ABOUT YOU

Today's Date:_______________

Name:____

What you Prefer To Be Called:____________ ☐ Male ☐ Female

Birth date:____/____/____Age:_____SS#:_________________

Home Address:____

____
City State Zip

Home Phone#:____

Cell Phone#:____

E-mail Address:____

Referred By:____

Employer:_________________________How Long?_______

Employer's Address:_____________________________________

____
City State Zip

Occupation:_________________Work Phone #:___________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name:____

INSURANCE INFO

Company Name:___________________________________

Address:____

Phone #:____

Insured's SS# :__________________________________

Group # (Plan, Local or Policy #):___________________

Primary care Physician:____________________________

____
City State Zip

Insured's Name:___________________________________

Relation:____________________Date of Birth____/____/____

Insured's Employer:________________________________

Please inform front desk of 2nd Insurance source.

IN EVENT OF EMERGENCY

Who should we contact?______________________________

Relation:_____________ Home Phone #:_________________

Cell Phone #:_____________________________________

Work Phone #:____________________________________

REASON FOR VISIT

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No

If so, please explain:____

The reason for this visit is a result of *(Please Circle):* work, sports, auto, trauma or chronic

*(Explain what happened):*____

Please describe the pain & it's location:____

When did condition begin?________________

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with you *(Please Circle):* work, sleep, or daily routine

If so, please explain:____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain:____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where?____

- We invite you to discuss with us any questions regarding our services. The best health services are base on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no finacial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature____Date___________

PAIN CHART

About you

Name:______________________________________File #______________________

Please describe your condition:____

____

Signature:____Date:___/___/___

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown below in the example.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	OOOOO	^^^^^	XXXXX	●●●●●

Example — XXXX 2

Example Right Front (right, left) Back (left, right) Left

Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

1 2 3 4 5 6 7 8 9 10

DOCTOR'S NOTES

____

____

____

____

THIS IS A CONFIDENTIAL HEALTH REPORT

NAME____Date______________
(last) (first) (middle)

HEIGHT_________________________WEIGHT__________________

CHILDREN (list ages & sex)____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL / FREQUENT

GENERAL
- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Pain, numbness or Cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet

GASTRO-INTESTINAL
- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digesting
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE & THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ear noise
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of the arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Swelling of ankles

RESPIRATORY
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

SKIN
- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inadbility to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstration
- ☐ ☐ Vaginal discharge

Pregnant ☐Yes ☐No
Date of last period____________
Previous miscarriages ☐Yes ☐No

DATE OF LAST: (Approx.)
- _________Physical examination
- _________Blood test
- _________Chest x-ray
- _________Spinal x-ray
- _________Dental x-ray
- _________Urine test

NONE	LIGHT	MODERATE	HEAVY	
☐	☐	☐	☐	Alcohol
☐	☐	☐	☐	Coffee
☐	☐	☐	☐	Tobacco
☐	☐	☐	☐	Drugs
☐	☐	☐	☐	Exercise
☐	☐	☐	☐	Soft Drinks

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Used a crutch, or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

*Please list any prescription drugs now taken, allergies and past surgeries-_________________________________

____

____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Foot Problems
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Malaria
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign your name____Date_________________

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

CASE HISTORY

OAKLAND FAMILY CHIROPRACTIC CENTER LLC

DR. Darren G. Hartung, D.C.

410 Ramapo Valley Rd., Oakland, New Jersey 07436
(201) 337-3377

INFORMED CONSENT

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in contesting to treatment.

Specific Risk Possibilities Associated with Chiropractic Care are:

Stroke: Stroke is the most serious complication of Chiropractic treatment. It is rare. According to the journal of CCA, vol. 37, no.2, June 1993, recent studies estimate the risk of this type of stroke is I in every 3 million upper cervical adjustments. Vertebral arteries, which supply the brain with blood, are located within the bones of the upper spine. Therefore, cervical treatment poses a small risk for a stroke, which is temporary or permanent brain dysfunction. On extremely rare conditions, death occurs.

Soreness: Chiropractic adjustments are sometimes accompanied with post treatment soreness. This is normal, but please advise your doctor of Chiropractic of the soreness.

Soft Tissue Injury: Occasionally, Chiropractic treatment may aggravate a disc injury, or cause minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause a rib injury or fracture. Precautions such as pre-adjustment X-rays are taken in cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns: Heat generated by physical therapy modalities can cause minor burns to the skin. These are rare, but should be reported, as well, as other side effects you may be experiencing.

Chiropractic is a system of health care delivery and therefore, as with any healthcare delivery system, we cannot promise a cure for any symptoms, condition or disease. An attempt to provide the best Chiropractic care is our goal, and if the results are not successful, we will refer you to another health care provider. If you have any questions, please ask your Doctor.

Having carefully read the above, I hereby give my informed consent to have Chiropractic treatment administered.

______________________________	______________________________
Patients Printed Name	Today's Date
______________________________	______________________________
Patients Signature	Parent/Guardian Signature if Minor

Dr. Darren G. Hartung | 410 Ramapo Valley Rd
Oakland, NJ 07436
(201) 337-3377

NAME (please print) ___________________________________

EMAIL ADDRESS____________________________________

CELL PHONE NUMBER_____________________________

CELL PHONE CARRIER_____________________________

I________________ HEREBY GIVE PERMISSION TO OAKLAND FAMILY CHIROPRACTIC CENTER TO SEND CHIROPRACTIC OR OFFICE RELATED INFORMATION TO MY EMAIL AND OR BY TEXT MESSAGE TO THE ABOVE ADDRESS AND PHONE NUMBER GIVEN.

