Dr. Richard Carlson
3069 English Creek Ave, Suite 201
Egg Harbor Township, NJ 08234
(609) 415-2821

Welcome to our office!

CONFIDENTIAL PATIENT CASE HISTORY

Name: _____ Sex:____ Marital Status:____ Race:____ DOB:_____

Address:_____ City:_____

State: ____ Zip Code:_____ Home Phone:_____ Cell Phone:_____

Social Security #:_____ Email Address:_____

Occupation:_____ Company Name:_____

Is this related to: Auto Accident ☐ Yes ☐ No; Work Injury ☐ Yes ☐ No; Slip & Fall Injury ☐ Yes ☐ No

MEDICAL HISTORY:

List any surgical operations and year performed: _____

_____

Do you currently or have you ever suffered from:

☐ Pacemaker ☐ Heart trouble ☐ Diabetes ☐ Take blood thinners

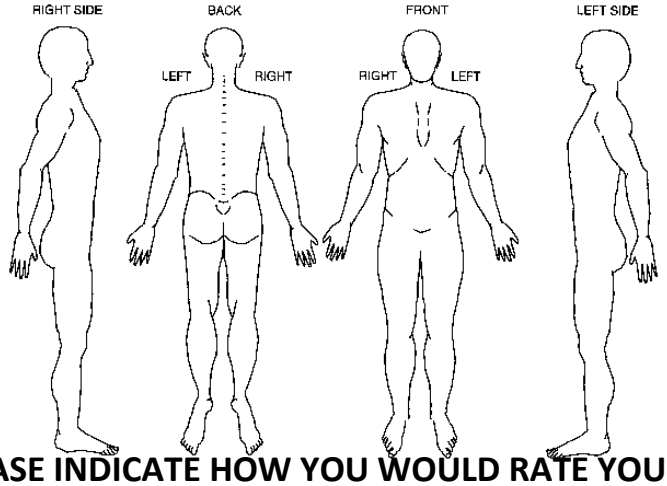
Are you currently on prescription medications? ☐ Yes ☐ No If yes, please list: _____

_____

Reason for Visit? _____

PAIN DRAWING: Please mark the figures below with the letters that best describe the sensation or pain you are feeling.

A = Ache	B = Burn	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	O = Other



PLEASE INDICATE HOW YOU WOULD RATE YOUR PAIN

(LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

HEALTH INSURANCE AND FINANCIAL RESPONSIBILITY:

If you have supplied a copy of your card, please write **"see card"** in the name space. If no insurance, write **"none."**

Primary Insurance Name: _____ Phone #: _____

ID # _____ _____ Group # _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Is a referral required? ☐ Yes ☐ No If yes, did you bring it with you today? ☐ Yes ☐ No

Secondary Insurance Name: _____ Phone #: _____

ID # _____ Group # _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Is a referral required? ☐ Yes ☐ No If yes, did you bring it with you today? ☐ Yes ☐ No

All services rendered are charge directly to you, the patient. You then are ultimately responsible for all payments regardless of whether or not this office accepts insurance assignment

I understand if I default in paying my portion due, I will be responsible for any and all collection fees, legal cost and attorney fees.

I DO NOT HAVE ANY ADDITIONAL INSURANCE COVERAGE OTHER THAT WHAT I HAVE PROVIDED ABOVE. IT IS MY RESPONSIBILITY TO PROVIDE THIS OFFICE WITH ANY CHANGES OR UPDATES WHEN IT COMES TO MY MEDICAL COVERAGE. IF I DO NOT PROVIDE THE PROPER INFORMATION REGARDING MY COVERAGE, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANYTHING NOT COVERED BY MY INSURANCE COMPANY.

I understand and agree that the health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to pay directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND FULLY ACCEPT ALL OF ITS TERMS.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative
I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Richard Carlson, DC/Optimal Health Chiropractic (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims with the health plan
- File appeals and grievances with the health plan
- Institute and necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary
- Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information
I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization
I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient's Signature: _____ Date: _____

OPTIMAL HEALTH CHIROPRACTIC & SPORTS INJURY

Relieving Pain by Restoring Function

We believe a clear definition of our office policy will allow both patient and the doctor to concentrate on the big issues – REGAINING AND MAINTAINING YOUR HEALTH.

TERMS OF ACCEPTANCE

The goal of chiropractic is to relieve pain by restoring function to the human body. Through correcting joint restrictions, muscle imbalances, and faulty movement patters we are working to help you live a happy and healthier life.

Through the use of joint manipulation, Post Isometric Relaxation, Active Release Technique, Graston, and functional rehabilitation we are working to improve the quality your joints, muscles, and movements.

Regardless of what disease or condition is called, the chiropractor does not offer to heal or treat it. Nor does the chiropractor offer advice regarding the treatment of disease. The only goal is to allow the body to do its job. The chiropractor promises no cure from and offers no treatment of disease.

I have read the above, understand it fully, and undertake chiropractic care on this basis.

_____ _____

Signature Date

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Optimal Health Chiropractic and Sports Injury all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Optimal Health Chiropractic and Sports Injury may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or on year from the date signed below.

_____ _____

Signature Dated

HIPAA 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.

The Health Insurance Portability and Accountability Act of 1996(HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices described how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (HCO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message(either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health Issues required by law: Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings; Law Enforcement, Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity, Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when requited by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

OTHER PERMITED AND REQUIRED USES AND DISCLOSURES will be made only with your consent, authorization or opportunity to object unless required by law.

YOU MAY REVOKE THIS AUTHORIZATION at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you will have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

_____ _____

Signed Dated

FOR OFFICE USE ONLY

☐ Patient Refused to Sign

☐ Patient Unable to Sign for the following reason _____

Date: _____

Dear Insurance Carrier,

I understand you may be holding up payment of my claims because you are waiting to update your records regarding my status and my coverage. The following is my updated information:

Name of patient _____ SS# _____ DOB _____
Insured Name_____ Policy ID#_____ Relation to Insured_____

PLEASE SELECT FROM SECTIONS BELOW & CHECK ONLY *ONE* STATEMENT THAT APPLIES TO YOUR INSURANCE COVERAGE – YOU MUST SIGN THAT SECTION:

Self:

_____ I am the patient AND the insured AND I have no other insurance coverage

_____ _____
Authorized Signature Date

Spouse / Partner:

_____ I am the patient, BUT the insured is my spouse/partner _____. I am not employed and therefore have no other insurance coverage of my own.

_____ I am the patient, BUT the insured is my spouse/partner _____. I am employed at _____ but have no coverage through that employer.

_____ I am the patient & have my own coverage - the following is my coverage information:
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Authorized Signature Date

Dependent Child (In school): (covered under parent's policy)

_____ I am a student & have 1 policy. Attached is my current school schedule.
Primary Ins _____ Insured Name: _____ Insured DOB: _____

_____ I am a student & have 2 polices. Attached is my current school schedule.
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Authorized Signature Date

Dependent Child Under (Not in school): (covered under parent's policy)

_____ I am a dependent on the policy and only covered under this policy :
Primary Ins _____ Insured Name: _____ Insured DOB: _____

_____ I am a dependent and covered under two policies :
Primary Ins _____ Insured Name: _____ Insured DOB: _____
Secondary Ins _____ Insured Name: _____ Insured DOB:_____

_____ _____
Authorized Signature Date

Revised 5/12/13

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