PAGANO CHIROPRACTIC CLINIC PC.

204 South Main Street
Carrolltown, Pa 15722
Phone: (814) 344-8740
Fax: (814) 344-8748

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PATIENT NAME:_____

ADDRESS:_____

BIRTHDATE:_____ TODAY'S DATE _____

I hereby authorize:_____to release to
(Hospital/Program)

PAGANO CHIROPRACTIC CLINIC, P.C.
204 SOUTH MAIN STREET, PO BOX 646
CARROLLTOWN, PA. 15722

(Complete Name and Address)

the following medical records which I understand may include mental health information, drug/alcohol information, and/or HIV information.

The extent or nature of information to be released is indicated below:

_____impatient care on _____(date of service)
_____emergency care on _____(date of service)
_____ambulatory/outpatient care on_____(date of service)

_____Complete medical record	_____Laboratory Reports	_____Medication Sheets
_____Abstract	_____Discharge Summary	_____Operative Report
_____X-rays	_____CT Scan	_____MRI
_____Other		

The purpose for release of the above information is indicated below:
_____Continued Care _____Insurance _____Legal _____Other_____(specify)

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication. This consent will remain in effect no more than one year from the date I signed this consent.

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 understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_____ _____ _____
Patient/Parent/Legal Guardian Signature Relationship Date Signed

_____ _____
Witness Signature Date Signed

If signed by other that patient, state relationship and reason for patient's inability to sign.

_____

A copy of this authorization has been_____accepted_____rejected by the patient/representative.

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

PAGANO CHIROPRACTIC CLINIC PC
POLICY ON NOTICE OF PRIVACY PRACTICES

Patient Rights

Pagano Chiropractic Clinic PC acknowledges that it must maintain and provide to patients a notice of privacy practices that informs patients about their rights concerning protection of their protected health information (PHI). Under the Privacy rule patients have the following rights:

- The right to receive a copy of Pagano Chiropractic Clinic PC notice of privacy practices.
- The right to request restrictions on certain uses and disclosures of PHI.
- The right to request restrictions on how Pagano Chiropractic Clinic PC communicates PHI to the patient.
- The right to request that PHI with respect to a specific item or service not be disclosed to a health plan for purposes of payment or health care operations if the patient paid out-of-pocket for that specific item or service.
- The right to inspect and copy PHI.
- The right to request an electronic copy of his/her health records if the Practice maintains an electronic health record.
- The right to request an amendment of PHI.
- The right to authorize the use and disclosure of PHI for certain purposes unrelated to treatment, payment, or health care operations ("TPO") and psychotherapy notes.
- Except for disclosures through an electronic health record, the right to request an accounting of the disclosures of PHI mad by Pagano Chiropractic Clinic PC for purposes other than TPO and made pursuant to a valid authorization.
- With respect to disclosures through an electronic health record, the right to request an accounting of the disclosures of PHI made by Pagano Chiropractic Clinic PC during the previous 3 years irrespective of the purpose of the disclosure.
- The right to receive written notice of a breach of Unsecured Protected Health Information by first class mail or by e-mail (if the patient has indicated a preference to receive information by email) as soon as possible but in no event later that 60 days after the discover of the breach.
- The right to complain about alleged violations to Pagano Chiropractic Clinic PC and to the Department of Health and Human Services.

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Pagano Chiropractic Clinic, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of patient or personal representative Date

_____

If signed by personal representative, relationship to patient

Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: _____

Refused to sign Physically unable to sign

(Other)_____

_____

_____

_____

Employee Signature:_____ Date:_____

INFORMED CONSENT TO CHIROPRACTIC CARE

Pagano Chiropractic Clinic, P.C.
204 South Main Street
Carrolltown, PA 15722
814-344-8740

Patient: Please discuss any questions or concerns with the doctor before signing this consent form.

I hereby consent to the performance of chiropractic adjustments and other chiropractic treatments including various modes of physiotherapy procedures including orthopedic examination, physical examination and chiropractic examination procedures on me(or on the patient named below for whom I am legally responsible) by the doctor of chiropractic/clinic named above.

