

WELCOME

Date: ___/___/___

Social Security #: _____

First Name /Middle Initial/Last Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Sex: Male Female

Birth date: _____

Married Widowed Single

Minor Separated Divorced

Partnered for _____ years

Occupation: _____

Patient Employer/ School: _____

Employer/ School Address: _____

Employer/School Phone#: _____

Spouses Name: _____

Birth date: _____

Social Security #: _____

Spouse's Employer: _____

Whom may we thank for referring you?

PHONE NUMBERS

Home #: _____

Cell #: _____

Best time and place to reach you: _____

IN CASE OF AN EMERGENCY, CONTACT

Name: _____

Relationship: _____

Home #: _____

Work#: _____

Cell #: _____

INSURANCE INFORMATION

Who is responsible for this account?

Relationship to Patient: _____

Insurance Co: _____

ID#: _____

Group#: _____

Is patient covered by additional insurance?

Yes No

Subscriber's Name: _____

Birth date: _____

Social Security #: _____

Relationship to Patient: _____

Insurance Co: _____

I certify that I, and/ or my dependent(s), have insurance coverage with

and assign directly to Dr. Patrick Borja 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 insurance 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 of the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

x _____

Signature of Patient/ Guardian

x _____

Please print Patient/ Guardian

HEALTH HISTORY

Place a mark in the boxes below to indicate if you have/ had any of the following:

- AID/HIV
- Alcoholism
- Allergy Shots
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorder(s)
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Fractures
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Herpes
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Osteoporosis

- Pacemaker
- Parkinson's Disease
- Pinched Nerve
- Pneumonia
- Polio
- Prostate Problems
- Prosthesis
- Psychiatric Care
- Rheumatoid Arthritis
- Scarlet Fever
- Sexually Transmitted Disease
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Tumors/ Growths
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Whooping Cough
- Other: _____

What treatment have you already received for your condition?

- Medications
- Surgery
- Physical therapy
- Chiropractic services
- None
- Other: _____

Name and contact information of other doctors who have treated you for this condition: _____

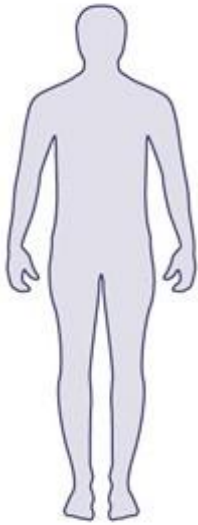
Date of Last: _____
Physical Exam: ____/____/____
Spinal Exam: ____/____/____
Dental X-ray: ____/____/____
Spinal X-ray: ____/____/____
Blood Test/ Urine Test: ____/____/____
MRI/ CT-Scan/ Bone Scan: ____/____/____

ACCIDENT INFORMATION

Is this related to:

- Auto Accident: ___/___/___
- Work Accident: ___/___/___

Attorney Name (if applicable):



FRONT



BACK

Please mark an "x" on *all* areas of the body where you are experiencing pain.

PATIENT CONDITION

Reason for visit today: _____

When did your symptoms appear?

Is this condition progressively worse?

Type of Pain:

- Sharp
- Stabbing
- Throbbing
- Numbness
- Aching
- Swelling
- Shooting
- Burning
- Tingling
- Dull
- Cramps
- Other

How often do you have this pain?

Does it interfere with your:

- Work
- School
- Sleep
- Daily Routine
- Recreation

Activities or movements which are painful:

- Sitting
- Standing
- Walking
- Bending
- Lying Down

Exercise

- None
- Moderate
- Daily
- Heavy

Work Activity

- Sitting
- Standing
- Light Labor
- Heavy Labor

Habits

- Smoking: _____ daily/weekly
- Alcohol: _____ daily/weekly
- Coffee/Caffeine: _____ daily
- High Stress Level: _____

Are you Pregnant and if so, due date:
_____/_____/_____

Medications: _____

Allergies: _____

Vitamins/ Herbs/ Minerals: _____

Injuries/ Surgeries and dates:

Falls: _____/_____/_____

Head Injuries: _____/_____/_____

Broken Bones: _____/_____/_____

Dislocations: _____/_____/_____

Surgeries: _____/_____/_____

The Spine and Wellness Center
Dr. Patrick Borja
3933 Perkiomen Avenue, Suite 101
Reading, PA 19606-2718
(610) 779-4588

Dear Patient:

Thank you for choosing us as your healthcare provider. The following is our financial policy. Our main concern is that you receive optimal care resulting in better health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We ask that you kindly read and sign our financial policy as well as complete our patient information form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks and for your convenience **VISA, MASTERCARD and DEBIT CARDS.** We will be happy to help process your insurance claims. **We accept assignment from most insurance companies; however you must understand that:**

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility, whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
3. If the insurance company does not pay your balance **in full** within **45** days, we kindly ask that you contact your insurance carrier to help speed things along.
4. If the insurance company does not pay **at all** within **45** days, we require you to pay the balance due.
5. Returned checks and balances older than **60** days may be subject to an additional collection fee and interest charges of 1 ½ % per month.

If you are in our office due to a personal injury covered by your auto or workers compensation policy, we will make every attempt to process your claims quickly, and some of the above statement may not apply due to certain state laws. In special circumstances we will require a letter of protection from your attorney for payment.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

We appreciate your confidence in us and we appreciate the opportunity to serve you.

Thank you,

Patrick M. Borja, DC

Print Name

Date

Signature

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

1. We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Please check which of the following we may leave information with:

- Cell phone
- Home phone (answering machine/voice mail)
- Spouse _____ (name)
- Significant Other _____ (name)
- Email
- Other _____

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information. Before we receive your request to revoke your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice

PRINTED NAME

SIGNATURE

AUTHORIZED PROVIDER REPRESENTATIVE

DATE

DATE

APPOINTMENT REMINDERS & HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on authorization you are giving us may be subject to re-disclosure by anyone who has access to the remainder of other information and may no longer be protected by the federal privacy rules.

You may have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternative, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Please check which of the following we may leave information with:

- Cell phone
- Home phone (answering machine/voice mail)
- Spouse _____ (name)
- Significant Other _____ (name)
- Email
- Other _____

Print Name (patient)

Date

Patient Signature

Authorized Provider Representative

Personal Representative Name Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient