

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____
ID
Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ 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.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) 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 one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

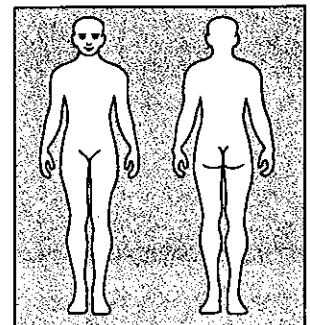
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | | | | | |
|---------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ | | |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Chicken Pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | | | | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/Day _____
 High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

_____ _____ _____ Pharmacy Name _____ Pharmacy Phone (____) _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
---	---	---

Mack Chiropractic Health Center
Dr. Patrick C. Mack DC
269 Route 31 S. Suite 5
Washington, NJ 07882
Phone: 908-689-5110 Fax: 908-689-5409

Office Policy Re: Insurance Checks

As a courtesy to our patients, this office will submit claims and wait for payment to be issued by your insurance company. Your insurance company will, within 15-30 days, process the claims. Some plans will mail payment and or Explanation of Benefits directly to the member/subscriber.

Upon the receipt of this correspondence, we ask that you bring in all checks and explanations promptly so we can credit your account. This must be done even after your treatment has concluded. Ultimately, it is your responsibility to forward all correspondence to this office.

If payment is not received by this office in a timely fashion, we will no longer be able to offer this courtesy, and all payments will be due at the time services are rendered.

I understand and agree to abide by these terms of payment.

Patient Name (Please Print)

Patient Signature

Mack Chiropractic Health Center
Dr. Patrick C. Mack DC
269 Route 31 S. Suite 5
Washington, NJ 07882
Phone: 908-689-5110 Fax: 908-689-5409

Date:

Patient Name: _____

Insurance Name: _____

I _____ attest to the fact that _____
Insurance company is the only health insurance that I have, according to the applicable
law of the state of New Jersey, I state that this attestation is true and binding.

Signature of patient/subscriber:

Date: _____

Witness:

Date: _____

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed w said physician by the insured or his/her family.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

H.M.O. DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO) Subsequent rejection of a claim as a result of this admission, due to current enrollment in an H.M.O. plan will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Verification of non-pregnancy

Date: _____ File #: _____

Date of L.M.P. _____

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

X _____
Print Patient's Name

X _____
Patient's Signature

X _____
Other than patient, Print name & relationship

X _____
Witness

Dr. Patrick C. Mack, D.C.
269 Route 31 South, Suite 5
Washington, NJ 07882
(908) 689-5110

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required by law to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and I brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint
 - The right to request restrictions on certain uses and disclosures or my protected health information, and that this practice is not required to agree to a request restriction.
 - The right to receive confidential communication of protected health information.
 - The right to amend protected health information.
 - The right to receive and accounting of disclosures of protected health information.
 - The right to obtain a paper copy of Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as a part of my healthcare, Dr. Patrick C Mack originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have been provided with a Notice of Information Practices that provides me a more complete description of information uses and disclosure. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Dr. Patrick C. Mack is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I further understand that Dr. Patrick C. Mack reserves the right to change their notice and practices prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should Mack Chiropractic change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

Patient's Signature

Date