APPLICATION FOR CARE

512 Arnold Ave
Point Pleasant Beach, NJ 08742
P: 732-295-4900 F: 732-295-8877

Today's Date: _____

Legal Name:_____Nick Name_____

Gender: □M □F □Other:_____Age_____Date of Birth: _____SS#_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell:_____SSN#_____

Marital Status (circle): S M D W Spouse Name: _____DOB:_____

E-mail:_____Occupation _____

CHIEF COMPLAINT _____Sleep Position _____

Have you seen a chiropractor before? □ No □ Yes If yes, when?

Type of Health Insurance: M/C Insurance Cash Auto-W/C

Primary Insurance: Subscriber Name:_____DOB:_____

Policy #:_____Group #:_____

Secondary Insurance: Subscriber Name:_____DOB:_____

Policy #:_____Group #:_____

Employer:_____Occupation:_____

_____

In case of emergency, contact:_____Relationship:_____

Primary phone number:_____Secondary number: _____

Who may we thank for referring you? _____

What is your primary complaint/ reason for seeking care today?

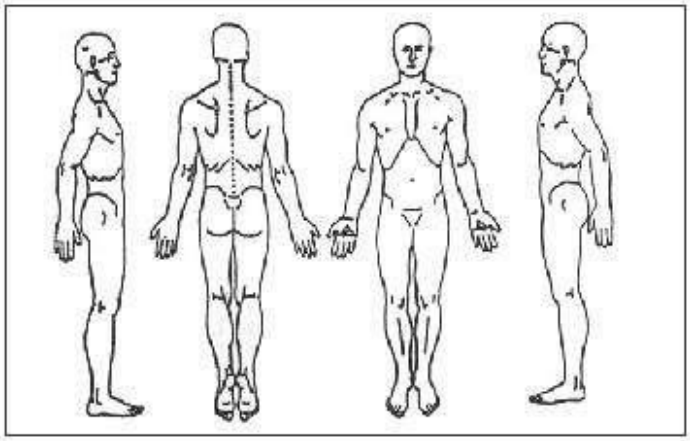
1._____

2. _____

3._____

Please mark the diagram to the right with the abbreviations listed below to indicate your symptoms.

S = Spasms
H = Shooting Pain
P = Sharp Pain
D = Dull Pain
F = Stiffness
T = Tingling
N = Numbness



How long ago did this episode of symptoms begin? _____

Have you had any similar problems in the past? How long ago was the first time? _____

What do you think caused the problem? _____

_____

Is this the first time you've sought treatment for this symptom? □ Yes □ No

Who else has treated you for this symptom? _____

What other methods/treatments have you tried so far? □ Medication (□Rx □OTC) □ Surgery
□ Physical Therapy □ Rest□ Lifestyle Change □ Chiropractic Care □ Massage Therapy □ Acupuncture

Family Health History

Please check all of the **conditions/symptoms** that apply to you or your family (P = Personal, F = Family

P/F	P/F	P/F	P/F
□ □ Alcoholism	□ □ Eczema	□ □ Miscarriage(s)	□ □ Ulcer(s)
□ □ Anemia	□ □ Emphysema/COPD	□ □ Mumps	□ □ Other:
□ □ Cancer	□ □ Epilepsy	□ □ Pleurisy	_____
□ □ Cold sores	□ □ Goiter	□ □ Pneumonia	□ □ Other:
□ □ Deep vein thrombosis	□ □ Gout	□ □ Polio	_____
□ □ Detached retina	□ □ Heart Disease	□ □ Rheumatic Fever	□ □ Other:
□ □ Diabetes Type 1	□ □ High Cholesterol	□ □ Stroke	_____
□ □ Diabetes Type 2	□ □ HIV/AIDS	□ □ Tumor(s)	

Recently, have your symptoms been… □ Same □ Better □ Gradually worse □ Much worse □ Intermittent

How often are you experiencing your symptom(s)? □Constantly □ A few hours at a time □ A few minutes at a time □Briefly □ Only with certain activities □ Randomly □ Other _____

Does anything help to relieve your symptom(s)? □ Ice □ Heat □ Stretching □ Pressure/Massage □ Rest □ Exercise □ Sitting □ Standing □ Lying down □ Medication □ Other _____

What makes your symptoms worse? □ Sitting □ Standing □ Walking □ Lying □ Bending □ Stretching □ Lifting □ Twisting □ Reaching out □ Other _____

What activities, if any, is your pain interfering with? □ Work/School □ Sleep □ Recreation □ Daily Routines □ Mood □ Stress □ Social Interactions □ Relationships □ Other _____

_____

_____

_____

_____

How would you rate your pain on a scale of 1-10, where 1 is no pain and 10 is intolerable pain?

