

CONFIDENTIAL PATIENT INFORMATION / INSURANCE INFORMATION

Patient's Name (FIRST) _____ (M) _____ (LAST) _____

Address: _____

Home (____) _____ - _____ Office: (____) _____ - _____ Cell (____) _____ - _____

Email: _____

Date of Birth ____/____/____ S.S. #: ____ - ____ - ____ Sex M ____ F ____

Patient's Status: Single ____ Married ____ Other ____ Employed ____ Student ____

Employer / School: _____ Phone: (____) _____ - _____

Address: _____
Street City State Zip

Name of Referring Physician: _____ Phone (____) _____ - _____

PRIMARY CARRIER:

Name of Insurance Company: _____ Phone (____) _____ - _____

Address: _____
Street City State Zip

Name of Insured: _____ S.S.#: ____ - ____ - ____

Address of Insured: _____
Street City State Zip

Phone of Insured: (____) _____ - _____ Name of Employer: _____

Work Phone Number: (____) _____ - _____ Relationship to Patient: Self __ Spouse __ Child __ Other __

Insured's D.O.B: ____/____/____ Insured's ID #: _____ Group #: _____

SECONDARY CARRIER:

Name of Insurance Company: _____ Phone (____) _____ - _____

Address: _____
Street City State Zip

Name of Insured: _____ S.S.#: ____ - ____ - ____

Address of Insured: _____
Street City State Zip

Phone of Insured: (____) _____ - _____ Name of Employer: _____

Work Phone Number: (____) _____ - _____ Relationship to Patient: Self __ Spouse __ Child __ Other __

Insured's D.O.B: ____/____/____ Insured's ID #: _____ Group #: _____

CONFIDENTIAL PATIENT MEDICAL HISTORY

PRESENT COMPLAINT(S):

Have you come to this office for the evaluation/treatment of scoliosis? NO YES

Do you have any complaints associated with or in addition to scoliosis? NO YES

Have you ever been diagnosed with scoliosis? NO YES At what age? _____

Please describe any CURRENT complaints and rate their pain:

(Rate pain from 1 to 10, with 1 being the least serious/painful and 10 being the most serious/painful)

When and how did your complaint(s) occur?

Symptoms appear to develop from: Scoliosis Job related injury Auto accident Birth
 Illness Unknown Cause Gradual Onset

Symptoms have persisted for: Hour(s) Day(s) Week(s) Month(s) Year(s)

Symptoms are typically worse in the: Morning Afternoon Evening

Symptoms and/or Complaints: Come & Go Are Constant

Have you ever had this before? NO YES, When? _____

If you were to guess, what do you think caused the problem/pain?

Name and location of doctors previously seen for this/these condition(s):

Please check the following activities that **AGGRAVATE** your condition:

Bending Reaching Coughing Sitting Turning Head Lifting Sneezing Walking

Lying Down Standing Straining at stool

Please check the following activities that **RELIEVE** your condition:

Bending Sitting Lifting Standing Lying Down Reaching Walking Turning Head

_____ **Date:** _____

Patient / Parent or Guardian's Signature

Please check **ADDITIONAL SYMPTOMS** you may be experiencing:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Numbness in fingers/arms |
| <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Numbness in toes/legs |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Pins and needles in arms |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Pins and needles in legs |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Fever | <input type="checkbox"/> Low resistance to | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Head seems | colds | <input type="checkbox"/> Stiff neck |
| <input type="checkbox"/> Coordination | too heavy | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Head Ache |
| Difficulties | | <input type="checkbox"/> Muscle jerking | <input type="checkbox"/> Migraine |

CURRENT MEDICAL HISTORY

Have you ever been treated for scoliosis? NO YES, When? _____

Have you worn or do you wear a scoliosis brace? NO YES, What type? _____

Have you been treated for any other health condition in the last year? NO YES, Describe Condition:

Are you allergic to any medications? NO YES, please list: _____

Are you taking any medications? NO YES, please list: _____

Are you taking any nutritional/vitamin supplements? NO YES, please list: _____

Are you pregnant? No YES Date of last menstrual period _____

Have you ever had a metal implant? NO YES, Describe procedure _____

Have you had orthodontic treatments? NO YES

Do you have visual problems or wear glasses? NO YES

Do you have any cardiac (heart) problems? NO YES _____

Have you been treated for your scoliosis with Physical therapy Chiropractic Care

Have you started your menstrual cycle? NO YES Regular Irregular

FEMALES: Date menstrual cycle started _____ MALES: Did your voice change? NO YES

Date: _____

Patient / Parent or Guardian's Signature

Case Study Release Form

Release of information for case report:

I, _____ freely give my consent for the release of information regarding my or my child's medical history, injury, surgery, and rehabilitation for use in the following case report, which may be submitted to a Professional Journal and/or for educational purposes: I understand my name or my child's name and likeness other than on X-ray will not be used in anyway.

Title:

I understand that this information may be used in publication and that my name will remain confidential.

Signature: _____

Witness: _____

Date: _____

NOTICES OF PRIVACY ACKNOWLEDGEMENT

**Scoliosis Systems of Chiropractic
1085 Park Ave Suite 1E
New York, NY 10128**

I UNDERSTAND THAT UNDER THE **Health Insurance Portability & Accountability Act of 1996** (“HIPPA”), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- 1 **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment directly and indirectly.**
- 1 **Obtain payment from third-party payers.**
- 1 **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact the organization at any time at the above address to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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Office Use Only

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

Possible costs for initial visit

Consultation Deposit	\$300
Comprehensive Consultation /Evaluation	\$550
X-rays (typically 3-6 films)	\$125 each
Chiropractic Office Visit	\$125
MRI interpretation	\$125
Formetric Scan	\$125
Spinecor Brace	\$3800
Additional Brace Option (top set-up)	\$400
Custom Orthotic	\$400
3-Year Outgrowth Policy (Orthotics)	\$60
Neurological Evaluation w/Vestibular testing	\$125-\$750
Schroth Exercise Intensive programs:	
Hourly	\$250
10 Hour	\$2000.00

This list represents most of the services that are performed on an initial visit. Not all patients will need all these services. Some will need additional services.

I acknowledge that the services rendered to me or my child, are to be **paid for in full at the time of service**. I assume **full responsibility** for any information my insurance carrier gave Scoliosis Systems or myself in regard to possible reimbursement for services. **Scoliosis Systems is not responsible for any contractual arrangement I may have with my insurance carrier and does not accept third party payment from the insurance company.**

Patient Name	Patient or Guardian Signature	Date
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CONSENT TO SHARE MEDICAL INFORMATION:

I consent to sharing Personal Health Information (*in writing/electronic transmission*) regarding medical records and X-Rays to the following providers/person(s) and insurance companies.

Name: _____

Address: _____

Email: _____

Contact Number: () _____ - _____ Fax Number: () _____ - _____

Name: _____

Address: _____

Email: _____

Contact Number: () _____ - _____ Fax Number: () _____ - _____

Name: _____

Address: _____

Email: _____

Contact Number: () _____ - _____ Fax Number: () _____ - _____

Name: _____

Address: _____

Email: _____

Contact Number: () _____ - _____ Fax Number: () _____ - _____

Name: _____

Address: _____

Email: _____

Contact Number: () _____ - _____ Fax Number: () _____ - _____

Patient / Parent or Guardian's Signature

Date