Advanced Chiropractic & Wellness Center

Dr. Richard A. Schwartz
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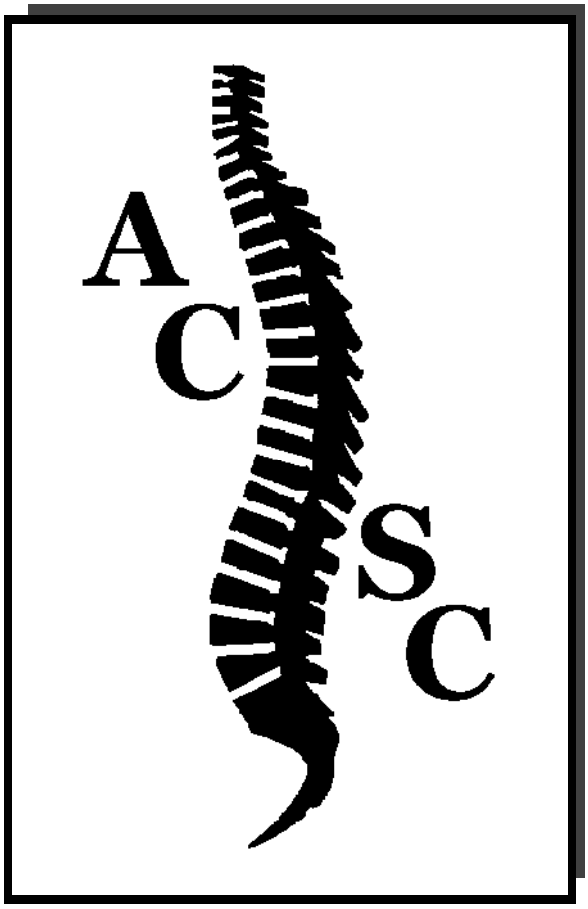

Welcome to Advanced Chiropractic & Wellness Center

It is our goal in this office to give you, our new patient, and the best possible overall care that we are able to provide.

In order to achieve this goal we must first spend some time collecting some information about your problem or problems. Please be as open and honest as you can on the following pages, it is all kept strictly confidential and allows us to give you the most accurate and complete treatment for your condition. Should you require assistance at any time filling this out, do not hesitate to ask someone for help.

Thank you for choosing our office, and please tell a friend.

Dr. Schwartz, Leslie, Min, Andrea, Danielle, David
Advanced Chiropractic & Spine Center **701 Limekiln Pike Maple Glen, PA 19002**

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NAME:_____ **DATE:**____/____/____

STREET ADDRESS:_____ **Apt/Suite #:**____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME#: (____) _____ **WORK#:** (____) _____ **ext.** ____

CELL/PAGER#:(_____) _____ **Email:**_____

Birthdate:____/____/____ **AGE:**____ **Social Sec#:**_____

Marital Status: **Single / Married / Separated / Divorced / Widowed**

Spouse's Name: _____ **Number of Children:** _____

Emergency Contact Name:_____ **& Phone #:** (___) _____

We would like to thank the patient who referred you to our office; whom should we thank for their kind referral:_____

If you were *not* referred by another patient, how did you hear about our office?

Insurance Information Section:

***If you need help completing this section, please do not hesitate to ask**

Many of our patients do not have health care coverage; we believe that everyone should have access to quality healthcare regardless of insurance status. If you do not have insurance, or it does not cover chiropractic care, check this box here: ☐

Insurance type: Auto WorkComp Medicare Other Carrier

Is this plan through your employer? Yes No

Name of Employer: _____ **Phone #:** (___) _____

Employer Address: _____

Type of Business: _____ **Position:** _____

Carrier Name: _____ **Plan Name:** _____

Phone #: (___) _____ **Plan Type:** ***HMO*** ***PPO*** **Other:** _____

Address: _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

(If Policy Holder is someone other then you)

Policy Holder Name: _____ **Policy Holder SS#**_____

Policy Holder DOB: _____

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What is THE MAJOR complaint(s) that brought you into our office today?

_____

Is your injury due to a work related accident or auto accident?

