



Lower Bucks  
Total Health and  
Wellness Center, P.C.

**NEW CHIROPRACTIC PATIENT INTAKE FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Email Address \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Gender M/F Marital Status M S D W

Referred By (If Any) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Years Employed \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

Is your condition due to a motor vehicle or work related accident? YES / NO \_\_\_\_\_

If Yes, have you filed a claim with your auto insurance or worker's compensation? YES / NO

Attorney's Name (if applicable) \_\_\_\_\_ Telephone \_\_\_\_\_

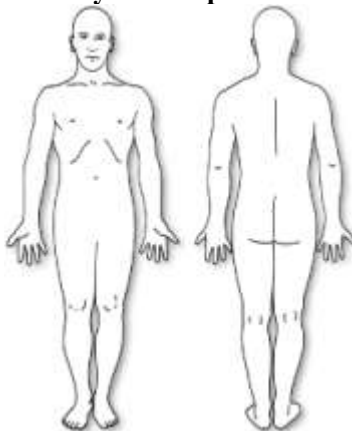
Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Date your problem began \_\_\_/\_\_\_/\_\_\_

Please describe how your problem began

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mark an X where you have pain or other symptoms





## Health History

Please mark an X next to any symptoms you are presently experiencing as well as any symptoms listed below that you have had in the past. Knowledge of these conditions may influence the type of treatment you receive at our office.

<b>Present</b>	<b>Past</b>	<b>Condition</b>	<b>Present</b>	<b>Past</b>	<b>Condition</b>
_____	_____	Neck Pain	_____	_____	Depression
_____	_____	Shoulder Pain (R/L)	_____	_____	Aortic Aneurysm
_____	_____	Upper Arm/Elbow Pain (R/L)	_____	_____	Hypertension
_____	_____	Hand/Wrist Pain (R/L)	_____	_____	Chest Pain
_____	_____	Upper Back Pain	_____	_____	Chest Pain
_____	_____	Lower Back Pain	_____	_____	Heart Attack (Date)_____
_____	_____	Hip/Upper Leg Pain (R/L)	_____	_____	Stroke (Date)_____
_____	_____	Knee Pain (R/L)	_____	_____	Cancer_____
_____	_____	Lower Leg Pain (R/L)	_____	_____	Prostate Problems
_____	_____	Ankle/Foot Pain (R/L)	_____	_____	Blood Disorder
_____	_____	Jaw Pain	_____	_____	Lung Disorder_____
_____	_____	Fainting	_____	_____	Arthritis
_____	_____	Epilepsy/Convulsions	_____	_____	Rheumatoid Arthritis
_____	_____	Visual Disturbances	_____	_____	Ulcer
_____	_____	Headaches	_____	_____	Liver/Gallbladder Problems
_____	_____	Tinnitus (Ringing in Ears)	_____	_____	Hepatitis
_____	_____	Rapid Heart Rate	_____	_____	Kidney Disorders (stones, etc)
_____	_____	Loss of Appetite	_____	_____	Bladder Infection
_____	_____	Anorexia	_____	_____	HIV/AIDS
_____	_____	Asthma	<b>Family History</b>		
_____	_____	Abnormal Weight Gain/Loss	_____	_____	Cancer
_____	_____	Diabetes	_____	_____	Diabetes
_____	_____	Excessive Thirst	_____	_____	Hypertension
_____	_____	Frequent Urination	_____	_____	Arthritis
_____	_____	Chronic Cough	_____	_____	Heart Problems
_____	_____	Chronic Sinusitis	_____	_____	Lung Problems
_____	_____	General Fatigue	_____	_____	Headaches
_____	_____	Irregular Menstrual Cycle	_____	_____	Back Problems
_____	_____	Irregular Menstrual Flow	<b>Do you have a permanent Disability Rating?</b>		
_____	_____	PMS	YES/NO		
_____	_____	Loss of Bladder Control	Location_____		
_____	_____	Abdominal Pain	Rating Percentage_____		
_____	_____	Constipation	Date Rating Was Received _____		
_____	_____	Irregular Bowel Habits	<b>Please Check All That Apply to You</b>		
_____	_____	Difficulty Swallowing	_____	_____	Tobacco
_____	_____	Heartburn/Indigestion	_____	_____	Alcohol
			_____	_____	Drug/Alcohol Dependence
			_____	_____	Coffe/Tea/Caffinated Soft Drinks
			_____	_____	Cups/Cans Per Day_____
			<b>Height</b> _____'		<b>Weight</b> _____

I certify that the information I have provided is complete and accurate to the best of my knowledge. I agree to notify this office immediately when I have changes in my health condition.

