Cofrancesco Chiropractic & Healing Arts

Welcome to Cofrancesco Chiropractic & Healing Arts. Please complete this form, and if you have any questions or concerns, please do not hesitate to ask for assistance, we are happy to help.

PATIENT INFORMATION

Name:_____, Nickname:_____
(first) (last)
Address:_____
(street) (city) (state) (zip)
Social Security #_____, Gender: Male / Female, Marital Status: Single / Married / Divorced / Widowed
Spouse:_____ Date of birth:_____ Whom were you referred by?:_____
Phone (H)_____ Cell:_____ (W) _____ Email:_____
Whom should we contact in case of emergency?_____

INSURANCE INFORMATION

Insurance Company:_____ ID#_____ Group #_____,
Employer:_____ Insurance is held by ?_____ DOB:_____
(self? Spouse? Name?)
Do you have additional insurance? If so, please complete the following:
Insurance Company:_____ ID#_____ Group #_____,
Employer:_____ Insurance is held by ?_____
(self? Spouse? Name?)

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CERTIFICATION OF ASSIGMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ _____ and assign directly to Dr. Cofrancesco and Cofrancesco Chiropractic & Healing Arts, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurances submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies)and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment is completed.

_____ _____
Signature of patient, parent, guardian or personal representative — Date

_____ _____
Print name of patient, parent, guardian or personal representative — Date

SYMPTOMS

Reason for your visit _____ When did you first notice the symptoms?_____ Where specifically is the problem located? _____ _____ Which activities are difficult to perform? □ sitting □ walking □ bending □ lying down □ other

Type of pain: □ sharp □ dull □ throbbing □ numbness □ aching □ shooting □ burning □ tingling □ cramps □ stiffness □ swelling □ other_____ Is the pain constant, or does it come and go?_____

What treatment have you already received for your condition?_____

□ Medication □ Surgery □ Physical □ Therapy □ Other Name and address of other doctor(s) who have treated you for your condition:_____

HEALTH HISTORY (check only those conditions that are applicable)

□ AIDS/HIV	□ Depression	□ Liver Disease	□ Rheumatoid Arthritis
□ Alcoholism	□ Diabetes	□ Measles	□ Rheumatic Fever
□ Allergy Shots	□ Emphysema	□ Migraine Headaches	□ Scarlet Fever
□ Anemia	□ Epilepsy	□ Miscarriage	□ Stroke
□ Anorexia	□ Fractures	□ Mononucleosis	□ Suicide Attempt
□ Appendicitis	□ Glaucoma	□ Multiple Sclerosis	□ Thyroid Problems
□ Arthritis	□ Goiter	□ Mumps	□ Tonsillitis
□ Asthma	□ Gonorrhea	□ Osteoporosis	□ Tuberculosis
□ Bleeding Disorders	□ Gout	□ Pacemaker	□ Tumors, growths
□ Breast Lump	□ Heart Disease	□ Parkinson's Disease	□ Typhoid Fever
□ Bronchitis	□ Hepatitis	□ Pinched Nerve	□ Ulcers
□ Bulimia	□ Hernia	□ Pneumonia	□ Vaginal Infection
□ Cancer	□ Herniated Disc	□ Polio	□ Venerial Disease
□ Cataracts	□ Herpes	□ Prostate Problems	□ Whooping Cough
□ Chemical Dependency	□ High Cholesterol	□ Prosthesis	□ Other
□ Chicken Pox	□ Kidney Disease	□ Psychiatric Care	

Are you pregnant? □ yes □ no Nursing? □ yes □ no Birth control pills? □ yes □ no

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking:_____

_____

Allergies?_____

DAILY HABITS

What type of exercise do you perform on a daily basis? □ None □ Moderate □ Heavy

What do your daily work habits include? (ex., sitting, standing, light labor, heavy labor, computer work)

_____

_____

What vitamins do you currently take?_____

_____

What kind of other nutritional supplements do you take (if any)?_____

_____

Do you smoke? □ yes □ no How much per day?_____ How much liquor do you consume on a weekly basis?_____ How much coffee or other caffeinated beverages do you consume on a daily basis?_____

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Release Statement: I understand that all Modalities offered at Cofrancesco Chiropractic & Healing Arts, including Chiropractic adjustments, Massage Therapy, Bowenwork, and Reiki are hands on therapies, and I give my permission for any of the Doctors or Therapists to touch my body.

