, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

**Service and Products:** missed appointment/s without cancellation and product fee are due at time of office visit.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. **This agreement will expire on the expiration date listed below.** The card holder may also revoke this consent at any time in writing.

1. Visa
2. MasterCard
3. Discover
4. American Express

Credit Card Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*(Please Print Name in Full)*

Credit Card Number : \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

Please fill out information below for any other person/s you authorize this credit card for:

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Credit Card Holder's Address: \_\_\_\_\_

Credit Card Holder's CVV number: \_\_\_\_\_

Credit Card Holder's Signature : \_\_\_\_\_ Date: \_\_\_\_\_



**CEDAR CHIROPRACTIC & SPORTS**

**77 West Main Street Lower Level Suite LL103 Hopkinton MA 01748**

**Telephone: (508)435-8182 Fax: (508)435-8182**

### **Patient Acknowledgment and Financial Responsibility Agreement**

I, [Patient's Name] \_\_\_\_\_, hereby acknowledge that I have been informed about the medical treatment that will be rendered to me. I understand that while my insurance may cover a portion of the charges, I am fully responsible for any outstanding balances that are not covered by my insurance provider.

I also acknowledge that all payment transactions are final and that there will be no refunds issued, except in the case where I have a credit balance on my account. I understand that it is my responsibility to verify my insurance coverage and to understand the terms of my policy.

By signing below, I confirm that I have read and understood this statement and agree to the terms outlined regarding my financial responsibility for the medical treatment provided.

**\*\*Patient Signature:\*\*** \_\_\_\_\_

**\*\*Date:\*\*** \_\_\_\_\_

**\*\*Provider's Signature:\*\*** \_\_\_\_\_

**\*\*Date:\*\*** \_\_\_\_\_