PATIENT REGISTRATION

Patient Information:

Name (Last, First):_____ Date: _____

Nickname: _____ Marital Status: _____

Birth Date: _____/_____/_____ Age: _____ Sex(Circle One): (Male / Female)

Address: _____
Street Apt/Unit City State Zip Code

Phone: _____ #: _____ #: _____
Home Cell Work

Email: _____

How would you like to receive appointment reminders? ***Check off preference(s)*** Text: ___ Call: ___ Email: ___

Race: ___ African American ___ Asian ___White ___ Other: _____

___ American Indian/Alaskan Native ___ Native Hawaiian/Other Pacific ___ Patient declined and/or unable to provide

Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

Insurance Information: ****ONLY FILL OUT IF YOU DID NOT BRING INSURANCE CARDS****

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Physician Information:

Name of Primary Care Physician: _____Phone: _____

Emergency Contact:

Name: _____ Relationship to Patient: _____

Phone (Home): _____ (Cell): _____

Legal:

Is this visit a result of a motor vehicle accident: ___ Yes ___ No Date of Injury: _____

Is this visit a result of a work-related injury: ___ Yes ___ No Date of Injury: _____

Is this visit a result of other legal injury: ___ Yes ___ No Date of Injury: _____

How did you hear about us? Please write name so we can thank them!

Family/ Friend: _____ Other: _____

Patient Name: _____ **DOB:** _____

Reason for visit, current symptoms, and severity: Date of Onset: _____

*** Please note 1 is mild pain and 10 is severe pain, circle one: ***

___ Headaches 1 2 3 4 5 6 7 8 9 10 ___ Pins/Needles 1 2 3 4 5 6 7 8 9 10 ___ 1-6 Days

___ Neck Pain 1 2 3 4 5 6 7 8 9 10 ___ Numbness 1 2 3 4 5 6 7 8 9 10 ___Week(s)

___ Mid Back Px 1 2 3 4 5 6 7 8 9 10 ___ Radiating pain 1 2 3 4 5 6 7 8 9 10 ___ Months

___ Low Back Px 1 2 3 4 5 6 7 8 9 10 ___ Ongoing

___ Other: _____

HEIGHT:

WEIGHT:

BP:(Staff Only)

Limitations:

___ Walking ___ Bending ___ Housework

___ Dressing / Grooming ___ Driving ___ Getting in/out of bed

___ Standing 30+ min ___ Grocery shopping / Errands ___ Climbing stairs / curbs

___ Recreational Activity or sport ___ Lifting / Carrying

Alleviating Factors:

___ Ice ___ Heat ___ Rest___ Activity ___ Over the counter meds ___ Prescribed meds

Prior Treatment:	**Location**		**Location**
___ Hospital	_____	___ X-Ray/ CT Scan	_____
___ Urgent Care	_____	___ MRI	_____
___ Primary Care	_____	___ Pain Management	_____
___ Physical Therapy	_____		

Have you had Physical Therapy in the past 12 months? Yes: _____ No: _____

If yes, were you being treated for the same problem as today? Yes: _____ No: _____

HEALTH HISTORY

If no change in health since last visit, please check here: ___ **Women:** Any chance you are pregnant? ___ Yes___ No

Medications:___ None List Here:_____

Allergies:___ None List Here: _____

Social History: Smoking? ___ Yes___ No Alcohol? ___ Yes ___ No Exercise? ___ Yes___ No

___ ½ Pack ___ Daily ___ Rarely

___ 1 Pack ___ Weekly ___ Occasionally

___ 1-2 Packs ___ Socially ___ Often

Medical History: ___ No Medical History

Date	Illness/Diagnosis	Duration	Treatment
Date	Illness/Diagnosis	Duration	Treatment

Psychiatric History: ___ None

___ Anxiety ___ Depression ___ Bipolar ___ OCD ___ PTSD Other: _____

Family History: ___ None Circle One

Diagnosis: _____ Living / Deceased Relationship: _____

Diagnosis: _____ Living / Deceased Relationship: _____

Surgical History: ___ None

Date or Year	Surgery	Facility or Provider
Date or Year	Surgery	Facility or Provider
Date or Year	Surgery	Facility or Provider

Patient Name: _____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services.

For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: hhs.gov - Understanding Health Information Privacy

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initials: _____

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Initials: _____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate. I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initials: _____

Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand it is my responsibility to obtain a referral from my PCP for specialty services if required from my insurance carrier. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage. You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initials: _____

Signature: _____ **Date:** _____

Verification of Claims Information

Motor Vehicle Accident / Worker Comp Only

Patient: _____ **DOB:** _____

For Motor Vehicle Accidents:

Auto Ins Company of Vehicle you were in:_____

For Work Comp Cases:

Name of Work Comp Ins Company: _____

Ins. Company Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Ins. Company Telephone #: (_____)_____

Date of Injury / Accident: _____/_____/_____

Claim #: _____

Adjusters Name: _____ **Tel#:** _____

ATTORNEY INFORMATION

Name of Law Firm: _____

Attorney Name: _____

Telephone: (_____)_____ **Fax:** (_____)_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Date of accident: _____

City/State of accident: _____

Did the accident occur while you were working?

