CHARSCHAN CHIROPRACTIC
AND SPORTS INJURY ASSOCIATES
FEEL BETTER IN AS LITTLE AS ONE VISIT

CONFIDENTIAL PATIENT HISTORY

490 Georges Rd. North Brunswick, NJ 08902 (732) 846-6400
1281 Raritan Rd. Scotch Plains NJ 07076 (732) 829-0009

DATE_____

(Please Print)

PATIENT'S NAME_____SOC SEC #_____

ADDRESS_____CITY_____STATE_____ZIP_____

AGE_____BIRTH DATE_____MARITAL: M S D W #CHILDREN_____ HEIGHT_____WT_____

HOME PHONE # _____ CELL PHONE # _____CARRIER _____

OCCUPATION_____EMPLOYER _____

EMPLOYER ADDRESS_____EMAIL_____

SPOUSE'S NAME_____OCCUPATION_____

SPOUSE'S EMPLOYER_____CELL PHONE#_____

WHO CAN WE THANK FOR REFERRING YOU?_____

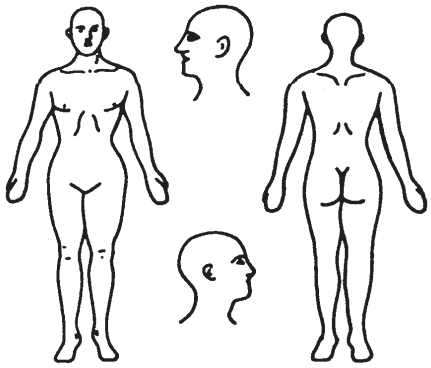
NAME AND ADDRESS OF NEAREST LIVING RELATIVE_____
(NOT LIVING WITH YOU)

Purpose of this appointment_____

Have you seen any physician for this condition (check all that apply) ☐Chiropractor ☐MD ☐None

What medications are you taking? _____

Please mark your areas of pain below:



Women: Are you pregnant at this time?
☐Yes ☐No

List surgeries and years

_____

_____

Have you suffered from:

☐Dizziness	☐High Blood Press	☐Neuritis
☐Backaches	☐Diabetes	☐Nervousness
☐Headaches	☐Arthritis	☐Digestive Probs
☐Heart Trouble	☐Asthma	☐Sinus Trouble
☐Allergies	☐Cancer	☐Neck Pain

Present Family Doctor_____

Address_____

Date of last Physical exam_____

By Whom_____

List conditions that you are most interested in getting corrected in order of importance and when each started.

1._____

2._____

3._____

4._____

What functions are you unable to perform or induce pain upon performance? (example: sit, bend, walk)

1._____

2._____

3._____

4._____

Have you ever had chiropractic care before? ☐Yes ☐No

Doctors name_____

Have you been treated for any health conditions by a physician in the last year? ☐Yes ☐No

If it determined that your health could be improved, would you want to receive chiropractic care at this office?
☐Yes ☐No

IF YOUR CONDITION IS THE RESULT OF AN INJURY, PLEASE COMPLETE THIS SECTION

IS YOUR CASE: ☐ Workers Compensation ☐ No Fault (Auto accident) ☐ Personal Injury

Date of Injury:_____ Time:_____ Location:_____

Please describe how the injury happened: _____

_____

Did you report your injury? ☐ Yes ☐ No To whom? _____

Were you Hospitalized? ☐ Yes ☐ No Where? _____

By ambulance? ☐ Yes ☐ No X-rays taken? ☐ Yes ☐ No By whom?_____

Date(s) of hospitalization_____ Medications prescribed_____

Are You presently working? ☐ Yes ☐ No Dates of time lost from work_____

Have you been treated by any other chiropractor or physician for this injury? ☐ Yes ☐ No If yes, Doctor's name and specialty _____

_____

List any previous injuries:

1. Type_____ When_____Hospitalized ☐ Yes ☐ No

2. Type_____ When_____Hospitalized ☐ Yes ☐ No

INSURANCE INFORMATION (Please Print)