**PATIENT
SIGNATURE:___________________________DATE:__________**

Dr. Darren G. Hartung

X-RAY REFUSAL FORM

This is to acknowledge that:

DARREN HARTUNG, D.C., has recommended that x-rays be taken so that a complete study and analysis may be made of my present condition (or subluxation).

I do not feel that my present condition (or subluxation) is serious enough to warrant the use of x-rays, so that a complete study and analysis may be made by Dr. Hartung. Therefore, you are hereby authorized and directed to provide Chiropractic Care to my present condition (or subluxation) to the best of your ability without a complete study and analysis of said condition (or subluxation).

Should any untoward effects or any further illness or injury develop, directly or indirectly, as a result of such Care provided, I shall assume full responsibility.

In consideration of your Chiropractic Care at my request without benefit of a complete study and analysis, I do herby release you from all cause of action, damages, and liabilities arising by reason of said Chiropractic Care, whether heretofore or hereafter occluding, and whether known or unknown by the parties hereto.

Date:____________________

Signed:

Patient's Signature:____

Doctor:____

Oakland Family Chiropractic Center LLC
410 Ramapo Valley Rd.
Oakland, NJ 07436

DR. Darren G. Hartung, D.C.

ASSIGNMENT OF HEALTH BENIFITS AND FINANCIAL RESPONSIBILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles, and charges denied or not covered by my insurance company. I realize that my care may be subject to pre-authorization by my insurance company, and I accept all responsibility for any treatments, which are determined to be not medically necessary.

I understand that my coverage does not cover routine maintenance, Preventative or well ness visits.

My initial office visit and examination is covered under my contract and will not be billed to me if continued treatment is determined to be medically necessary. Oakland Family Chiropractic will submit all required documentation to the insurance company, or their designee, so that a review relative to determination of medical necessity can be made of subsequent treatment. I understand that both Oakland Family Chiropractic and myself
will receive direct notification from the insurance company, or their designee, and will be advised as to whether additional treatment has been approved or denied and the number of visits that have been approved for a specified time period. Charges for services determined to be not medically necessary by the insurance company will be my responsibility.

Insurance policy limitation are per individual insurance policy plan, as are co-payments, co-insurance, deductibles, pre-authorization, and/or referrals.

I have read and understand my obligations for payment for care in the absence of insurance coverage. The parties appearing below, hereby agree to the following conditions, covenants and terms regarding the assignment of health benefits appearing for the patient’s policy.

I, hereafter referred to as “Patient”, understand that voluntarily agree to assign all applicable health provisions pertaining to payments or benefits appearing in my insurance policy in consideration or treatment rendered by Dr. Darren G. Hartung, hereafter referred to as “Doctor”.

That patient, the policy holder, requests, orders and directs my insurance carrier, to pay Doctor directly to his office at Oakland Family Chiropractic Center LLC, the sum due the Doctor for treatment rendered as a result of illness/injuries Patient sustained.

That Patient gives Doctor the exclusive right to secure the funds assigned the patient, including the right of securing counsel to represent the Doctor in collecting all sums due for treatment rendered.

The Doctor and patient hereby enter into this assignment of benefits freely and voluntarily and evidenced by the signatures appearing below: That Patient and Doctor warrant that they have read this assignment of benefits and that each understand the legal effect of the same, and agree that each shall be bound by the covenants, terms and conditions appearing herein.

____________________________ ____________________________

PRINT PATIENT’S NAME SIGNATURE (Patient, Parent or Guardian)

____

DATE

Darren G. Hartung, D.C., Oakland Family Chiropractic Center LLC
NOTICE OF PRIVACY PRACTICES

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

Darren G. Hartung, D.C., Oakland Family Chiropractic Center LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, and reporting to the Food and Drug Administration problems with products and reactions to medications.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes.

Change of Ownership.
In the event that Darren G. Hartung, Oakland Family Chiropractic Center LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Darren G. Hartung, D.C., Oakland Family Chiropractic LLC is not required to agree to the restriction that you requested.

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- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Darren G. Hartung, D.C., Oakland Family Chiropractic Center LLC amend your protected health information. Please be advised, however, that Darren G. Hartung, D.C., Oakland Family Chiropractic Center LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Darren G. Hartung, D.C., Oakland Family Chiropractic Center LLC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Darren G. Hartung, D.C., Oakland Family Chiropractic Center LLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Darren G. Hartung, D.C., Oakland Family Chiropractic Center LLC is required by law to comply with this Notice.

Darren G. Hartung, D.C., Oakland Family Chiropractic Center LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Darren G. Hartung, D.C. Oakland Family Chiropractic Center LLC by calling this office at 201-337-3377. If Darren G. Hartung, D.C., is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Darren G. Hartung, D.C., Oakland Family Chiropractic Center LLC has handled your health information should be directed to Darren G. Hartung, D.C., by calling this office at 201-337-3377. If Darren G. Hartung, D.C., is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of April 14, 2003

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Darren G. Hartung, D.C.,Oakland Family Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

______________________________________ ______________
Patient's Signature Date

______________________________________ ______________
Authorized Facility Signature Date

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