Automobile accident ___ Date of accident ___/___/___ Accident report filed Y N

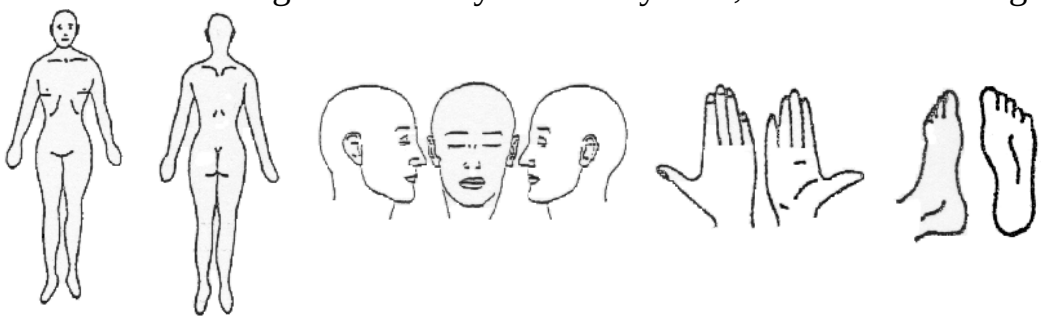
Injury on the job ___ Date of accident ___/___/___ Accident report filed Y N

Have you **ever** seen a Chiropractor? No___ Yes (who)_____

My Current Family Physician is _____ Ph.#_____

I am / may be **Pregnant**: Y N If Yes, are you under a doctors care: Y N

Please mark the diagrams where you feel any Pain, Numbness & Tingling:



Which of the following apply to you presently: (Please **X** all that apply)

	PAIN		NUMBNESS		TINGLING	
	Left	**Right**	**Left**	**Right**	**Left**	**Right**
Head						
Neck						
Upper Back						
Mid back						
Lower Back						
Shoulder						
Arm						
Forearm						
Hand & Fingers						
Buttock						
Hip						
Thigh						
Leg						
Foot						

My pain and symptoms may be aggravated by the following:

Coughing ___ Sneezing ___ Straining of Stool ___ Neck Movement ___

Reaching ___ Lifting ___ Bending at Waist ___ Sitting ___

Standing ___ Walking ___ Weather Changes ___ Other ___

Since my symptoms began, I have noticed a change in my:

Bowel Functions ___ Bladder Function ___ Ability to Maintain an Erection ___

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The following questions are to help us assess your present total health. The questions may or may not ***seem*** to have anything to do with your illness, condition, or accident…however injuries to your neck, head, and back can often directly impact your present health. Place an **X** if you are now (**or in the past six months**) suffering from any of the following:

General
Chills ___ Fatigue ___ Weight Changes ___ Weakness ___ Night Sweats ___ Fever __

Skin
Redness ___ Rash ___ Itching ___ Eczema ___ Hair changes ___ Nail Changes ___
Color Changes ____ Abnormal Growths / Moles ___

Neurologic
Fainting ___ Headaches ___ Convulsions ___ Dizziness ___ Seizures ___

Eyes
Vision Problems R / L Pain R / L Discharge R / L Auras or Halos R / L

Ears
Problem Hearing R / L Ringing R / L Pain R / L Discharge R / L

Nose
Allergies ___ Sinus Infection ___ Pain ___ Bleeding ___ Unable to Smell ___

Mouth / Throat
Blisters/Sores ___ Bleeding ___ Unable to Taste ___ Strange Tastes ___ Discharge ___

Heart / Lungs
Cough ___ Wheezing ___ Difficulty Breathing ___ Murmur ___ Chest Pain ___
Palpitations ___ Too Fast / Slow Heart Rate ___ Swollen Limbs ___ Blue Limbs ___

Breasts
Lump(s) in Breast(s) ___ Pain/Soreness ___ Redness ___ Redness\Itching ___
Dimpling ___ Discharge ___

Stomach / Intestines / Digestion
Decreased Appetite ___ Increased Appetite ___ Abdominal Pains ___ Reflux ___
Vomiting ___ Diarrhea ___

Reproductive Function / Urination / Bowel Function
Unable to Hold Urine ___ Frequent Urination ___ Painful / Burning Urination ___
Irregular Menstruation ___ Painful Menstruation ___ Abnormal Vaginal Bleeding ___
Impotence ___ Sterility ___ Constipation ____ Painful Stool ___ Bloody Stool ___

Glandular
Hot / Cold Intolerance ___ Goiter___ Shakes / Tremors ___ Sugar in Urine ___

Mental
Depression ___ Anxiety___ Mood Swings ___ Phobias ___ Memory Loss ___

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Which of the following illnesses have *you ever had*?