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Parent/Guardian **MUST** sign for all patients under 18 years of age

**INSURANCE INFORMATION**

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Insurance Carrier** \_\_\_\_\_

**Insurance ID#** \_\_\_\_\_ **Group #** \_\_\_\_\_

***ATTENTION MEDICARE PATIENTS***

*Please notify us if your Social Security Number is different from your Medicare ID number*

**Subscriber's Name** \_\_\_\_\_

**Subscriber's Date of Birth** \_\_\_\_\_

**Subscriber's Employer** \_\_\_\_\_

**Relation to Subscriber**                  SELF                  SPOUSE                  DEPENDENT

I understand and agree that I am responsible for payment of any services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable.

Patients with group or individual insurances are responsible for any unpaid balance in the event that their insurance does not cover chiropractic care or is terminated while they are under care at this office.

I fully accept full responsibility and I release the Lower Bucks Total Health and Wellness Center, Inc. and its doctors from any and all liability in the unlikely event that a problem occurs from my treatment. By signing below, I affirm that the provided information above is correct and consent to chiropractic care at this office.

\_\_\_\_\_  
**Patient's Name (print)**

\_\_\_\_\_  
**Patient's Signature** **Date**

Parent/Guardian **MUST** sign for all patients under 18 years of age



Lower Bucks  
Total Health and  
Wellness Center, P.C.

**NOTICE OF PRIVACY PRACTICES**

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

Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

**Disclosure of Your Health Care Information**

**Treatment**

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or healthcare operations.

example

On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Lower Bucks Total Health and Wellness Center, P.C.

It is our policy to provide a substitute health care provider, authorized by Lower Bucks Total Health and Wellness Center, P.C. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to sickness, vacation or an emergency situation.

**Payment**

We may disclose your health information to your insurance provider for the purposes of payment or health care operations.

example

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Lower Bucks Total Health and Wellness Center, P.C. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy to you, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services rendered.”

## **Workers' Compensation**

We may disclose your health information as necessary to comply with State Worker's Compensation Laws.

## **Emergencies**

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about medical condition or in the event of an emergency or of your death.

## **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

## **Judicial and Administrative Proceedings**

We may disclose your health information in the course of any administrative or judicial proceedings.

## **Law Enforcement**

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

## **Deceased Persons**

We may disclose your health information to coroners or medical examiners.

## **Organ Donation**

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

## **Research**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

## **Public Safety**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

## **Specialized Government Agencies**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

## **Marketing**

We may contact you for marketing or fundraising purposes, as described below:

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, dates and times and request your participation in such events. It is not our policy to disclose any personal health information about your condition for the purpose of Lower Bucks Total Health and Wellness Center, P.C. sponsored fund-raising events.”

## **Change of Ownership**

In the event that Lower Bucks Total Health and Wellness Center, P.C. is sold or merged with another organization, your health information/record will become the property of the new owner.

## **Your Health Information Rights**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised however, that Lower Bucks Total Health and Wellness Center, P.C. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information
- You have a right to request that Lower Bucks Total Health and Wellness Center, P.C. amend your protected health information. Please be advised, however, that Lower Bucks Total Health and Wellness Center, P.C. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Lower Bucks Total Health and Wellness Center, P.C.
- You have the right to a paper copy of this notice of Privacy practices at any time upon request.

## Changes to This Notice of privacy Practices

Lower Bucks Total Health and Wellness Center, P.C. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make provisions effective for all information that it maintains. Until such amendment is made, Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to comply with this Notice.

Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please call Charles Flood, D.C. by calling his office at 215-788-3608. If Charles Flood, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

## Complaints

Complaints about your privacy rights or how Lower Bucks Total Health and Wellness Center, P.C. has handled your health information should be directed to Charles Flood, D.C. by calling his office at 215-788-3608. If Charles Flood, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

**This notice is effective as of**

10 / 5 / 07

I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide Lower Bucks Total Health and Wellness Center, P.C. with my authorization and consent to use my disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

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**Patient's Name (print)**

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**Patient's Signature**

**Date**

Parent/Guardian **MUST** sign for all patients under 18 years of age

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**Authorized Facility Signature**

**Date**