

Enfield Health and Wellness Center

Date _____

Name _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Home Telephone () _____ Age _____ Birthdate _____ Martial Status: M S W D

Work Telephone () _____ # Children _____ Spouse's Name _____

Cellular Telephone () _____ Whom may we thank for referring you? _____

Email Address _____

Occupation _____

HEALTH INFORMATION

Please check conditions or symptoms you currently have or have had in the past:

Main Complaint _____

Have you had previous chiropractic care? Yes No Date _____

Have you had previous physical therapy? Yes No Date _____

Other Complaints _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

Does this condition affect your work? Yes No

Does this condition affect your family or social life? Yes No

What aggravates this condition? _____

Other Doctors seen for this condition _____

Are you taking any medication? Yes No If yes, please list _____

What helps your symptoms? _____

Have you had: Surgery? Yes No Falls? Yes No Accidents? Yes No

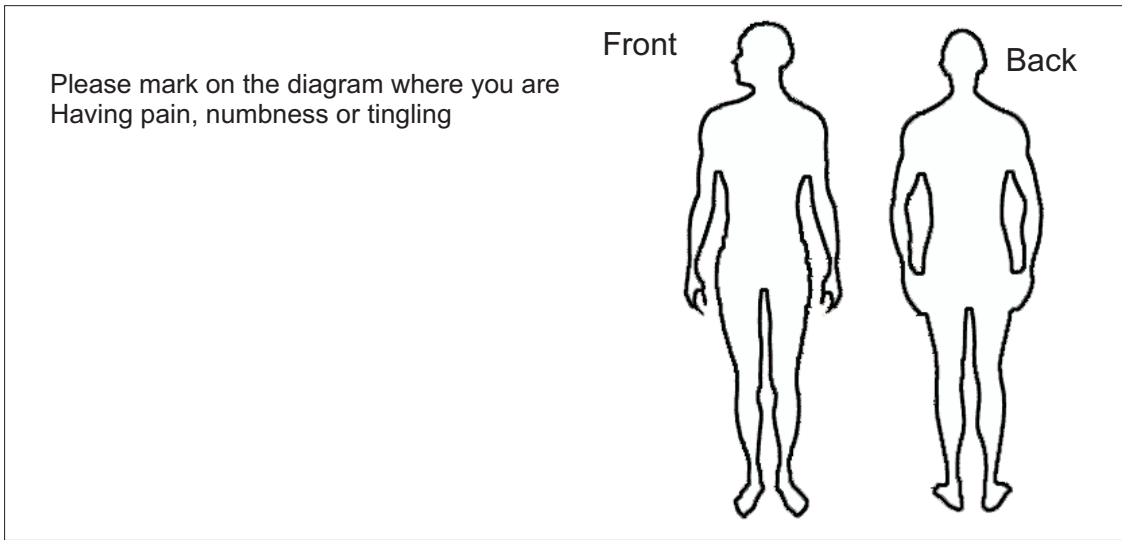
When? _____ Please describe _____

_____ Date of last physical examination _____

Who is your Primary Care Physican? _____

Are you Pregnant? Yes No

- Abdominal Pain
- Anemia
- Arm or Shoulder Pain
- Arthritis: *rheumatoid, gout, osteoarthritis*
- Back Pain
- Bladder Problems
- Cancer
- Chest Pain
- Circulatory Problems
- Constipation
- Depression
- Diabetes
- Digestive Disorder
- Dizziness
- Fatigue
- Fractures
- Headaches
- Heart Problems
- High or Low Blood Pressure
- Hip or Leg Pain
- Hot Flashes
- Immune System Problems
- Insomnia
- Kidney Problems
- Liver/Jaundice/Hepatitis
- Loose Stool
- Lung or Bronchial Disorder
- Memory Problems
- Menstrual Problems
- Metal Implants
- Neck Pain
- Nervousness
- Neurological: *Strokes, Seizures*
- Numbness
- Osteoporosis
- Palpitations
- Prostate Disorder
- Sinus Problems
- Swollen Joints
- Thyroid
- Visual Problems



INSURANCE INFORMATION

Is this condition due to:

A work related injury? Yes No An automobile accident? Yes No

Do you have Health Insurance? Yes No Medicare # (if applicable) _____

Company _____

Address _____

Policyholder _____ Employer _____

Group# _____ ID# _____

Complete only for:

JOB INJURY INFORMATION

Date _____ Time _____

Location _____ Description of accident _____

Worker Compensation Case # _____ Worker Compensation Insurance Carrier Claim # _____

Worker Compensation Insurance Carrier _____ Address _____

Employer's name _____ Address _____

Hospitalized? Yes No Name of Hospital _____ X-rays taken? _____

Other Doctors seen _____

Time lost from work (dates) _____ to _____

Complete only for:

ATTORNEY INFORMATION

Have you lost any days of work? Yes No Dates _____

Insurance Companies Involved -Your Company _____

Other Companies _____

Have you been contacted by an insurance adjuster or
company representative regarding this claim? Yes No

Do you have an attorney that has advised you in this case? Yes No

Attorney Name _____ Telephone _____

Address _____

TYPES OF CARE

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care: Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it.