No Illnesses / Conditions Allergies___ Arthritis ___ Asthma ___ Sinus Trouble___
Hay Fever___ Tuberculosis___ Diabetes___ Epilepsy___ Thyroid Problems___
High Blood Pressure___ Low Blood Pressure___ Heart Problems___ Ulcer___
Cancer___ Polio___ Rheumatic Fever___ Serious Injury___ Bone Fracture(s)___
Dislocated Joints___ Spinal Disc Disease___ Multiple Sclerosis___ Scoliosis___
Mental/Emotional Difficulty___ Prostate Problems___ Kidney Problems___
Bleeding Disorder___ AIDS\HIV+____ Sexually Transmitted Disease___

If any member of your immediate family has an illness / problem listed above, please enter the relation and the condition: _____

Past Surgeries or Hospitalization_____

The following Social History will help in our treatment of your problem(s):
I smoke: Never __ ½ Pack a day or Less___ ½ to 1 Pack a day ___ A Pack or More ___

I drink alcohol: Never ___ With some Meals ___ Socially ___ Often ___ Daily ___

I currently am taking the following over the counter & prescription medication(s):
_____

I usually exercise: Aerobic___ Weight Training ___ Running ___ Other ___
1-2x per week___ 3-4x per week ___ Daily ___

My normal hobbies, sports, activities & family responsibilities include:
_____

My current condition(s) / problem(s) keep me from doing the following:
_____

Please Read the following agreement and sign date below:

I understand and agree that both health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Advanced Chiropractic & Spine Center, Inc. and its affiliates will prepare any necessary reports and forms to assist me in my collections from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account and not paid to me directly. Additionally, any payments made to me directly by an insurance agent / carrier for the purpose of covering billed services of this office will be signed over / remitted within 14 business days if the billed amount was not already prepaid. If your injuries are a result of an automobile accident(s) or workman's compensation claim, and a lawyer(s) was\were retained, I authorize that all proceeds of claims or suits be paid directly to the care provider(s) immediately upon receipt of settlement before any other payout related to this claim. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services rendered me will become immediately due and payable.

_____ _____/_____/_____
Patient's Signature or Legal Guardian Date

What are your objectives?

Mark all that apply

My Primary objective in seeing Dr. Schwartz is:

- o *To simply get an explanation of my condition.*
- o *I am only interested in short-term symptom relief care.*
- o *To become pain free as soon as possible.*
- o *I am interested in symptom relief care & corrective care to maintain spinal stability & optimal Nerve function.*
- o *I would like to schedule an appointment for my family members for a spinal check up to ensure proper growth and development throughout all stages of life.*
- o *I really have no idea, I'll let the doctor decide what's best.*

My attitude toward being here is:

- o *Hopeful and interested.*
- o *Neutral.*
- o *Fearful.*
- o *Leary and skeptical.*
- o *Antagonistic – I don't really want to be here, someone else urged me to come.*

Thank you for your answers. Now we can tailor your program to fulfill your specific objectives!

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device / table in order to move your joints with a chiropractic "adjustment". You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint(s). Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, x-ray, digital imaging, therapeutic ultrasound, dry hydrotherapy, axial traction, extension compression traction, rehabilitation, exercising and stretching, inter-segmental traction, flexion-distraction traction, therapy ball, massage therapy, soft tissue therapy, various topical pain relief gels creams and/or lotions, may also be used in conjunction with your treatment.

Possible Risks: I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. As with any health care procedure, complications are possible following a chiropractic manipulation. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. Complications, while extremely rare, could include but are not limited to: fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, and injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options & referrals which could be considered may include the following:

- *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases. Medications such as Vioxx have been shown to cause heart damage & death.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence / addiction in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. Many patients treated in hospitals leave with conditions worse than their original complaint.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases. Surgery can result in permanent loss of function or death.

Risks of remaining untreated: Delay of proper chiropractic treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. Patients who do not follow their approved chiropractic treatment plan may revert to their original symptoms, or even become worse from failing to finish treatment.

Informed consent:

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and/or procedures and herby give my full consent to treatment.

Printed Name (or guardian)	**Signature**	**Date**

WITNESS:

Printed Name	**Signature**	**Date**

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Office Procedures – SHORT FORM

This is the **short form** that is *required by the federal government* for ALL physicians and healthcare providers as of April 14th 2003. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. You may request at any time to read the more detailed LONG form version of our office's privacy policy. This requirement is detailed in the HIPAA (Health Insurance Portability and Accountability Act), for more information on HIPAA you can visit the official website at http://www.cms.hhs.gov/hipaa/ If you have any questions about this Notice please contact our Privacy Contacts who are *Leslie Gold and Dr. Schwartz.*

HIPAA Consent Short Form as per Federal HIPAA Law #101-191
Please review the following information in its entirety, and sign at the bottom.

- There may be times our office may need to use your private health information (PHI) to contact you either by phone or mail in regards to issues such as:
  - Appointment Reminders, Information about treatment & treatment alternatives
  - Insurance information and/or billing issues, etc.
  - Cards (such as birthday, get well, etc.), thank you notes for referrals & referral board
  - Other health information that may be of interest to you, including a health newsletter

- In our attempt to contact you we may not get your directly. This means that contact may be either through a letter, postcard, or voice mail (answering machine). Should you have a reason to exclude one of these methods, please let a member of our staff know your request. However, our office does reserve the right to contact you by any means necessary if we feel that it is a warranted medical emergency.

- Please submit any exclusion from contact to our office in writing, so we can make this request a permanent part of your health file.

- In order to achieve a more relaxed and family approach to healthcare, our office chooses to practice in an open style of treatment. In most cases exam and treatment rooms are often left open, ***except*** where modesty is appropriate. If at any time you would like to increase your privacy by being treated in a sealed room, or if there are issues you would like to discuss in a more secure and private fashion, please ask a member of our staff ***prior*** to your treatment or consultation. Additionally in order to keep a more personal atmosphere, our reception space is open air to the public. We chose not to employ a privacy shield or glass window so our patients feel more at home and have direct contact with the staff should they need it, rather than having to knock and feel intrusive. If at anytime you would wish to communicate with the staff privately, or have the staff exclusively communicate to you or about your PHI in a more secure location, please make the staff aware of this request.

I acknowledge that once I sign this consent form, that I will agree to the terms and conditions as set down by Federal HIPAA Law. Should you wish to read the ***LONG*** form of our office privacy policies please make this request before signing this form. Please see a member of our privacy team if you have any questions or need assistance in completing this form.

Printed Patient name: _____ Signed: _____ Date: ___/___/_____

Printed Witness name: _____ Signed: _____ Date: ___/___/_____

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Patient Acknowledgement Form

Welcome!

- Due to tight Scheduling, if you are late, your scheduled time may need to be adjusted accordingly.
- **Massage** Cancellations require a 24-hour notification. Failure to provide 24 hours notice will require full payment of the session missed unless I am able to fill the appointment time. There is frequently a waiting list for appointments and cancellations with less than 24 hours notice do not allow me enough time to notify someone else.
- If you are ill, please call me prior to your appointment and discuss it with me. Chiropractic can safely be utilized with almost all illnesses. Clients with special considerations (skin allergies/conditions, medical conditions, pregnancy, etc.) may contact me prior to their appointment.
- Gift certificates have a six month expiration date. While I am willing to work with someone if they call me before the end of this period, those calling after the expiration date will be asked to pay one half the face value of the certificate.
- If you are involved in a personal injury/workman's compensation case, a records fee will be assessed to the office requesting the documentation. Records will be released upon receipt of payment from the requesting office.
- If you are currently being treated by other health practitioners, please inform me. It is important for me to establish communication with them for your best care.
- I encourage your questions! Please feel free to ask, or write them down and we'll discuss them.

  I strive to provide a professional and comfortable environment to all of my clients and I therefore appreciate your understanding of my efforts to clarify these points. Thank You!

I HAVE READ, UNDERSTOOD, AND AGREE TO ABIDE BY THE ABOVE POLICIES:

Signed_____

Date_____