I have had the opportunity to discuss with the doctor the intended benefits of chiropractic care and other treatments that may be utilized during the course of my treatment at Pagano Chiropractic Clinic, P.C. Alternatives to proposed chiropractic treatment at Pagano Chiropractic Clinic, PC have also been discussed with me.

Although chiropractic adjustments and associated physiotherapeutic modalities are usually beneficial and seldom cause any problem or injury I understand and am informed that there are some risks to treatment. Risks include and are not limited to fractures, disc injuries, sprain/strain injuries and very rarely strokes.

I understand that the treatment I will be receiving may include any of the following:

- _____ Manual traction
- _____ Doctor assisted muscle stretching
- _____ Chiropractic adjustments
- _____ Electric Stimulation
- _____ Hot and cold packs
- _____ Myofascial Release
- _____ Neuromuscular re-education

I understand that chiropractic is not an exact science and therefore reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone related to the chiropractic or other treatment rendered by Pagano Chiropractic Clinic, P.C. that I have requested and authorized. I have had an opportunity to read this form in its entirety and ask questions regarding its content. My questions have been answered to my satisfaction and I hereby consent to the proposed treatment and any other treatment(s) deemed necessary by Pagano Chiropractic Clinic, P.C. to treat my conditions(s).

Patient name (print): _____

Signature of Patient: _____ Date_____

Signature of Parent/Guardian: _____ Date_____
(If patient is a minor)

Staff Witness Signature: _____ Date_____

FINANCIAL POLICY AND AGREEMENT

("Agreement" – Rev. 02-23-05)

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Incorporation of Assignment Terms and Definitions. I have reviewed the Office's Assignment form titled in short as "Assignment" or "Assignment / Lien." The terms and definitions contained in the Assignment are incorporated herein by reference.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Terms of My Coverage. I understand that in any given situation, a Payer may refuse to pay for a particular Charge incurred at the Office, or may actually request a refund from the Office after making payment. I understand, for instance, that a Payer may deny payment for a Charge, stating that the Charge is "not covered" under its policy or exceeds some other limitation. I also understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary, either in whole or in part, and should therefore be denied, downcoded, or bundled with another code. Unless otherwise agreed to in writing, I agree that I am solely and exclusively responsible for verifying all exclusions and limitations in the policy of any Payer. I also agree that I am solely and exclusively responsible for verifying criteria used by any Payer to assess the medical necessity of my Charges. Should any Payer deny payment, or request a refund, based on an exclusion or limitation in the policy, or should any Payer deny payment or request a refund based on the rationale that a Charge was not medically necessary, consistent with the previous provision, I agree that I am personally and fully responsible for the denied portion of my Charges, minus any applicable fee schedule discounts.

Collection of Higher of Allowed Amounts When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office insofar as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, my treatment, or my Charges, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Agreement, my treatment, or my Charges.

PAGANO CHIROPRACTIC CLINIC, P.C.
204 SOUTH MAIN STREET
P.O. BOX 648
CARROLLTOWN, PA 15722
814-344-8740

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ Date: ___/___/___

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ___/___/___

Pagano Chiropractic Clinic, PC

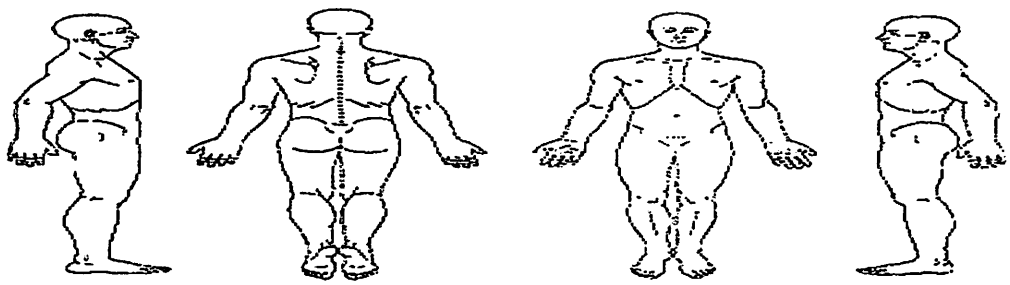
New Patient Intake Form

Patient Name: _____ Today's Date: _____

1. Please indicate your reason for today's visit: Sports Injury Auto Accident Work Injury Other Injury

2. Please describe the specifics of your injury (*when* and *how* did it happen and *where* do you have symptoms)_____
   _____
   _____

