Health Care Plus, P.C.
Chiropractic / Physical Therapy
Adam T. Grand, D. C/ Shawn John D.P.T

CONFIDENTIAL CASE PATIENT HISTORY

PATIENT INFORMATION:

Please complete the questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Name: ____ Social Security #________________________

Address__________________________________ City __________State_______ Zip ____________

Home Telephone ____________________Other Telephone _______________________________

E-mail Address ____

Age ___________ Birth date __________ Marital Status: M S W D Children__________________

Occupation_________________ Employer_______________ Referred by_____________________

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HEALTH INFORMATION

What is your major complaint? ____

____

Other complaints: ____

How long have you had this condition? ________ Have you had this or similar conditions in the past?____

What activities aggravate your condition? ____

Is this condition getting progressively worse? ☐Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your ☐Work ☐ Sleep ☐ Daily Routing ☐Other ________________

How long has it been since you really felt good? _____________________________________

Other doctors who treated this condition: ____

____

List any surgical operation and year: ____

____

Drugs you take:

Nerve pills		Pain Killers		Muscle Relaxers		“Pep” Pills	
Tranquilizers		Insulin		Birth control pills			

Other ______________ Age of Mattress: ______ Comfortable? _________________________

Are you wearing ☐ Heels lifts ☐ Sole lifts ☐ Inner soles ☐ Arch Supports

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never
Describe: ____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years

☐ Over 5 years ☐ Never Describe: ____

Date of last Physical Examination____
Present Complaints:

1. Dizziness
2. Backaches
3. Arthritis
4. Heart Trouble
5. Diabetes
6. Headaches
7. Asthma
8. Neuritis
9. Digestive Disorders
10. nervousness
11. Sinus Trouble
12. Neck Pain

FAMILY HEALTH INFORMATION: (Many health problems are the result of the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture.)

Name	Relation	Past and Present Health Problems

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Patient's insurance		Employee ID No.	
Auto insurance		Policy No.	
Worker's Compensation		Group No.	
Others		Medicare No.	

PLEASE LIST ALL OTHER SOURCES OF INSURANCE:

Spouse's insurance		Employee ID No.	
Auto insurance		Policy No.	
Worker's Compensation		Group No.	
Others		Medicare No.	

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon 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 determinate my care and treatment, any fees for professional services rendered me will be immediately due and payable.
(Clinic policy requires payment arrangements be made on the first visit)

Patient's Signature____Date_________________
Guardian or Spouse's Signature____

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Financial Policy

Payment is due when is rendered. As a courtesy to our patients we allow other payments options within the guideline of this policy. These options must be agreed upon, in writing at the beginning of your treatment plan.

CASH

We accept cash, check, visa and MasterCard. We will arrange a weekly or monthly payment plan for treatments, if necessary.

GROUP MAJOR MEDICAL INSURANCE:

Patients are responsible for payment at the time of the first visit, once we verify your coverage and when you have completed the necessary paperwork we will submit your services to your insurance:

1. Patient Case history Form
2. Authorization to pay Physician
3. Financial Policy
4. Insurance Claim Form

There are two (2) ways of handling your insurance paperwork and your exchange with us. The first way is to pay us directly and send in the insurance paperwork yourself. We will help you with any questions you may have. The second way is to utilize our free service of having us file your claim. You sign the form authorizing the insurance company to pay us directly. We will gladly do this for you; but if your insurance company fails to send payment within forty five (45) days on your behalf, remember the exchange is between you and our center. At that point, it is your obligation to pay the fee promptly and directly to our center.
YOU ARE REQUIRED TO PAY FOR INITIAL EXAM, X-RAYS AND OTHER SERVICES ON YOUR FIRST VISIR AND FOR SUBSEQUENT VISIT UNTIL ALL INSURANCE FORMS ARE COMPLETED AND NECESSARY PLANS HACE MADE.

WORKER'S COMPENSATION:

Patient's must return a written authorization form and fill out an accident form. We will accept assignment on work-related cases, when verification has been received and when the proper forms are filed. Until this time payment is due as services are rendered.

ACCIDENT AND PERSONAL INJURY:

Patients must bring a copy of the **Policy Report, auto insurance Dec Page** and must complete all necessary form, which include but are not limited to:

1. Accident Questionnaire and Confidential Patient Case history Form
2. Authorization to Pay Physician
3. Affidavit of: Residence, Personal information and insurance Eligibility
4. Assignment, Lien and Authorization insurance Benefits and Attorney
5. Application for Benefits-Personal injury Protection

We accept direct payment from the insurance company. We will not allow payment to be handled though an attorney. We will send report as requested by your attorney. Please keep us up to date all actions and conditions regarding this case any changes in your address, telephone number and insurance coverage.

MEDICARE:

Our office is a participating Medicare provider. We will submit your claims as a courtesy to you. Medicare recipient must present their enrollment card at the onset of treatment.

COLLECTIONS

If legal or collection action is necessary to collect any outstanding balance with respect to the above, you shall also be obligated to reimburse our office for all reasonable cost, expenses and attorney fees, incurred with respect to the same in addition to the outstanding balance and interest.

I HAVE READ THE ABOVE AND UNDERSTAND FULLY.

Patient's Signature____Date____________________

Guardian or Spouse's Signature____

33 Riverview Drive Wayne, NJ 07470 (973)694-4450 Fax (973)696-4878 healthcareplus@optonline.net

Authorization to Pay Physician

I hereby authorize the ____ insurance Company to pay by check made out and mailed directly to:

HEALTH CARE PLUS
33 Riverview Drive, Wayne, NJ 07470

The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment /toward the total charges for Professional Services rendered.
This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charge over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check to me and mail it as follows.

HEALTH CARE PLUS
33 Riverview Drive, Wayne, NJ 07470

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Name (Print Please) ____

Patient's Signature____Date___________________

Guardian or Spouse's Signature____

By signing above, the co-payment of treatment would be a financial hardship on me.

Privacy Policy
Authorization to use or disclose Protected Health information

In the course of your care as a patient at Health Care Plus, P.C., we may use or disclose health released information about 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 maybe disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care record may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that maybe of interest to you.
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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.
If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have right to confidential communication 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 maybe 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 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 disclose 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 medical and/or chiropractic treatment 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 you home or, if you would like the information in a specific please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and health information therein. We are also required to provide you with this notice of our privacy policy practice 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 charges. Any change in our privacy notice will apply for all of your health information in our files.
If you would like further information or have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct complaint to: **Dr. Adam Grand.**
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 ______________________________. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledge that I have received a copy of this notice.

Name (Print Please) ____
Patient's Signature____Date____________________
Guardian or Spouse's Signature____

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Authorization to treat in an ‘’ Open-Adjusting’’ Environment

Your authorization is requested for purposes of delivering your care in an “open-adjusting” or “open-door’’ and adjusting environment as described in the offices privacy notice.

This office utilizes and “open-adjusting” environment for ongoing patient care. “open-adjusting” involves several patients being seen in the same adjusting at the same time. Patients are within sight of one another and some ongoing routing details of care are discussed within earshot of other patient and staff.
This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting report of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in and open-adjusting environment other arrangements will be made for you.

In the course of your care in either of these environments routine details of your condition and care may be disclosed to other patients on staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditions on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future please advise us a according in writing.

If you agree to this authorization a copy will be maintained by this office and a copy will be provided to you.

Thank you for your cooperation and understanding.

Name (Print Please) ____
Patient’s Signature____Date____________________
Guardian or Spouse’s Signature____

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