ADVANTAGE
FAMILY & SPORTS
CHIROPRACTIC

N O T I C E O F P R I V A C Y P R A C T I C E S (H I P P A)

Disclosure of Your Health Care Information

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

Payment: We may disclose your health information to our billing service and your insurance provider for the purpose of payment and/or health care options.

Worker's 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 your medical condition or in the event of an emergency.

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 proceeding.

Phone/Email: As a courtesy to our patients, it is our policy to call your home or email you to reschedule your appointment, confirm our receipt of diagnostic results (such as MRI, etc), or to inform you of an upcoming orientation. If you are not at home, we leave a message on your 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 appointment along with a request to call our office if necessary.

Change of Ownership: In the event that Advantage Family and Sports Chiropractic[AFSC] is sold or merged with another organization, your health information/record will become the property of the new owner.

Testimonials: Our office is always willing to accept personal testimonials on how chiropractic care in our office has benefited you or your family. From time to time, we will post these testimonials for others to read or include them in our website. Shared personal information such as your full name or age is at your discretion. **Changes to this Notice of Privacy Practices**

AFSC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, AFSC is required by law to comply with this Notice.

AFSC 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 and/or complaints regarding this notice or if you want more information about your privacy rights, please contact **Dr. Vito Minervini by calling the office at (973)-361-4378**. If Dr. Minervini 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 ____/____/____ and is reviewed biannually by our HIPPA compliance officer (Dr. Vito Minervini).
I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide Advantage Family & Sports Chiropractic Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

_____ _____

Patient's Name (PRINT) Patient's Signature :Date

_____ _____

Authorized Facility Signature : Date

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that AFSC 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 amend your protected health information. Please be advised that AFSC 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 the reasons for our denial 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.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

ADVANTAGE
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CHIROPRACTIC

New Patient Application

NAME: _____TODAY'S DATE:_____
DATE OF BIRTH: _____
WHO MAY WE THANK FOR REFERRING YOU? _____
STREET ADDRESS: _____APT# _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____EMAIL: _____
CELL PHONE: _____
OCCUPATION:_____WORKPHONE:_____
EMPLOYER:_____
PRIMARY CARE PHYSICIAN:
_____
ADDRESS:
_____
_____
PHONE NUMBER: _____

ARE YOU EXPECTING? YES NO

DO YOU HAVE CHILDREN? YES NO AGES? _____

HAVE YOU RECEIVED CHIROPRACTIC CARE PREVIOUSLY? YES NO
IF YES, YOUR DOCTOR'S NAME?
_____
WHEN WAS YOUR LAST ADJUSTMENT?
_____

Your Health History

As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. On a daily basis we all experience physical, chemical AND emotional stresses that can accumulate and result in serious loss of health potential. Your answers to the following questions will give us a general view of the stresses that you face in your lifetime, thus allowing us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential.

YOUR CHILDHOOD (0-17 YRS) ~ CHECK ALL THAT APPLY TO YOU

___ Vaccinations ___ Antibiotics ___ Surgery ___ Recurrent Illness ___ Serious Falls
___ Smoker___ Active in Sports ___ Car Accident ___ Severe Emotional Stress
___ Alcohol Use ___ Drug Use ___ Chiropractic Care

YOUR ADULT YEARS ~ CHECK ALL THAT HAVE APPLIED TO YOU

___ Neck Pain ___ Shoulder Pain ___ Mid-Back Pain ___ Low-Back Pain
___ Knee Pain ___ Arm Pain/Tingle ___ Hand Pain/Tingle ___ Head Injuries
___ Sports Injuries
___ Headaches ___ Migraines ___ Fatigue ___ Dizziness/Vertigo ___ Balance Issues
___ Blurred Vision ___ Ringing in Ears ___ Fainting ___ Sinus Problems ___ Allergies
___ Asthma ___ Diarrhea ___ Constipation ___ Difficult Breathing ___ Chest Pain
___ Heart Disease ___ High Blood Pressure ___ Stroke ___ Diabetes ___ PMS
___ Menopause ___ Breast Lump/Pain ___ Birth Control Pills ___ Infertility
___ Mood Swings___ Depression
____ Cold Sweats ___ Cold Hands ___ Feet Numb ___ Heartburn
___ Loss of Smell ___ Jaw Pain ___ Infections ___ Spinal Tap ___ Used Cane/Walker
___ Traction ___ Surgery ___ Dislocations ___ Falls/Accidents ___ Broken Bones

ARE YOU CURRENTLY TAKING MEDICATION? YES NO
NAME(S):
_____

AVG. HOURS OF SLEEP PER NIGHT: ____ TYPICAL SLEEP POSITION:
_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE
(If you are here for general wellness, initial here, and go to the Chiropractic Care Agreement! _____)

WHAT IS YOUR PRIMARY CONCERN?

