WEST HARTFORD
CHIROPRACTIC
the art of chiropractic

Compassionately offering innovative, comprehensive chiropractic care based on each patient's individual needs in order to restore and maintain optimal health.

New Patient Application

Name:_____ Gender:_____ Date of Birth:____/____/_____

Cell Phone:_____ Home Phone:_____ E-Mail Address:_____

Home Address:_____
Street / P.O Box City State Zip Code

Status: ○ Student ○ Employed ○ Unemployed ◉ Self-Employed ○ Retired

Marital Status: _____ Age:_____ Height:_____ Weight:_____ SS#:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

Employer:_____ Occupation (if retired, prior occupation):_____

Work Restrictions: ○ Yes ○ No Number of children:_____

Reason For Visit: ☐ Acute Care ☐ Chronic Care ☐ Routine Care ☐ Auto Accident ☐ Workman's Comp

Billing: ○ Self Pay ○ Health Insurance Person responsible for account: _____

Primary Insurance: _____ Policy#: _____ Group#: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

General Consent

I certify that the information I have reported with regard to my personal information and my insurance coverage is correct and that the information in my chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with the minimum disclosure necessary. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing here, in this statement, relieves me of the primary responsibility and obligation to pay for medical services provided, within 30 days when a statement is rendered. In the event of any outstanding balance, this matter will be referred to collections, and will include attorney's fees and court costs. For Medicare and Medical Assistance: I authorize the release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or related claims.

Patient Signature: _____ **Date** _____

Parent or Legal Guardian Signature: _____ **Date** _____

West Hartford Chiropractic ● 345 N. Main St. West Hartford, CT 06117 ● (860) 232-5556 ● westhartfordchiropractic@gmail.com

Reason for Visit

Describe the major concern you wish to discuss: _____

Specify: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Radiating ☐ Numbness ☐ Other: _____

When did your concern begin? _____ Did it begin: ◯ Gradually ◯ Suddenly

How did it begin? _____ How often does it bother you? _____

If you are experiencing pain, 0 being none and 10 being the worst, how much pain are you in?

● 1 2 3 4 5 6 7 8 9 10

(none) (moderate) (worst)

Commitment to resolving the underlying cause for these concerns:

● 1 2 3 4 5 6 7 8 9 10

(none) (somewhat) (fully)

Is your condition: ☐ Improving ☐ Worsening ☐ Unchanged ☐ Constant ☐ Intermittent ☐ Episodic

What makes your condition worse?

☐ Lifting	☐ In/out of car/bed	☐ Exercise/activity	☐ Sitting to standing	☐ Lying down
☐ Pulling	☐ Driving	☐ Sneezing	☐ Sitting	☐ Nighttime
☐ Pushing	☐ Household chores	☐ Coughing	☐ Standing	☐ Beginning of day
		☐ Walking	☐ Other: _____	

What makes your condition better? ☐ Exercise/activity ☐ Rest ☐ Position ☐ Stretching
☐ Heat/ice ☐ Medication: _____ ☐ Other: _____

What would you like to be able to do that you currently CANNOT do? _____

Describe any additional concerns: _____

How did you hear about us?: _____

Chiropractic Care

What would you like to gain from chiropractic care? _____

_____

_ There are typically two paths of chiropractic care. The first path (**Corrective Care**) focuses on getting to the root of your primary condition. This path will provide relief of secondary conditions, as well as structural correction of the spine. The second path (**Relief Care**) focuses on relieving secondary conditions such as pain, muscle tension, and general physical discomfort. This is a short-term fix. The doctors at WHC will consider your individual needs and desires when recommending your care program.

Please select the type of care you are considering:

◯ Corrective Care (Long-term) ◯ Relief Care (Short-term) ◯ I want the doctors to select the best care for me

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Current or Past Treatment

Chiropractor	☐ Yes	☐ No	*Who/When?* _____
Last Adjustment Date	_____		
Primary Care	☐ Yes	☐ No	*Who?* _____
Provider Specialist	☐ Yes	☐ No	*Who?* _____
Physical Therapist	☐ Yes	☐ No	*Who?* _____
Massage Therapist	☐ Yes	☐ No	*Who?* _____
Acupuncturist	☐ Yes	☐ No	*Who?* _____
Other	☐ Yes	☐ No	*Who?* _____
X-Rays:	☐ Yes	☐ No	*Where/When?* _____
EKG:	☐ Yes	☐ No	*Where/When?* _____
MRI/CT:	☐ Yes	☐ No	*Where/When?* _____

Social History:

Tobacco			**If yes, please describe:**
Alcohol	☐ Yes	☐ No	*Packs per day/how long?* _____
Caffeine	☐ Yes	☐ No	*How often/how much?* _____
CBD/Marijuana Illicit	☐ Yes	☐ No	*Cups per day?* _____
Drugs Exercise	☐ Yes	☐ No	*Type/how much?* _____
	☐ Yes	☐ No	*Type/how much?* _____
	☐ Yes	☐ No	*How often/how long?* _____

List all surgical operations/hospital stays you have had and their dates:

_____

List all medications/supplements, including over the counter, prescription, vitamins, herbs, homeopathic remedies:

_____

List all known allergies, specifically to medications and latex. Indicate how severe of an allergy:

_____

Any Cancer (benign or malignant):_____ Treatment: _____

Are you currently or possibly pregnant? ☐ Yes ☐ No *How many weeks?* _____ *Due date* _____

Have you ever taken birth control pills? ☐ Yes ☐ No Are you currently taking birth control pills? ☐ Yes ☐ No

Are you seeing an OB-GYN regularly? ☐ Yes ☐ No Provider:_____ Date of last exam:_____

Number of: Pregnancies _____ Abortions _____ Miscarriages _____ Children _____

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Check all conditions you are experiencing/have experienced

NEUROLOGICAL	Current	Past
Headaches	☐	☐
Dizziness	☐	☐
Tremor	☐	☐
Stroke	☐	☐
Nausea	☐	☐
Parkinson	☐	☐
Speech Problems	☐	☐
Trouble Concentrating	☐	☐
Muscle Weakness/Paralysis	☐	☐
Memory Loss	☐	☐
Direct Head Trauma	☐	☐
Poor Coordination	☐	☐
Seizures	☐	☐
Tunnel Vision	☐	☐
Balance Disturbances	☐	☐
Loss of Consciousness	☐	☐
EYES	**Current**	**Past**
Blurred Vision	☐	☐
Double Vision	☐	☐
Eye Pain	☐	☐
Failing Vision	☐	☐
EARS, NOSE & THROAT	**Current**	**Past**
Sinus Problems	☐	☐
Seasonal Allergies	☐	☐
Difficulty Swallowing	☐	☐
Hearing Impairment	☐	☐
Ear Pain/Ache	☐	☐
Ringing/Buzzing in Ears	☐	☐
Frequent Colds	☐	☐
Enlarged Glands	☐	☐
RESPIRATORY	**Current**	**Past**
Asthma/ COPD	☐	☐
Shortness of Breath	☐	☐
Chronic Cough	☐	☐
Coughing up Phlegm	☐	☐
Spitting up Blood	☐	☐
CARDIOVASCULAR	**Current**	**Past**
High Blood Pressure	☐	☐
High Cholesterol/Triglycerides	☐	☐
Chest Pain/Angina	☐	☐
Heart Disease	☐	☐
Murmur	☐	☐
Hardening of the Arteries	☐	☐
Swelling of Ankles	☐	☐
Poor Circulation	☐	☐
Varicose Veins	☐	☐
GASTROINTESTINAL	**Current**	**Past**
Abdominal Pain	☐	☐
Ulcer/GERD	☐	☐
Nausea/Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Hemorrhoids	☐	☐
Loss of Bowel Control	☐	☐
Loss of Bladder Control	☐	☐
Bloody/Black Stools	☐	☐
Jaundice	☐	☐
Liver Disease	☐	☐
Gallbladder Disease	☐	☐

URINARY/REPRODUCTIVE	Current	Past
Increased Urination Frequency	☐	☐
Pain with Urination	☐	☐
Blood with Urination	☐	☐
Kidney/Bladder Infection	☐	☐
Kidney Stones	☐	☐
Prostrate Problems	☐	☐
Lump in Testicles	☐	☐
Painful Menstruation/Cramps	☐	☐
Excessive Flow	☐	☐
Irregular Cycle	☐	☐
Hot Flashes	☐	☐
Swollen Breasts	☐	☐
Lumps in Breasts	☐	☐
Difficulty Conceiving	☐	☐
ENDOCRINE	**Current**	**Past**
Diabetes	☐	☐
Thyroid Disease	☐	☐
Adrenal Disease	☐	☐
HEMATOLOGIC	**Current**	**Past**
Anemia	☐	☐
Bleeding Disorder/Bruising	☐	☐
Use of Blood Thinners	☐	☐
MUSCULOSKELETAL	**Current**	**Past**
Hernia	☐	☐
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Gout	☐	☐
Bursitis	☐	☐
Fractured Bones	☐	☐
Osteoporosis	☐	☐
Neck Pain	☐	☐
Upper Back Pain	☐	☐
Mid Back Pain	☐	☐
Lower Back Pain	☐	☐
Shoulder Pain	☐	☐
TMJ/Jaw Pain	☐	☐
Numbness in Extremities	☐	☐
CONSTITUTIONAL	**Current**	**Past**
Unexplained Weight Loss/Gain	☐	☐
Unusual Fatigue	☐	☐
Change in Appetite	☐	☐
Fever	☐	☐
Night Sweats	☐	☐
Cancer	☐	☐
Fibromyalgia	☐	☐
Use of Corticosteroids	☐	☐
Intravenous Drug Use	☐	☐
HIV/AIDS	☐	☐
Hepatitis	☐	☐
Tuberculosis	☐	☐
Eczema/Rash	☐	☐
Lyme Disease	☐	☐
PSYCHIATRIC	**Current**	**Past**
Insomnia	☐	☐
Anxiety	☐	☐
Depression	☐	☐
ADD/ADHD/Autism Spectrum	☐	☐
Medication	☐	☐