_____ _____

Signature of patient, parent, guardian or personal representative Date

Cofrancesco Chiropractic & Healing Arts

FEE POLICY

Our fee schedule is as follows:

5-point Examination - $70.00
Lateral and A/P full-spine X-rays - $150.00
Extremity X-rays (if necessary) - $50.00
Specific Adjustment utilizing the Gonstead Method of Chiropractic - $50.00

PAYMENT IS DUE AT TIME OF SERVICE. Please let us know if you require any special payment arrangements. We accept most Anthem Blue Cross/Blue Shield and Medicare health insurance plans. If you have other insurance coverage for your visits, we will provide you with the necessary forms for reimbursement from your insurance company after your payment.

Missed Appointment Policy.

We require a minimum of three hours advance notice to cancel or reschedule an appointment. Failure to notify this office, in the time specified, will result in a charge of the full office visit fee.

Delinquent Accounts Agreement.

I hereby agree that if my account with Cofrancesco Chiropractic & Healing Arts becomes delinquent, I will assume the cost of any and all expenses associated with the collection of my delinquent account. Those costs will include, but not necessarily be limited to, attorneys fees, court costs, sheriff fees, and other related expenses.

I have read the above, and understand and agree with the statements.

_____ _____
Patient Signature Date

_____
Print name

Cofrancesco Chiropractic & Healing Arts

STATEMENT OF INTENT

We at Cofrancesco Chiropractic & Healing Arts detect and correct VERTEBRAL SUBLUXATIONS to help the body restore its natural balance and healing capacity. We do not diagnose or treat diseases of any nature.

VERTEBRAL SUBLUXATIONS are misalignments of the bones (vertebrae) within the spinal column. The spinal nerve roots, which exist between each vertebra, can become irritated or inflamed, causing interference to nerve function. The position and movement of all vertebrae, including the pelvic bones, profoundly influence the health and spinal joints and intervertebral discs.

The criteria for the detection of VERTEBRAL SUBLUXATIONS are as follows, based on the Gonstead Method:

VISUALIZATION. Before we begin your physical examination, we first carefully notice the way you walk and move, your posture, and any asymmetries to your frame and musculature.

STATIC PALPATION. The chiropractor feels along the spinal column for *edema* (swelling), *point tenderness* (over the vertebrae), and *muscle spasm*.

MOTION PALPATION. The chiropractor gently moves the vertebra to determine its mobility, detecting *fixation*.

INSTRUMENTATION. *Thermographic* (heat) findings taken with a hand held scope, to find abnormal heat distribution, a sign of severe nerve dysfunction.

X-RAY EXAMINATION and ANALYSIS. These are used to determine condition of the spine and discs, and to measure the exact position of the vertebra.

THE GONSTEAD METHOD

(The Procedure and Its Effect on Specific Vertebral Adjustments)

A specific vertebral adjustment corrects the subluxation with the shortest vector to neutral position or "three-dimensionally back to center". This procedure can safely and efficiently correct and/or reverse the harmful effects of VERTEBRAL SUBLUXATIONS. This is not to be confused with manipulation or manipulative therapy, which is a rotational movement applied to a vertebra.

With the exception of taking x-rays, the above-referenced procedures are performed at every office visit, to best detect and correct vertebral subluxations.

_____ _____

Patient Signature Date

_____

Print name

Cofrancesco Chiropractic & Healing Arts

NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

_____ _____

Patient Signature Date

_____

Print name

Cofrancesco Chiropractic & Healing Arts

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (included identifying or locating) a family member, your personal representative or another person responsible for your care, of the location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity object to such use or disclosures. In the vent of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing person to pick up filled prescription, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.