____ Yes ____ No

Did the police come to the scene of the accident?

____ Yes ____ No

Which of the following were you in the incident?

____ Driver ____ Passenger ____Pedestrian

____ Other: _____

Were you wearing a seatbelt? ____ Yes ____ No

Did airbags deploy? ____ Yes ____ No

Reports Filed: ____ Police Report ____ Other

Were you aware or was the accident a surprise?

____ Aware ____ Surprise

Pick ONLY ONE of the next two statements:

____ My Vehicle hit another vehicle

____Another vehicle hit my vehicle

Immediately following the accident did you notice:

____Confused ____Disoriented ____Light Headed ____Dizzy ____Nausea ____Blurriness

____ Other: _____

Have you taken time off from work as a result of the accident? ____ Yes ____ No

If Yes, are you still out of work? ____ Yes ____ No

Start and end date of time out of work : _____ to _____ (MM DD YYYY)

Were you compensated for time lost out of work? ____ Yes ____ No

Have you retained an attorney? ____ Yes ____ No

If yes, Atty name or Firm name: _____

Only after all the previous questions have been answered, use this space below to further describe what happened to the best of your knowledge.

_____

_____

_____

_____

_____

HARBOR CHIROPRACTIC GROUP, LLC

Harbor Chiropractic / Coastal Rehabilitation
Chiropractic — Physiatry — Physical Therapy
49 State Road, Watuppa Building Suite 10, North Dartmouth MA 02747
Ph: 508-999-4040 Fax: 508-993-9387

NOTICE OF IRREVOCABLE LIEN AND ASSIGNMENT OF BENEFITS AUTHORIZATION FOR RELEASE OF TREATMENT RECORDS

PROVIDER'S LEGAL & EQUITABLE, LIEN-ATTORNEY'S ACCEPTANCE

Name of Practice & Provider:_____

Patient Name & Address: _____

Name of Patient (PIP):_____ **Date of Injury/Illness**: _____

Name of Ins. Co.(PIP):_____

Name of Other Party (BI):_____

Other Party's Ins. Co:_____

Name of Law Office & Attorney:_____

In consideration of the agreement of the Provider named above to provide me with injury treatment services, I hereby to the extent of my treatment bills irrevocably assign to my Provider all my right(s), title and interest to and in all applicable insurance and indemnification reimbursement benefits of applicable insurance companies including but not limited to: automobile PIP (Personal Injury Protection) coverage; Medical Payment Coverage and health care coverage to which I may be entitled to pay my provider for services rendered to treat me on and after the above date in connection with my injury or illness.

I further grant to my Provider an irrevocable Equitable Lien and an Official Legal Lien as set forth in Ch 111§70A through Ch111§70D Mass. General Laws to and in any insurance benefits that may be due me and I furthermore authorize my Provider to provide my Attorney and any applicable insurance companies involved with a full report concerning my condition and treatment, including but not limited to office notes, dates of visits and charges incurred.

I hereby authorize and direct any and all applicable insurance companies to make immediate payment directly to my said provider for all benefits and sums due me that may be due him or her upon receipt by you of my Provider's itemized statement for treatment services rendered to me.

It is further agreed that payment by any insurance company involved as herein directed to my Provider of any itemized statement shall be considered the same ag if paid by the insurer directly to me.

I am aware that I remain personally responsible to my Provider for the full amount of any unpaid treatment bills and further direct any Attorney representing me to withhold from proceeds upon any final settlement or final disposition of my case an amount equal to that to pay any outstanding unpaid balance of my bills, This includes any balance due as a result of an Independent Medical Exam (IME) that discontinued my personal injury protection benefits and/or my medical payments benefits.

Patients Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

AGREEMENT OF ATTORNEY: I hereby agree to honor the above irrevocable Lien and Assignment and pay the Provider all sums received by me from insurers attributable to the Provider's bills and also agree to pay the Provider any lawful balance due from the proceeds of any settlement recovery.

Attorney's Signature: _____ Date:_____

HARBOR CHIROPRACTIC GROUP, LLC

Harbor Chiropractic / Coastal Rehabilitation
Chiropractic — Physiatry — Physical Therapy
49 State Road, Watuppa Building Suite 10, North Dartmouth MA 02747
Ph: 508-999-4040 Fax: 508-993-9387

HEALTH INSURANCE AFFIDAVIT

In order for this office to process your claim efficiently, it is necessary to obtain the following information regarding other health benefits available to you.

Any medical expenses in excess of $2,000.00 will not be paid under your auto policy if those expenses will be compensated, paid or indemnified by an outside insurance carrier.

Bills submitted to your Auto Insurance carrier over the $2,000.00 limit must be accompanied by an Explanation Of Benefits from your health carrier or a copy of this Affidavit.

If you have Health Insurance benefits available to you, please complete Section One.

If you **DO NOT** have health benefits available to you, **Please Sign & Date Section Two.**

SECTION ONE: (Complete if you have Health Insurance)

Health Insurance Company: _____

Policy Number: _____

Signature: _____ Date: _____

SECTION TWO:

I hereby certify that I **DO NOT** have any accident and/ or health benefits available to me through my own policy or that of a household member.

Signature: _____ Date: _____