Right now:	1	2	3	4	5	6	7	8	9	10
At its Worst:	1	2	3	4	5	6	7	8	9	10
At its Best:	1	2	3	4	5	6	7	8	9	10

Patient Health History Current **medications, vitamins**, etc.	Taking for:

Please list all **allergies** and/or sensitivities you have: _____

_____

List and describe any **serious accidents** (please give approximate dates) _____

_____

List and describe any **surgeries and hospital stays** (please give approximate dates) _____

_____

Please list all **broken bones and sprains**: _____

_____

Do you have a primary care physician? □ No □ Yes (Who?_____) Do you give consent for us to share your treatment progress with the above providers? □ No □ Yes

Functional Rating Index

For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. **Pain Intensity**

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. **Sleeping**

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain;need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on long short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

No pain	Occasional pain; 25%	Intermittent pain; 50%	Frequent pain; 75%	Constant pain; 100%

8. Lifting

No pain with heavy weight	Mild pain with heavy weight	Moderate pain with moderate weight	Moderate pain with light weight	Severe pain with any weight

9. Walking

No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

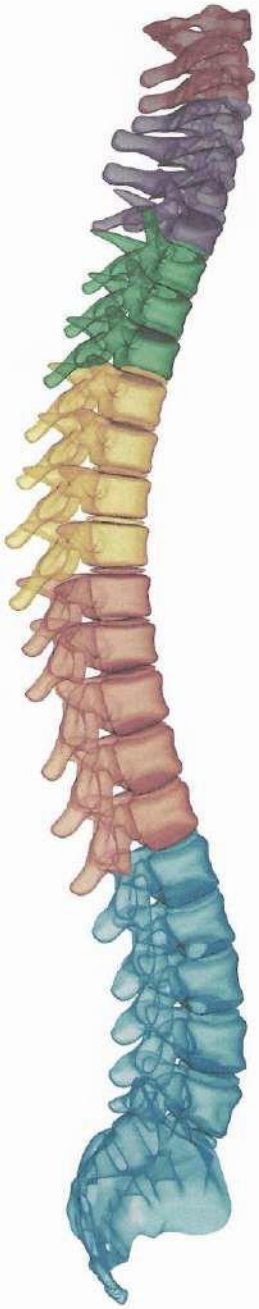
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain any standing

Patient Name _____ Date_____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS (PAST / PRESENT)	
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress	☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance

Patient Name: _____ Date: __/__/____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Release of Information: Your Protected Health Information (PHI) will be used by Seacoast Family Chiropractic to disclose to others for the purposes of treatment, obtaining payment, and/or supporting the daily operations of this office. You should review the Notice of Patient Privacy Policy for a more complete description of how your PHI may be used or disclosed. It describes your rights to the limited use of your PHI, including your demographic information. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the front desk. This office reserves the right to modify the Privacy Practices outlines in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations.

Revocation of Consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I,_____**(print)** acknowledge that I have reviewed the above information and I authorize this office to release information concerning my condition and treatment to my insurance company, attorney, insurance adjuster and/or other health care providers deemed necessary for treatment purposes, processing my claim, benefits and payment of services rendered to me as well as coordinated treatment. I do understand that if I choose to refuse release of this information, that my PHI will be used within the office for purposes of my care, to those individuals designated by the

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic procedures, various forms of physical examination, x-ray studies, and/or any clinical services that are deemed necessary in my case to be administered by the doctor and/or any support staff employed or contracted by this office or clinic. I understand that, as with any health care procedure, complications are possible following chiropractic manipulations and/or manual therapy techniques. The risks of complications due to chiropractic treatment have been labeled as “rare” and include, but are not limited to muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fracture, disc injury, stroke, dislocations and sprains.

I understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations, allowing the body to return to improved health. It can also be used to alleviate other symptoms through a conservative approach with hopes to avoid more invasive procedures. I further understand that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has the right to terminate responsibility for my care. I further understand that there are other treatment options available for my condition, and that I have the right to a second opinion should I have concerns as to the nature of my symptoms and/or treatment options. If during the course of my care my insurance company requires me to take an examination from any other doctor, I will notify this facility/physician immediately. I understand that failure to do so may jeopardize my case.

I,_____**(print)** have read the above consent and have had the opportunity to ask questions regarding its content. By signing below, I agree to the above-named procedures and intend this consent to

X-Ray Consent

In the event that X-Rays are recommended, I hereby authorize the performance of diagnostic x-rays. At this time, I know of no other condition which the taking of x-rays would further complicate and I consent to having diagnostic x-rays performed. With full understanding of the above, and believing that I am currently not at risk, I wish to have an x-ray examination performed in the present and/or future if requested by the doctor.

Female Patients Only: This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor or certified staff of Seacoast Family Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child. _____**Intinal**

With full understanding of the above, and believing that I am currently not at risk, I wish to have an x-ray examination performed today if requested by the doctor.

Patient/Guardian Signature:_____Date: _____

Financial Policy

Our goal is to help each of our patients enjoy the benefits of good health. These payment options are provided to help make quality care affordable to you please ask our office manager any questions you may have.