Other conditions not mentioned above: _____

Family History

Do any of your immediate family members (mother, father, grandparents, siblings) have/have had the following:

Condition	Yes	No	Who
Arthritis	☐	☐	_____
Rheumatoid Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Epilepsy	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease/Conditions	☐	☐	_____
Migraines	☐	☐	_____
High Blood Pressure	☐	☐	_____
Psychiatric Conditions	☐	☐	_____
Stroke	☐	☐	_____
Spine/Back Disorder	☐	☐	_____
Fibromyalgia	☐	☐	_____
Other	☐	☐	_____

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Patient Financial Agreement

ASSIGNMENT OF BENEFITS
I authorize West Hartford Chiropractic, LLC to apply for benefits on my behalf for services rendered by West Hartford Chiropractic, LLC. I understand that this health care facility will be paid directly by the insurance company or other payer. A photocopy of this assignment is considered as valid as the original. I certify that the information I have reported with regard to my personal information and my insurance coverage is correct and that the information in my chart is confidential. This assignment will remain in effect until revoked by me in writing.

Initial _____

GUARANTEE OF PAYMENT
I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. I understand that there is no guarantee that my insurance companies or pre-paid health plans will cover or pay for all of my services. I agree that I am financially responsible for any outstanding balance or services rendered that are not covered under my insurance plan.

Initial _____

INSURANCE AGREEMENT
West Hartford Chiropractic, LLC is not responsible for informing me of my insurance benefits. As a courtesy, they will verify my benefits with provider services. However, it is my responsibility to know my personal benefits prior to the first appointment by contacting member services. West Hartford Chiropractic reserves the right to address my claim once they receive a response from my insurance company.

Initial _____

COPAYMENT POLICY
I agree to pay my copayment and/or coinsurance in full at time of services rendered.

Initial _____

CANCELLATION POLICY
To maintain our excellence in patient care and to acknowledge the doctor's time, West Hartford Chiropractic requires a 24 hour cancellation notification for chiropractic appointments. I will notify the clinic of my cancellation 24 hours prior to my appointment. Otherwise, I will be charged a $60 fee for the missed appointment. I understand that if I miss/cancel three (3) consecutive appointments, I may be subject to discharge from care at West Hartford Chiropractic, LLC.

Initial _____

Patient Signature: _____ Date _____

Parent or Legal Guardian Signature: _____Date_____

WEST HARTFORD CHIROPRACTIC, LLC: NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practice describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, and health care operations as well as for other purposes that are permitted or required by law. This notice also describes your right to access and control your PHI. PHI is information about you, including demographic information, that relates to your past, present, or future physical and mental health or related conditions and health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time and a new notice will be provided upon your request. The new notice will apply to all PHI that we maintain at the time. Please review this notice carefully and then sign the acknowledgement at the end of this document.

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office involved in your care and treatment. Your PHI may also be used and disclosed for the purpose of payment to this health care facility. The following are examples of the types of uses and disclosures that the physician's office is permitted to release.

TREATMENT: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the management of your health care with a third party that has obtained your permission to have access to your PHI. We will also disclose PHI to other physicians involved in your treatment, when we have the necessary authorization from you in writing.

PAYMENT: Your PHI may be used to obtain payment for your health care services. This may include actions such as billing of day to day services, making a determination of eligibility for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review.

HEALTH CARE OPERATIONS: We may disclose your PHI in order to support the business activities of your physician's practice. These activities include quality assessments, employment reviews, training of medical students/interns, licensing, and conduction of other business activities. We may call you by name in the waiting room upon your appointment time or if we need to provide you with information pertaining to your care in our office. We may use or disclose your PHI, as necessary, to contact you regarding your appointments or other business related activities. We will share your PHI with third party business associates such as those who provide billing and transcription services for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related services that may be of interest of to you. We may also disclose your PHI for other marketing activities such as using your PHI to send you a newsletter about our practice and the services we offer. We may be required by law to disclose records that you have not authorized. For example, if we receive a subpoena for records or if we need to disclose your PHI to protect public health we will not need to authorize our disclosure prior to releasing the information. We will keep all disclosure of your medical records to the minimum necessary.

