New Patient Form

James J. O'Rourke, D.C.
Ocean View Chiropractic Center
1 Hope Corson Road
Ocean View, NJ 08230

Patient Name: _____ Date: ____/____/_____

Address: _____

City: _____ State: _____ Zip: _____

Home #_____-_____-_____ Cell # _____-_____-_____ Work # _____-_____-_____

Email_____ Text/Cell Phone Provider_____

Date of Birth: ____/____/_____ Age: _____ SSN: _____ Gender: (circle one) M F

Height _____ Weight_____ Blood Pressure _____/_____ Marital Status S M D W

For Women: Are you pregnant or nursing? Y N If pregnant, due date: ____/____/_____

Ethnicity: (circle one) Hispanic/Latino Not Hispanic/Latino I choose not to specify

Preferred Language: (circle one) English Spanish Other_____ I choose not to specify

Race: (circle one) White Black/African American Asian American Indian/Alaskan Native

Native Hawaiian or other Pacific Island other _____ I choose not to specify

Do you currently smoke tobacco? (circle one) Y Former Smoker Never Unknown

If yes, how often do you smoke: (circle one) Current everyday Current someday Unknown

Primary Care Physician: _____ Phone #: _____-_____-_____

Occupation_____ Employer: _____

Please list medications and /or supplements you are currently taking and why:

Medication/ Supplement	Dosage/Frequency	Medication Purpose	Medication/ Supplement	Dosage/Frequency	Medication Purpose

Please list if you have any allergies (food, medication, seasonal, such as pollen etc.:_____

_____

Please list any surgeries you have had: _____

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Present Condition Assessment

When did your symptoms begin? (Please provide approximate date): ____/____/_____

Please describe your current condition and how the problem began: _____

_____

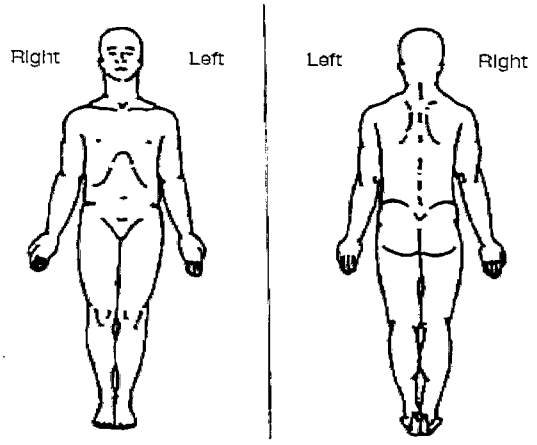
What makes the pain: better _____worse_____

Who have you seen for this condition? Chiropractor Medical Doctor PT other_____

On a scale from 1 to 10 please rate the intensity of your pain right now: (circle one)

0 (no pain) 1-2 (minimal) 3-4 (mild) 5-6 (moderate) 7-8 (severe) 9-10 (unbearable)

Please indicate on the figure where you have any of the following using the scale below:



A= Ache
B= Burning
N= Numbness
P = Pins & Needles
S= Stabbing
O= Other

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions now or **P** if you have had these conditions previously.

Allergies	N	P	Constipation	N	P	Neck Pain or Stiffness	N	P
Arthritis	N	P	Cramps	N	P	Prostate Trouble	N	P
Asthma	N	P	Diabetes	N	P	Sciatica	N	P
Back Pain	N	P	Digestion Problems	N	P	Sinus Infections	N	P
Bronchitis	N	P	Dizziness	N	P	Sleep Problems or Insomnia	N	P
Cancer (Indicate where)	N	P	Headache	N	P	Thyroid Condition	N	P

Please feel free to note any other information you feel would be important for the Doctor to know: _____

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Patient Financial Policy

James J. O'Rourke, D.C.
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Thank you for choosing Ocean View Chiropractic as your healthcare provider. We are committed to making your treatment successful. Please read and sign the following financial policy prior to beginning treatment.

_____ In-network insurance plans

Your insurance plan is agreement between you and your health insurance company. You are responsible to know your insurance policy. We recommend that you call your insurance plan to verify how many visits your plan will allow, the amount of your co-payment and deductible. The balance will become your responsibility if denied by your insurance company for any reason. You have the right to appeal the reimbursement for services with your insurance company based on your health care insurance contract.

_____ Out-of-network insurance plans

We are a participating out-of-network provider with some insurance plans. Most insurance plans allow for out-of-network benefits. With these plans the health insurance company will not issue payment to our office but will issue payment directly to you. By signing below you agree to endorse any and all checks from your insurance company and forward them to our office within 30 days of receiving payment.

By signing below, you will authorize insurance payment directly to our office for in-network insurance plans. For out-of-network plans, should payment be sent to you, it will be your responsibility to forward the payment to our office within 30 days of service.

You further assign your rights to benefits under your contract of insurance or other third party payment to Ocean View Chiropractic.

If your insurance plan requires a referral prior to beginning treatment, it will be your responsibility to have the referral issued prior to beginning treatment.

By signing below you certify that you have read and understand the above information and affirm that all information provided is true. You understand your rights and obligations as a patient under this agreement.

_____
Patient Name/Print

_____ _____
Signature Date

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

James J. O'Rourke, D.C.
Ocean View Chiropractic Center
1 Hope Corson Road
Ocean View, NJ 08230

Patient Name: _____ Date of Birth: _____

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can access this information. Please review it carefully.

Disclosure of your patient health information (PHI) without authorization is strictly limited to defined situations that include emergency care, quality assurance activates, public health, research and law enforcement activities. Any other disclosures for the purpose or treatment, payment or practice operations will be made only after obtaining your consent.

The patient understands and agrees to allow this chiropractic office to use their patient health information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. All covered entities under HIPAA identify and recognize the patient health information as described above including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history, physical, consultation notes, reports, progress notes, treatment plans, requests for and reports of consultations, correspondence and records received by other medical providers.

All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the duration of my treatment.

This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires. The patient understands that they have the right to revoke this authorization, in writing, at any time. You may inspect and receive copies of your records within 30 days of request. There may be a reasonable cost-based fee for copying, postage and preparation of requested records. Any facsimile, copy or photocopy of the authorization shall authorize this chiropractic office to release the records requested herein. In addition you may designate a representative to receive information. The following person(s) have my permission to receive my personal health information: _____

_____

By signing below, I fully acknowledge and agree to the above terms and conditions.

Patient's Signature _____ Date____/____/_____

Guardian's Signature Authorizing Care: _____Date____/____/_____