PORZIO CHIROPRACTIC CENTER
1153 West Main Street
Waterbury, CT. 06708
(203) 756-7449

ABOUT YOU

Patient's Name: ____
LAST FIRST MI

What You Prefer To Be Called: ________________ □ Male □ Female

Birth date: ____/____/____ Age:_____ SS#: ________________

Mailing Address: ____

____
CITY STATE ZIP CODE

Home Phone #: ____

Work Phone#: ________________________________ Ext: ________

Would you like to receive text reminders? Please provide us with you cell phone company carrier. ** NOTICE: Standard text/data charges may apply **

Cell Phone#: ________________________________ Carrier: ________

E-Mail Address: ____

How did you hear about our office?: ________________________________

Employer: ____

Employer Address: ____

____
CITY STATE ZIP CODE

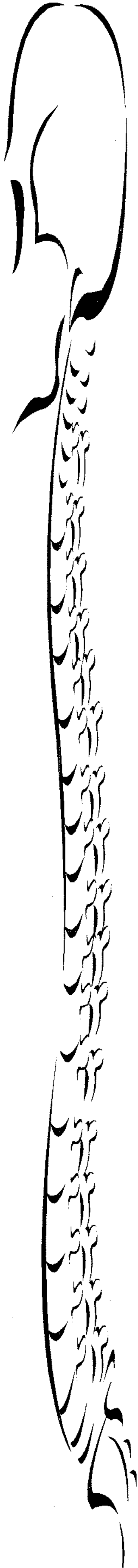
Occupation: ____

Status: □ Minor □Single □Married □Divorced □Separated □Widowed

Spouse's Name: ____

Do you have children? □ Yes □ No How many? ________

Name: ______________________________ Date: ______________



REASON FOR TODAY'S VISIT

The reason for this visit is a result of (Please circle): auto, work, sports, trauma or chronic

(Explain what happened): ____

____

Please describe the pain and its location: ____

____

When did this condition begin? ____/____/____

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

Rate your pain today on a 0-10 scale (Please circle: 0 = no pain and 10 = severe pain)

0 1 2 3 4 5 6 7 8 9 10

Is this condition interfering with your: (Please circle): Work, Sleep, or Daily Routine

If so, please explain: ____

Have you had this similar condition in the past? □ Yes □ No

If so, please explain: ____

Have you been treated by a Medical Physician for this condition? □ Yes □ No

If so, where? ____

Have you ever been treated by a Chiropractor before? □ Yes □ No

If so, whom? ____

IN THE EVENT OF AN EMERGENCY

Who should we contact? ____

Relation: ____

Home Phone #: ______________________ Cell Phone #: ______________________

Who is your Medical Doctor? ______________________ Phone #: ______________________

Name: ______________________________ Date: ______________

HEALTH HISTORY

Are you taking any of the following medication?

□ Nerve pills □ Pain killers (including aspirin) □ Muscle relaxers □ Stimulants

□ Blood thinners □ Tranquillizers □ Insulin □ Other(s) ________________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	**Y** N Heart Surgery/Pacemaker	**Y** N Heart Murmur
Y N Congenital Heart Defect	**Y** N Mitral Valve Prolapse	**Y** N Artificial Valves
Y N Alcohol/Drug Abuse	**Y** N Venereal Disease	**Y** N Hepatitis
Y N HIV+/Aids	**Y** N Shingles	**Y** N Cancer
Y N Frequent Neck Pain	**Y** N Emphysema/Glaucoma	**Y** N Anemia
Y N High/Low Blood Pressure	**Y** N Psychiatric Problems	**Y** N Rheumatic Fever
Y N Severe/Frequent Headaches	**Y** N Kidney Problems	**Y** N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	**Y** N Sinus Problems	**Y** N Asthma
Y N Diabetes/Tuberculosis	**Y** N Difficulty Breathing	**Y** N Chemotherapy
Y N Lower Back Problems	**Y** N Artificial Bones/Joints	**Y** N Arthritis

Please list any other serious medical condition(s) you have or ever had:

