



# A Therapeutic Effect

## Personal Data

<b>Patient's Name:</b> _____	<b>Today's Date:</b> _____
<b>Address:</b> _____ _____	<b>Phone Number:</b> <small>daytime</small> _____
<b>email:</b> _____	<small>evening</small> _____
<b>Date of Birth:</b> _____ / _____ / _____ <small>month day year</small>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Occupation:</b> _____	<b>Referred by:</b> _____
<b>Emergency Contact:</b> _____	<b>Phone Number:</b> <small>daytime</small> _____
<b>Relationship:</b> _____	<small>evening</small> _____

Are you currently under a Physician's care?    Yes                      No

If yes, please explain: \_\_\_\_\_

Please list any past or present injuries, accidents, or medical treatment including surgeries:  
\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant?                      Yes                      No                      \*If yes, some services may not be administered.\*

Please list all known allergies: \_\_\_\_\_

Please list all medications and supplements you are taking: \_\_\_\_\_  
\_\_\_\_\_

### CANCELLATION POLICY

If you are unable to keep your appointment - for any reason - please give us as much notice as possible. For appointments broken with less than 12 hours notice, we reserve the right to charge 50% of the standard fee. Appointments that no show will be charged in full to cover the therapist's time.



**Chiropractic New Client Information**

**Client Name:** \_\_\_\_\_

**What is your main complaint:** \_\_\_\_\_

**Date symptoms began:** \_\_\_\_\_ **How symptoms began:** \_\_\_\_\_

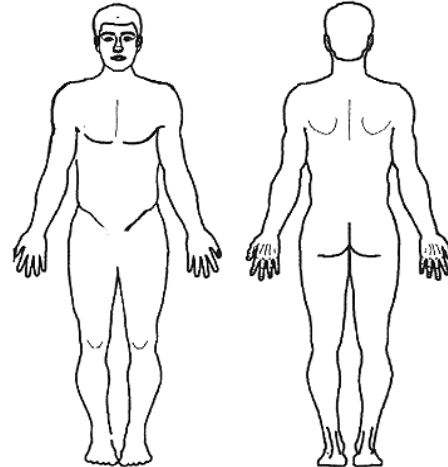
**Do you have:** Headaches Neck pain Mid-back pain Low back pain  
(please circle) Other (describe) \_\_\_\_\_

**Is this:** Work Related Auto Related N/A

**Mark an X on the picture where you have pain or other symptoms**

**How do you feel today:**

1 2 3 4 5 6 7 8 9 10  
No Pain Unbearable Pain



**How often are your symptoms present?**

- 0-25% (Intermittent)
- 26-50%
- 51-75%
- 76-100% (Constant)

**In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores)?**

1 2 3 4 5 6 7 8 9 10  
No interference Unable to carry on any activities

**Have you had spinal x-rays, MRI, CT Scan for your area(s) of complaint?** Yes No

If yes, date(s) taken: \_\_\_\_\_ What areas were taken? neck mid back low back

**Please circle all of the following that apply to you:**

- Recent Fever Prostate Problems Diabetes Prescription birth control
- High Blood Pressure Urinary Problems Pain at Night Pain Unrelieved by Position or Rest
- Abnormal Weight Gain Abnormal Weight Loss Epilepsy/Seizures Marked Morning Pain/Stiffness
- Dizziness/Fainting Menstrual Problems Osteoporosis Numbness in Groin/Buttocks
- Visual Disturbances Stroke (date) \_\_\_\_\_ Corticosteroid Use (corisone, prednisone, etc.)
- Cancer / Tumor (please explain) \_\_\_\_\_ Currently Pregnant, # of weeks \_\_\_\_\_
- Surgeries (explain) \_\_\_\_\_
- Medications \_\_\_\_\_
- Other Health Problems (explain) \_\_\_\_\_

**Family History** (please circle) Cancer Diabetes High Blood Pressure Rheumatoid Arthritis Heart Problems/Stroke

**I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# A Therapeutic Effect

## Responsible Party Form

I \_\_\_\_\_ give A Therapeutic Effect permission to bill my insurance(s).  
print name

I \_\_\_\_\_ will be responsible for any outstanding balance.  
print name

Signature \_\_\_\_\_

Date \_\_\_\_\_

**While we participate with most major insurance companies, individual insurance coverage and plans vary greatly. Until our office contacts your insurance company to verify coverage, we cannot guarantee that your services will be covered by your insurance. Please let us know if you have any questions or concerns. Thank you!**

### Medical Insurance Information

Primary Insurance: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Policy or ID #: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_  
(on back of card)

Subscriber Name: \_\_\_\_\_  
First Middle Last

Relationship to Subscriber: Mother Father Spouse Child

Group #: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN (optional): \_\_\_\_\_

Secondary Insurance: YES NO

Name of Insurance: \_\_\_\_\_

Policy or ID #: \_\_\_\_\_

Claims Mailing Address: \_\_\_\_\_  
(on back of card)

Subscriber Name: \_\_\_\_\_  
First Middle Last

Relationship to Subscriber: Mother Father Spouse Child

Group #: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN (optional): \_\_\_\_\_

**\*\*\*\* You will be contacted by our billing manager if you do not have this information with you\*\*\*\***

# Patient consent form

A Therapeutic Effect

## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **A Therapeutic Effect** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **A Therapeutic Effect** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

**A Therapeutic Effect** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **A Therapeutic Effect 313D Primrose Lane, Mountville, Pa 17554 (717) 285.9955**.

With this consent, **A Therapeutic Effect** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **A Therapeutic Effect** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **A Therapeutic Effect** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **A Therapeutic Effect** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **A Therapeutic Effect** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **A Therapeutic Effect** may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Print Patient' Date

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Print Name of Patient or Legal Guardian, if applicable

# HIPAA Authorization form

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## A Therapeutic Effect

### Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **A Therapeutic Effect** to use and/or disclose certain protected health information (PHI) about me to \_\_\_\_\_.

This authorization permits **A Therapeutic Effect** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose: \_\_\_\_\_

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire ONE year to the date of authorization.

The Practice will \_\_\_ will not \_\_\_ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **A Therapeutic Effect**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: **A Therapeutic Effect**

Signed by:

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.