Corrective Care: Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem.

Check here if you want the Doctor/Physical Therapist to select the type of care appropriate for your condition.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in obtaining payment from the insurance company and that any amount authorized will be paid directly to the Enfield Health and Wellness Center and be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 or treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Enfield Health and Wellness Center, LLC
143 Hazard Avenue
Enfield, CT 06082

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Enfield Health and Wellness Center, LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Enfield Health and Wellness Center, LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Enfield Health and Wellness Center, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Enfield Health and Wellness Center, LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Susan Sadowski and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Enfield Health and Wellness Center, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions of complaints please contact Susan Sadowski @ 763-2225.

Patient Signature

Date

Enfield Health and Wellness Center, LLC
143 Hazard Avenue
Enfield, CT 06082

Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic and physical therapy procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the chiropractors and physical therapists who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other physical therapy procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of physical therapy and 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 and/or physical therapist to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor/therapist to exercise judgment during the course of the procedure which the doctor/therapist feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Enfield Health and Wellness Center, LLC
143 Hazard Avenue
Enfield, CT 06082

I, _____ hereby authorize
_____ to release my protected health information,
as described below, to:

RECEPIENT INFORMATION:

I request that the information to be released consist of the following (CHECK ALL THAT APPLY):

<input type="checkbox"/> complete medical record	<input type="checkbox"/> medical history, evaluation reports
<input type="checkbox"/> treatment or tests	<input type="checkbox"/> hospital records
<input type="checkbox"/> allergy records	<input type="checkbox"/> laboratory reports
<input type="checkbox"/> consultation documentation	<input type="checkbox"/> surgical reports
<input type="checkbox"/> X-ray reports	<input type="checkbox"/> immunizations
<input type="checkbox"/> PX data	<input type="checkbox"/> other (specify) _____

I also specifically authorize that any sensitive information regarding) CHECK ALL THAT APPLY): HIV/aids, substance abuse, or mental health be released to the above recipient.

It is my understanding that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed by the recipient without obtaining any further authorization.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATION:

I understand that I may, upon request, be provided a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that the practice may not condition my treatment, payment, or enrollment/eligibility for benefits on my decision to sign this form. I understand that I may revoke my Authorization or to receive a copy of my revocation, I am to contact Dr Sadowski at 860-763-2225. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person or organization listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid until: _____

I have had an opportunity to review and understand the content of this authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

INDIVIDUAL'S SIGNATURE _____ **DATE:** _____

REPRESENTATIVE'S SIGNATURE (if applicable) _____

DESCRIPTION OF REPRESENTATIVE'S RELATIONSHIP: _____

FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and to assure that you will be receiving the very best care available for your condition. To familiarize you with the financial policies of our office, we would like to explain how your medical bills will be handled.

PRIMARY CARE PHYSICIAN REFERRAL(S)

In the event that your insurance company requires a referral from your primary care physician, you agree that you are responsible for providing this office with the original referral within five (5) days of your first office visit. If the referral condition is not met, you agree to pay in full for all services provided to you within (30) days of receiving a bill from this office.

EXPLANATION OF INSURANCE COVERAGE

Many insurance policies cover chiropractic/physical therapy care and we participate with most plans. It is your responsibility to become familiarized with your allowed benefit. As a courtesy to you, our office will be happy to verify your insurance and bill your insurance company in a timely manner. We require that you, the patient, be aware and responsible for the payment of your deductibles, co-insurance and/or co-payments on the day that services are rendered before you are seen by your healthcare provider. For patients with deductible, we require that you pay an "estimated" fee for service based on our cash fee for service plan. This per visit payment plan will help to avoid you receiving a large bill at the end of treatment.

CASH PLANS

Effective January 1, 2011 our "cash" fee is: for Physical Therapy service, \$85 for evaluation and \$60 per treatment and with our chiropractor, \$60 for examination \$45 per treatment.

CANCELLATION POLICY

All services are provided by appointment only and this time is reserved for your exclusive use. We must request 24 hours notice to cancel or change an appointment and we will charge you \$25 for missing a scheduled appointment.

VOLUNTARY TERMINATION OF CARE

If you suspend or terminate your care at any time, your portions of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately, will be personally responsible for payment, regardless of your insurance coverage.

ASSIGNMENT OF BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and other dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that will be bound by signature as though the undersigned had personally signed the particular claim. Pay and hereby assign directly to Enfield Health & Wellness Center all benefits, if any, other wise payable to me for the services provided as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefit, when received by and paid to Enfield Health and Wellness Center, LLC to be applied to my account, in accordance with the above said assignment. I also acknowledge that any insurance benefit paid directly to me for services rendered need to be signed over to Enfield Health & Wellness Center to be applied to my account.

I have read and understand the office's financial policy.

Signature

Date