____

Please list anything that you might be allergic to: ______________________________

List previous surgeries/treatments with dates: ______________________________

List any past serious accidents with dates: ______________________________

Family Health History: ____

____

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

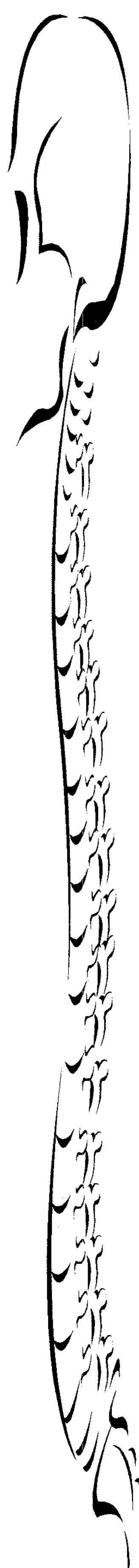
- I authorize the staff to perform necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

- I understand the information I have provided and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibly to inform this office of any changes to the information I have provided.

Signature: ______________________________ Date: ______________

□Adult Patient □Parent/Guardian □Spouse

Name: ______________________________ Date: ______________



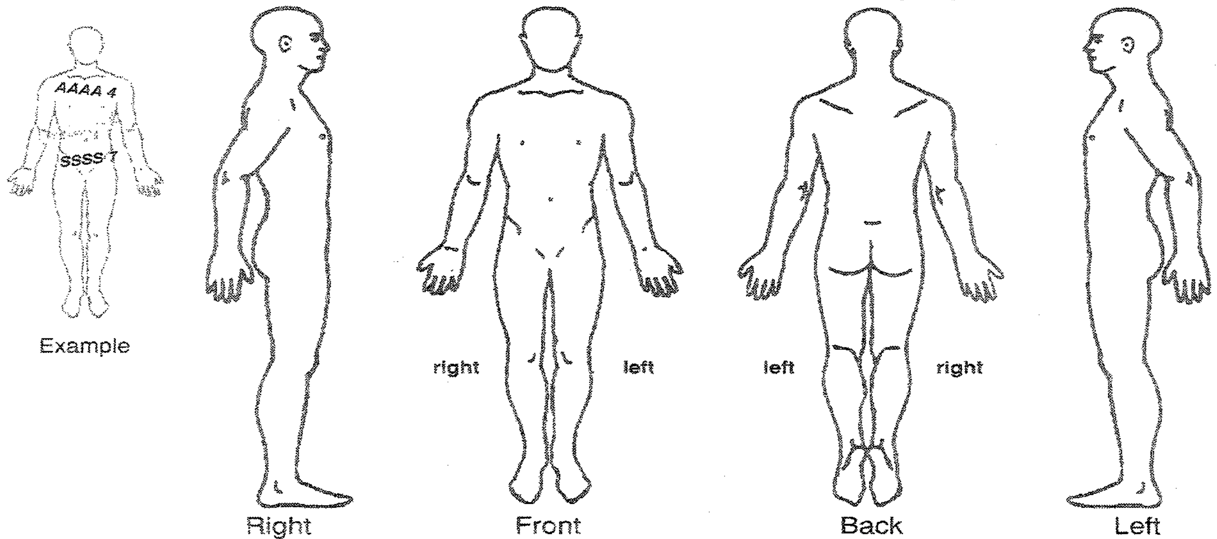
PAIN CHART

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below.

Make all areas with the appropriate symbols and indicate the degree of pain using a scale from **1 (discomfort) to 10 (extreme pain)**

Description →	**Numbness**	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
Symbol→	*NNNN*	*PPPP*	*BBBB*	*AAAA*	*SSSS*



Do you: Take Supplements or Vitamins? □ Yes □ No Exercise? □ Yes □ No

Are you on a special diet? □ Yes □ No Since: ____/____/____

Do you smoke? □ Yes □ No How much? _______ How long? __________

Are you wearing: □ Heel Lifts □ Sole Lifts □ Inner Soles □ Arch Supports

What is the age of your mattress? ________ Is it comfortable? □ Yes □ No

For Women: Are you taking Birth Control? □ Yes □ No

Are you pregnant? □ Yes □ No How long? _____ Nursing? □ Yes □ No

bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

~We will use your health information for regular health operations.

For Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your records to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Other Uses and Disclosures of Your Health Information.

~We will use your information for:

Business Associates: We may disclose your information to our business associates such as medical transcriptionists or others who assist in the operations of our practice. We may provide copies of various reports to a physician or other healthcare providers, that would assist him or her in treatment to you. Examples include physician services in the emergency department and radiology, and certain laboratory's.

Workers Compensation: We may disclose health information to the extent authorized and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Required by Law: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health and safety of others.

Appointments and Reminders: We may call to remind you of appointments if you have one or have missed an appointment and we may leave a message on your answering machine or voice mail system. At your request, we may mail a reminder postcard of an appointment via USPS.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: We may, using our best judgement, disclose to a family member , other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your case or payment related to your care.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose health information relative to adverse events with respect to food, supplement, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

NOTICE OF PRIVACY PRACTICES

FOR

PORZIO CHIROPRACTIC CENTER

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

Introduction

At Porzio Chiropractic Center, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Porzio Chiropractic Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

* Basis for planning your care and treatment,
* Means of communication among the many health professionals who contribute to your care,
* Legal document describing the care you received,
* Means by which you or a third-party payer can verify that services billed were actually provided,
* A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your record is the physical property of Porzio Chiropractic Center, the information belongs to you. You have the right to:

* Obtain a paper copy of this notice of information practices upon request,
* Inspect and copy your health record,
* Request an amendment to any health record you believe is inaccurate,
* Request an accounting of disclosures of your health information,
* Request communications of your health information by alternative means or at alternative locations,
* Request a restriction on certain uses and disclosures of your information, and
* Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Porzio Chiropractic Center is required to:

* Maintain the privacy of your health information,
* Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
* Abide by the terms of this notice,
* Notify you if we are unable to agree to a requested restriction, and
* Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will change this Notice and make the new Notice available upon request.
We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.
For Example: A bill may be sent to you or a third-party

For More Information or to Report a Problem

If you have any questions and would like additional information, you may contact the practice's Privacy Officer, Carol D. at (203) 756-7449.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

~We will use your health information for treatment.

For Example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating once you're discharged from this hospital.

~We will use your health information for payment

payer. The information on or accompanying the

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Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Porzio Chiropractic Center **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____
____
____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed____

Date:_________________________

If not signed by patient, please indicate relationship to patient (e.g., Guardian, HealthCare Administrator)

Relationship:____

Date:_________________________

Internal Use Only:
If patient or patient's representatives refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time)________________________________

By: (name and title):____________________________________

ROBERT J. PORZIO, D.C., P.C.

CHIROPRACTIC KINESIOLOGIST

1153 WEST MAIN STREET

WATERBURY, CONNECTICUT 06708-2792

TELEPHONE (203) 756-7449

FAX (203) 597-1153

Missed Appointment Policy

You, the patient, must notify the office at least two hours prior to your appointment that you are unable to keep your appointment. Failure to do so will result in a fee.

If you can't make your appointment, please let us know as soon as possible so we can offer it to someone else. Your consideration is appreciated because the sooner you call us, the greater our chances are of providing this time to someone else. If a person fails to show for an appointment and does not provide at least 2 hours' notice prior to cancelling, then our health care professionals will charge the rate of $15.00 for payment of the missed appointment. These charges will not be billed to your insurance provider. Your appointment time is allotted to you, so we will charge you for failure to call.

This policy applies to the following missed appointments:

- The appointment was not the person's first visit
- The individual was previously informed of the policy
- The cancellation was not due to a medical emergency
- Failure to cancel in more than 2 hours' notice

This applies to **all** patients

Thank you for your cooperation in helping us provide the best care possible to you!

Print name: ____

Patient or Legal Guardian Signature: ____________________ *Date:* __________