A Therapeutic Effect

Personal Data

Patient's Name: _____ **Today's Date:** _____

Address: _____ **Phone Number:** _____ (preferred) OK to leave message? **Y or N**

_____ _____ (other) **Y or N**

** Please indicate best number for us to call should we need to cancel an appointment due to weather, illness, or other emergency **

email: _____

How should we confirm your appointments? Automated Text and/or Automated Email (please circle)

Date of Birth: ____ / ____ / ____ (month / day / year) **Sex:** Male ☐ Female ☐ Transgender ☐

Occupation: _____ **Referred by:** _____

Emergency Contact: _____ **Phone Number:** _____ (preferred) OK to leave message? **Y or N**

Relationship: _____ _____ (other) **Y or N**

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

If yes, please explain: _____

Please list and date 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: _____

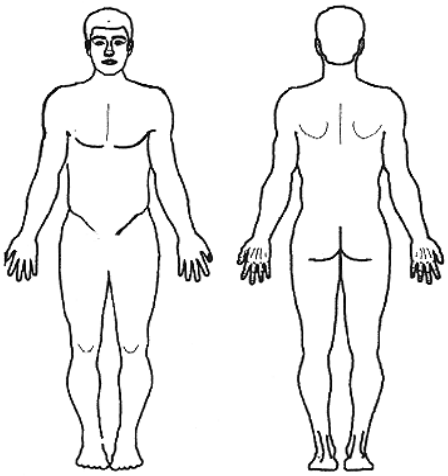
Date symptoms began: _____ **How symptoms began:** _____

Do you have: (please circle) Headaches Neck pain Mid-back pain Low back pain

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 rendred 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 #: _____ Group #: _____

Claims Mailing Address: _____ Phone Number: _____
(on back of card)

_____

Subscriber Name: _____ Date of Birth: _____
First Middle Last

SSN (optional): _____

Relationship to Subscriber: Self Mother Father Spouse Child

Secondary Insurance: YES NO

Name of Insurance: _____

Policy or ID # _____ Group # _____

Claims Mailing Address: _____ Phone Number: _____
(on back of card)

_____

_____

Subscriber Name: _____ Date of Birth: _____
First Middle Last

SSN (optional): _____

Relationship to Subscriber: Self Mother Father Spouse Child

****** 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.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

HIPAA Authorization form

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.