3. Indicate on the drawings where your symptoms are located:



4. How would you describe the type of pain?

□ Sharp □ Dull □ Achy □ Stiffness □ Burning □ Shooting pain □ Numbness
□ Tingling □ Sharp with motion □ Electric shock □ Stabbing pain

5. What is your: Height_____ Weight_____ Age_____
6. What is your occupation? _____

7. Indicate the severity of your pain on the scale below from 0-10 (10 being worst, 0 being no pain)

   0 1 2 3 4 5 6 7 8 9 10 (Please circle)

8. How often are symptoms present? □ Constant (76-100% of the time) □ Frequent (51-75% of the time)
   □ Occasional (26-50% of the time) □ Intermittent (1-25% of the time)

9. Are your symptoms changing with time? □ Getting worse □ Getting Better □ Staying the same

10. Have you seen any other chiropractors, medical doctors, orthopedists or physical therapists for this condition? If so, *who* and *when*? _____

11. What makes your symptoms better? _____

12. What makes your symptoms worse? _____

13. Please list any current prescription medications you are taking: _____
_____

14. Please list any current over the counter supplements or medications you are taking: _____
_____

15. Please list any prior surgical procedures you have had and approximate dates performed: _____
_____

16. How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. Do you perform any regular exercise? ☐ Yes ☐ No Please describe what types of exercise or activities that you perform and how often _____

18. Have you ever had a concussion(s)? If so,when? _____

19. If you had a concussion, did you lose consciousness? ☐ Yes ☐No If *yes*, how long were you unconscious? _____

20. For each of the conditions listed below, place a check in the "***past***" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "***present***" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ Hypertension	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart attack	☐	☐ Excessive thirst
☐	☐ Upper back pain	☐	☐ Chest pains	☐	☐ Frequent urination
☐	☐ Mid back pain	☐	☐ Stroke	☐	☐ Smoking / Tobacco use
☐	☐ Low back pain	☐	☐ Angina	☐	☐ Drug / alcohol dependence
☐	☐ Shoulder pain	☐	☐ Kidney Stones	☐	☐ Allergies

Past	Present	Past	Present	Past	Present
☐	☐ Elbow / Arm pain	☐	☐ Bladder infections	☐	☐ Depression
☐	☐ Wrist / hand pain	☐	☐ Loss of bladder control	☐	☐ Lupus
☐	☐ Hip pain	☐	☐ Prostate problems	☐	☐ Epilepsy
☐	☐ Upper leg pain	☐	☐ Abnormal weight gain	☐	☐ HIV / AIDS
☐	☐ Knee pain	☐	☐ Loss of appetite	☐	☐ Abdominal pain
☐	☐ Ankle / foot pain	☐	☐ Ulcer	☐	☐ Hepatitis
☐	☐ Gall bladder disorders	☐	☐ Cancer	☐	☐ Asthma
☐	☐ Sinus problems	☐	☐ General fatigue	☐	☐ Dizziness / Vertigo
☐	☐ Other _____				

For Females only:

Past	Present
☐	☐ Birth control pills
☐	☐ Hormone replacement
☐	☐ Most recent pregnancy _____

21. Does anybody in your immediate family have a past medical history of any of the conditions listed below?

☐ Rheumatoid arthritis ☐ Heart problems ☐ Diabetes ☐ Lupus ☐ Cancer
☐ ALS ☐ Marfan's Syndrome ☐ Blood clots ☐ Seizures ☐ Osteoporosis

Patient Signature_____ Date_____

Doctor's notes

_____

_____

_____

_____

_____

_____

_____

Pagano Chiropractic Clinic, PC New Patient Intake Form

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Female: _____ Male: _____

Email Address: _____ Primary Care Physician: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at (circle) Home/Work/Cell I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? ____ Yes ____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release - By signing below, I authorize Pagano Chiropractic Clinic, PC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Pagano Chiropractic Clinic, PC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____