OTHERS INVOLVED IN YOUR HEALTHCARE: We may disclose your PHI to a member of your family or to any other person that you identify, unless you object. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary based on our professional judgment. We may use or disclose your protected health information to an authorized public or private entity to assist or to coordinate your care. These authorized entities may include, but are not limited to, research agencies, organ donation agencies, public health and safety, the Department of Children and Family, the Food and Drug Administration, and oversight agencies. Also, we may use or disclose your protected health information when we are required to do so by law.

PATIENT RIGHTS

1. You have the right to inspect and copy your health information. (Prior notice required, fees may apply)
2. If you feel that the health information we have about you is incomplete or inaccurate, you have the right to request an amendment to your medical records. The request must be made in writing with the reason that supports your request. If we do not agree with your statement, you have a right to ask that your statement be placed in your medical record.
3. You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical record disclosures made by us except for disclosures made for treatment, payment, and health care operations.
4. You have the right to receive a paper copy of this notice.
5. You may be asked to sign a specific authorization for the release of medical records for disclosure of your protected health information.
6. You have the right to request that we communicate with you in confidence about your PHI.
7. You have the right to request that we communicate with you about your PHI by different means or to different locations. Your request must be made in writing.

COMPLAINTS: We are required by law to maintain the privacy of your PHI. You may complain to the Secretary of the U.S Department of Health and Human Services or you may complain to us if you believe that your privacy rights have been violated. You may reach our Privacy Contact: Sarah Laub at 860-232-5556. Or you can email us at westhartfordchiropractic@gmail.com.

PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received the Notice of Privacy Practices regarding my personal health information (PHI). I have been provided an opportunity to review it. I understand that this notice of privacy is to protect my personal health information (PHI).

Patient Name: _____ **Date:** _____

Signature:_____

WEST HARTFORD CHIROPRACTIC, LLC
INFORMED CONSENT/AUTHORIZATION FOR CHIROPRACTIC TREATMENT

Medical doctors, Chiropractic doctors, Osteopaths, and Physical Therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I, the patient, do hereby give my consent to the performance of conservative, noninvasive treatment to my joints and soft tissue. I also consent to the use of physical therapy, ultra sound, hot or cold packs, infrared laser, electrical stimulation, and exercises in addition to my chiropractic care.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures. These risks include:

Soreness: I am aware that it is common to experience muscle soreness in the first few treatments.
Dizziness: I am aware that temporary symptoms like dizziness and nausea, can occur, but are relatively rare.
Fractures/Joint Injury: I am aware that in isolated cases, underlying physical defects, deformities, or pathologies may render me susceptible to injury. When osteoporosis, degenerative disc disease, or another abnormality is detected, this office will proceed with extra caution.
Stroke: I am aware that strokes from chiropractic adjustments are extremely rare. Nerve or brain damage, including stroke, are reported to occur once in ten million treatments.
Therapy Burns: I am aware that some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Alternative Treatments Available

There are reasonable alternatives to the procedures performed in this chiropractic office including:

Medications: I am aware that medication can be used to reduce pain/inflammation. I am aware that the long-term use or overuse of medication may have harmful effects and may only provide short-term relief of symptoms.
Rest/Exercise: I understand that rest may temporarily reduce inflammation and pain but is not likely to reverse my underlying condition. The same is true of ice, heat, or other home therapy. I understand that exercises are of value and may be prescribed by the doctor but are not corrective of injured nerve and joint tissue.
Surgery: I understand that surgery may be necessary for joint stability and/or serious disc rupture. Surgical risks may include unsuccessful outcomes, pain, reactions to anesthesia, and prolonged recovery.
Non Treatment: I understand that the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening of the underlying condition. These risks may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Appointment Policy

Office visits are scheduled according to the severity of your secondary condition at the recommendation of the doctor. Your condition may require numerous appointments over the next few weeks or months. **The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume responsibility of strict adherence to the appointment program recommended by the doctor.**

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of the visits that count, not on the days of which you receive the service. If, for any reason, you are unable to keep an appointment, we **require** that you telephone immediately to reschedule that visit. If a visit is missed completely, then this office reserves the right to charge a $60 fee for any missed appointments.

I have read or have had read to me the above explanation of chiropractic treatment. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this informed consent and authorization for treatment.

Signature of Patient or Guardian: _____ **Date:** _____

Patient's Name Printed: _____