_____

PLEASE RATE THE SEVERITY OF THE ISSUE: 1 2 3 4 5 6 7 8 9 10
Mild To Debilitating

WHAT IS YOUR SECONDARY CONCERN?

_____

PLEASE RATE THE SEVERITY OF THE ISSUE:1 2 3 4 5 6 7 8 9 10
Mild To Debilitating

ARE THE HEALTH CONCERNS LISTED ABOVE A RESULT OF: AUTO ACCIDENT / WORKER'S COMP/NEITHER

HOW/WHEN DID YOUR SYMPTOMS BEGIN?

_____
_____
_____
_____
_____

DESCRIBE THE QUALITY OF YOUR DISCOMFORT:
___ Intermittent (25%) ___ Occasional (50%) ___ Frequent (75%) ___ Constant (100%)

___ Aching ___ Tingling ____ Numbness ___ Sharp ___ Dull ___ Burning
___ Throbbing ____ Varies ____ Improving Rapidly ___ Improving Slowly
____Slowly Getting Worse ____ Rapidly Getting Worse

DOES ANYTHING MAKE YOUR SYMPTOMS FEEL BETTER?

_____
DOES ANYTHING MAKE YOUR SYMPTOMS FEEL WORSE?

_____
HAVE YOU LOST TIME FROM WORK AS A RESULT OF YOUR SYMPTOMS? YES NO
FROM ____/____/____ TO ____/____/____
HAVE YOU SEEN OTHER CARE PROVIDERS REGARDING THIS? YES NO

Chiropractic Care Agreement

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. **Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom.** It is important that each patient entering a course of care with our office understand both the objective and the method that will be used to attain our goal. Please read the following terms thoroughly in order to understand better what happens during the course of a chiropractic office visit.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Subluxation: Vertebral Subluxation is a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others**. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

All questions regarding Dr. Minervini's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

_____ _____

Patient Signature **Date**

Health Insurance
If you expect your health insurance to contribute to the cost of your care, please allow us to copy your insurance card. We will verify your policy's chiropractic coverage, and provide you with an explanation of your insurance coverage at your report of findings.
Subscriber Name: _____ Insurance:_____
Group #: _____ Policy #: _____

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Dr. Minervini to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to Dr. Minervini any and all plan documents, insurance policy and/or settlement information upon written request from the doctor in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with Dr. Minervini against such insurers and/or employee health care plan in my name but at the doctor's expense.
Signature: _____ Date: _____

For Patients Using Medicare - *Advanced Beneficiary Notice for Non-Covered Services*
I, _____, do understand that Medicare does not cover all of the services rendered during the course of an office visit. Medicare will only cover a spinal adjustment. They will not cover extremity manipulation, therapeutic activities, or exercises. These services may be necessary in aiding or expediting the healing process. These services may or may not be used on every visit. I do understand that in order to accept these services, a fee will be charged in the amount of their regularly scheduled fees on top of any co-pays, coinsurances, deductibles, or any other monies that are directly charged from my insurance company. Therefore, I understand that I have the option to accept or deny these services.

_____ _____
Patient Signature **Date**

X-Rays
X-rays are sometimes a necessary tool for Dr. Minervini to see and evaluate your posture as well as possible abnormalities. Some insurance carriers do not cover X-rays in this office; however, we do have an x-ray machine on site for your convenience as well as to expedite the report of findings process. You have the option to either call your insurance company for the nearest capitated site approved for you to receive X-rays or you may choose to have X-rays taken here at a cost between $25.00 & $35.00 per view if not covered by your insurance plan. Typically, Dr. Minervini will take a straight on view and view from the side of each region of your spine that is involved. For example, if you are here for lower back pain, usually 2 views of the low back will be obtained. Please initial next to your choice below:
_____ I understand that X-rays are not covered in this office and that I am financially responsible for payment of any X-rays deemed necessary. I also understand that Dr. Minervini will discuss this with me beforehand.
_____ I choose to have X-rays obtained at my nearest capitated site and will need a referral. I understand that this may delay my report of findings and my ability to start chiropractic care immediately.

Thank you so much for taking the time to fill this out thoroughly. Welcome to the Practice!