260 W. Crescent Avenue Suite 2 Allendale NJ 07401
Email: epicsstherapy@gmail.com

CONFIDENTIAL PATIENT CASE HISTORY

Name: ______ DOB: ______ Age: ______

Home Address: ______

City: ______ State: ______ Zip: ______

Home #: ______ Number of Children: ______

Work #: ______ Marital Status: ☐ S ☐ M ☐ D ☐ W

E-Mail: ______ Spouse's Name: ______

Employer: ______ Spouse's Phone #: ______

Social Security #: ______ Referred by: ______

HEALTH INFORMATION

What is your major complaint? ______

Other complaints: ______

How long have you had this condition (approximate date)? ______

Have you had this or similar conditions in the past? ______

What activities aggravate your condition? ______

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Sometimes ☐ Comes &Goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other: ______

How long has it been since you really felt good? ______

Other doctors who treated this condition: ______

Any past surgeries and years: ______

Drugs you now take: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers
☐ "Pep" Pills ☐ Tranquilizers ☐ Insulin
☐ Birth Control ☐ Other: ______

Age of mattress: ______ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

Have you been in an auto accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never

Describe: ______

Date of Last Physical Examination:

Have you ever suffered from?

1. Dizziness ☐ Yes ☐ No
2. Backaches ☐ Yes ☐ No
3. Heart Trouble ☐ Yes ☐ No
4. Diabetes ☐ Yes ☐ No
5. Arthritis ☐ Yes ☐ No
6. Headaches ☐ Yes ☐ No
7. Asthma ☐ Yes ☐ No
8. Neuritis ☐ Yes ☐ No
9. Digestive Disorder ☐ Yes ☐ No
10. Nervousness ☐ Yes ☐ No
11. Sinus Trouble ☐ Yes ☐ No
12. Neck Pain ☐ Yes ☐ No

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No

Name of Company: Policy #:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Medical Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Medical Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: ______________________________ Date: ________________

Guardian or Spouse Signature: ______________________________ SS #: ________________

Doctor's Signature: ______________________________ Date: ________________

ASSIGNMENT/ DIRECT PAYMENT TO DOCTOR
PRIVATE/GROUP ACCIDENT AND HEALTH INSURANCE

PATIENT: ______________________________

EMPLOYER: ______________________________

GROUP NO: ______________________________

SSN/ID: ______________________________

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

____

____

If policy provisions prohibit direct payment to physician, I hereby also instruct and direct you to make out the check to me and mail to one of the addresses above. Payment is for the professional or medical expense benefits allowable, and otherwise payable, to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Agreement of Rights and Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

______________________________ ______________________________

Date **Signature of Policy Holder**

____

Witness

PATIENT CONSENT OR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Epic Spine & Sports to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Epic Spine & Sports notice of privacy practices provides a more complete description of such uses and disclosures. I have the night to review the Notice of Privacy Practices prior to signing this consent. Epic Spine & Sports reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Epic Spine & Sports, 260 W. Crescent Avenue Suite #2, Allendale, NJ 07401.

With this consent Epic Spine & Sports may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent Epic Spine & Sports may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With the consent of Epic Spine & Sports may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Epic Spine & Sports restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Epic Spine & Sports to use and disclose of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Epic Spine & Sports may decline to provide treatment to me.

Patient's Name: ______________________________ **Date:** ________________

Signature of Patient of Legal Guardian: ______________________________

Print Name of Patient or Legal Guardian: ______________________________

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: ______________________________ **Date:** ______________

Office Signature: ______________________________ **Date:** ______________

X-RAY CONSENT FORM

Patient Consent to X-Ray:

I hereby authorize the performance of diagnostic x-rays. The doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: ____ Date: ______________

Consent to X-Ray a Minor:

I am a parent or legal guardian of ________________________, who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. The doctor has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: ____ Date: ______________

Females: Regarding Possibility of Pregnancy:

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor has 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.

Signed: ____ Date: ______________