Do you have health insurance? ☐ Yes ☐ No If yes:

Name(s) of insurance company(s) _____

Address_____Policy #_____

Spouses Insurance Company name_____

Address_____Policy #_____

PAYMENT ACKNOWLEDGEMENT (Please sign)

I understand and agree that my health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Charschan's office will prepare any necessary reports and forms to assist me in making collection from the insurance carrier and any amount authorized to be paid directly to Dr. William Charschan's 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 payments, co-payments and non-covered managed care services. 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. In the case of managed care plans, I agree to abide by the protocols designed by my plan and understand that any care not authorized by my plan is my responsibility. Charschan Chiropractic will do their best to preauthorize all my care and I am fully responsible for any care not preauthorized by my carrier.

If I violate this agreement and Dr. Charschan's office sends my account to a collection agency or attorney for collection, I will be responsible for all collection and court costs as well as yearly interest on the unpaid balance.

Patient's (or legal guardian) signature_____Date _____

Insured Signature_____Date _____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

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AND SPORTS INJURY ASSOCIATES
IT'S ALL BETTER IN AS LITTLE AS ONE VISIT

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1281 Raritan Rd. Scotch Plains, NJ 08902 732-8290009
William D. Charschan D.C.,I. C.C.S.P., Director
www.backfixer1.com, www.whypeoplehurt.com

HIPAA patient authorizations Form.
Patients must read and sign at each x.
This form is to be placed in the patient file

Patient Authorization for appointment reminders, scheduling related matters, health products and other office communications

It is our desire to for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues. Our patients also receive our newsletter which has informative articles, health tips and products that can help you stay healthy

The use of this information is intended to make your experience with our office more efficient, productive and offer ideas and products than can help you stay healthy. If you choose not to authorize this information use your decision will have no adverse effect on your care from ___/_____/____(today's date) or on your relationship with our staff.

Your signature indicates your authorization of this activity.

x_____ x_____ x_____
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

x_____ x _____ x _____
Personal Representative Printed Personal Representative Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Charschan Chiropractic and Sports Injury Associates, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further**,** you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

You can request medical records (EPHI) in electronic format if available in either Microsoft Word or PDF Formats. This can include super bills and other information you are requesting.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

If there is a Breach of PHI (Private Health information released without permission unintentionally), we are required under the Breach Notification Rule to do the following

Notice to Individuals: Our office must notify any affected individuals without reasonable delay, within 60 days.

Notice to Media – If a breach affects more than 500 residents of a state or local jurisdiction our office must notify a prominent media outlet that is appropriate for the size of the location with affected individuals.

Notice to HHS – Notices on breaches affecting 500 or more individuals must be submitted to HHS(health and human services) at the same time that notices to individuals are issued. If a breach affects fewer than 500 individuals, our office is required to report the breach to HHS within 60 days after the end of the calendar year in which the breach occurs via the HHS web portal.

Notice by Business Associates to Covered Entities – A business associate of our office must notify us if the business associate discovered a breach of unsecured PHI. Notice must be provided without unreasonable delay and no case later than 60 days after the discovery of the breach.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Constance Amaczi, office manager or Dr. William Charschan, owner.

If you would like further information about our privacy policies and practices please any of our office staff. We also have an explanation posted in our reception area.

This notice is effective as of ___/____/___ (today's date). This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

x_____ x _____ x_____
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

x_____ x _____ x _____
Personal Representative Printed Personal Representative Signature Date

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Patient Consent for Treatment

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:
By signing this form, you are granting consent to Charschan Chiropractic and Sports Injury Associates to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our main office at (732) 846 6400. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

x_____ x _____ x_____
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

x_____ x _____ x _____
Personal Representative Printed Personal Representative Signature Date

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MEDICARE CONSENT TO RELEASE INFORMATION: (Please sign if you have Medicare only)
I certify that the information given by me in applying for payment under Title XVIII and *I* or Title Xl of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

x_____ x _____ x_____
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

x_____ x _____ x _____
Personal Representative Printed Personal Representative Signature Date

Version 1-20-2015