Insurances

If you have health insurance, please understand that this is ***an agreement between you and your insurance company, and you are responsible for knowing your benefits.*** We will bill your insurance for services rendered in the office. We will check your benefits prior to receiving care, however insurance companies will never allow that a quote of coverage is a guarantee of benefits. You are responsible for your deductible, copay or co-insurance as we are and **out-of-network provider for Aetna, United Health Care and Cigna insurance companies**. You're getting this notice because SEA COAST FAMILY CHIROPRTIC isn't in your health plan's network. **Patient Initials _____ Staff Initials _____** This means that SEA COAST FAMILY CHIROPRTIC doesn't have an agreement with your plan. We are a **in network** provider for Horizon BCBS of NJ and all out of state Blue Cross plans. After your deductible has been met, we accept your co-payment (the amount your insurance will not pay) at the time of service and bill your insurance company for the balance.

Horizon NJ Health/ NJ Family Care Community Plan

If you have ***Horizon*** NJ Health/ NJ Family Care Community Plan, please understand we are a non-participating provider. This means that SEA COAST FAMILY CHIROPRTIC doesn't have an agreement with your plan, and you will be responsible for any services rendered by SEA COAST FAMILY CHIROPRTIC. **Patient Initials _____ Staff Initials _____**

Medicare

Medicare/Medicare Advantage Patients: Medicare Part B only covers manipulation of the spine. All other services are not covered and will be your responsibility. You will be required to meet your annual Part B deductible, which is currently $_____ and pay 20% of the allowed fee on the spinal manipulation, which is currently $_____, in additional to 100% of all non-covered services. Medicare Part B patients with a Supplemental policy will generally have their Part B deductible and the 20% covered by the supplement. However supplemental policies generally do not pay for services that Medicare does not allow. Medicare patients will be required to sign an Advance Beneficiary Notice prior to starting care, any time there is a significant change in diagnosis, and/or at the beginning of each year. ***Medicare Advantage*** plans generally follow the same guidelines as Medicare Part B, except you may have a copay instead of a deductible/20% plan**. Patient Initials _____ Staff Initials_____**

Private Pay Patients (Non Insurances) As a courtesy, our established Private Pay patients receive a Paid At Time of Service-Non-Billing discount. We accept cash, Visa, Master Card and personal checks. Your account is to be paid in full at the time of service. Payment is expected at time of service. A discount is given for adjustment payment full at the time of service. **Patient Initials _____ Staff Initials _____**

Missed appointment / late cancelations

If you are unable to keep an appointment, you must cancel within 24 hours prior by calling the office at (732-295-4900). Fees will be assessed for patients that do not show up to appointments or fail to give appropriate notice. The fees are as follows.

Chiropractic Appointment: $50.00 (For any Missed appointment)
Chiropractic Appointment: $25.00 (For any Late Cancel appointment)
Massage Therapy: $40.00 (For any Missed/Late Cancel appointment)

Insurance companies do **NOT** pay for missed appointment or late cancellation charges and that payment will be your responsibility. When a missed appointment or late cancellation fee is charged, a notice will be texted to you will be expected to submit payment upon receipt. Please also remember that keeping scheduled appointments is critical to achieving your treatment goals.

I have read the above policy regarding my financial responsibility to the practice of SEA COAST FAMILY CHIROPRTIC for providing medical services to the below named patient. I agree to pay the full entire amount of all bills incurred by me or the below named patient or any amount due after payment has been made by my insurance plan and any contractual adjustments have been made. **Patient Initials _____ Staff Initials _____**

To avoid costly collections procedures, we request that all patients provide a credit card number and authorization for use if payment is not received for services provided or no show/ cancellation fees due. SEA COAST FAMILY CHIROPRTIC will send a text message to inform you of the charges being applied to your card on file. By signing this wavier. I give authorization for charges to be made to my credit card by SEA COAST FAMILY CHIROPRTIC.

Card Type: VISA Master Card American Express Discover

Card Number: _____Expiration Date: _____ CVS Code_____

Person whose name appears on the credit card_____

Address where the bill for the credit card is received: _____

Patient Name_____ Patient/Guardian Signature_____ Date_____

Credit Card Holder _____ Credit Card Holder Signature _____ Date_____

Signature on file I authorize the use of this form on all my insurance submissions to be used in lieu of my signature. I authorize release of information to all my insurance company for the purpose of normal billing procedures. I authorize Dr. Costa (Seacoast Family Chiropractic) and their staff to act as my agent in helping me obtain payment for my insurance company. I authorize payments be made directly to Seacoast Family Chiropractic. I permit a copy of this form to be used in place of the original.

Printed Name of Patient/Responsible Party _____

Signature of Patient/Responsible Party _____

Date Signed _____ Witness Signature _____

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

As part of the no surprise billing compliance plan, as of January 1st, 2022

Our clinic has a single fee schedule that applies to all patients for each service provided.

Most Common Services Billed Fee

New Patient Examination $150.00
Established Patient Re-evaluation $95.00
Spinal Manipulation (1 area) $60.00
Spinal Manipulation (whole spine) $80.00
Extra-Spinal Manipulation (hand, shoulder, foot, etc) $55.00
Maintenance Visit $55.00
Therapy $55-$75.00
Laser $30.00 -$55.00
Cervical (Neck) X-ray $100.00
Thoracic (Mid-Back) X-ray $100.00
Lumbar (Low-Back) X-ray $100.00
Insoles Foot orthotics $500.00
*Supports/Vitamins/Supplies Priced as marked