*Klein Chiropractic Institute*
*1944 Corlies Avenue, Suite 101A*
*Neptune, NJ 07753*
*Phone: 732-576-2225 Fax: 732-576-2227*
*Email: KCI1944@YAHOO.COM Website: KCI1944.COM*

## Dr. Newton Klein

We are pleased to welcome you to our practice. Please take a few minutes to fill out this for as completely as you can. If you have any questions, we will gladly assist you. We look forward to working with you in maintaining your health.

# PATIENT INTAKE FORM

Name _____ Social Security # _____
**Last Name** **First Name** **Initial**
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Cell Provider for text reminders _____ Email _____
Ex: **AT&T, Verizon, Sprint, etc.**
Claim #_____ Adjustor Name & #_____
Primary Insurance _____ Secondary Insurance _____
Sex □ M □ F Birthdate _____ □Single □Married □Widowed □Sep □Divorced

Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Notify in case of Emergency _____ Phone _____
Referred to this Office □Friend/Family _____ □Yellow Pages □Insurance Website □Mail
□Social Media □Clinic Location _____ □Other_____

Primary Doctor Name_____ Phone _____
Doctor Address_____

Have you ever been treated by a Chiropractor? □Yes □NO (If yes when & why?)
_____

## PRIMARY INSURANCE INFORMATION

**Insurance_____ ID #_____ Phone _____**
Person responsible for Account_____ Soc Sec # _____
Relationship to Patient_____ Birthdate_____
Address (if different from patient) _____State _____Zip Code _____

## SECONDARY INSURANCE INFORMATION

**Insurance_____ ID #_____ Phone _____**
Person responsible for Account_____ Soc Sec # _____
Relationship to Patient_____ Birthdate_____
Address (if different from patient) _____State _____Zip Code _____

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# ELECTRONIC HEALTH RECORDS INTAKE FORM

*This form complies with CMS EHR incentive program requirements*

FIRST NAME_____ LAST NAME _____

EMAIL ADDRESS: _____@_____

Preferred method of communication for patient reminders: □Email □Phone □Mail

DOB: _____ GENDER: □Male □Female □Other

Preferred Language: _____

Smoking Status: □Every Day □Occasional □Former Smoker _____how long □Never Smoked
Date Started Smoking: _____

| Family Medical History (Record one diagnosis in your family history and the affected) | | | | |
|---|---|---|---|---|
| Diagnosis (Write below) **Ex: Heart Disease** | Father | Mother **X** | Sibling: _____ | Offspring: _____ |
| | | | | |
| | | | | |
| | | | | |

Race (check one) □ American Indian or Alaska Native □Asian □Black or African American □White (Caucasian)
□Native Hawaiian or Pacific Islander □Decline to Answer

Ethnicity (check one) □Hispanic or Latino □Not Hispanic or Latino □ I Decline to Answer

| Are you currently taking any medications? *(Include regularly used over the counter medications)* | |
|---|---|
| Medication Name | Dosage and Frequency (i.e., 5mg once a day, etc.) |
| | |
| | |
| | |

| Do you have any medication allergies? | | | |
|---|---|---|---|
| Medicine Name | Reaction | Onset Date | Additional Comments |
| | | | |
| | | | |
| | | | |

☐ I choose to decline receipt of my clinical summary after every *visit (These summaries are often blank as a result of the nature and frequency of chiropractic care)*

Patient Signature: _____ Date: _____

***For Official Use Only***
Height: _____ Weight: _____ Blood Pressure: _____/_____

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## PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1._____ 2._____

3._____ 4._____

SYMPTOMS DEVELOPED FROM: □Job Related Injury □Auto Accident □Other □Accident
□Illness □Unknown Cause □Gradual Onset □Date Occurred: _____

Is the pain getting: □Worse □Better □Same □Comes and goes?
How often do you have pain? _____

Have you been treated by a medical physician for this condition? □YES □NO
If yes, when and where? _____

Please list any medication (including pain killers) you are taking: _____
_____

Please list any falls, Trauma, Injuries within the last 5 years:
_____

Women: Are you pregnant? □YES □NO If Yes, how far along? _____ Nursing: □YES □NO

## Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

| | | | |
|---|---|---|---|
| ☐Heart Attack/Stroke | ☐High Blood Pressure | ☐Arthritis | ☐Gout |
| ☐Congenital Heart Defect | ☐Frequent Neck Pain | ☐Jaw Pain | ☐Anemia |
| ☐Alcohol / Drug Abuse | ☐Severe Frequent Headaches | ☐Wrist Pain | ☐Hepatitis |
| ☐Fainting/Seizures/Epilepsy | ☐Diabetes / Tuberculosis | ☐Shoulder Pain | ☐Shingles |
| ☐Emphysema/Glaucoma | ☐Kidney Problems | ☐Arm Pain | ☐Ulcer/Colitis |
| ☐Psychiatric Problems | ☐Artificial Bones/Joints | ☐Leg Pain | ☐Dizziness |
| ☐Difficulty Breathing | ☐HIV Positive / AIDS | ☐Cancer | ☐Cholesterol |
| ☐Lower Back Problems | ☐Severe/Frequent Earaches | ☐Numbness | ☐Ringing in Ears |

☐Tingling, Where? _____

## Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor. I authorize my insurance company to pay the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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**PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENT HAS BEEN APPROVED**

Dear Patient,

Welcome to Klein Chiropractic Institute, LLC. Our objective is to make your visit as pleasant and as comfortable as possible. We have simple financial requirements; all deductibles and co-pays are to be paid at the time of your initial visit, (unless other arrangements have been previously approved). As per your insurance company's requirement, we are objected to request that you remit your annual deductible. If you have financial problems or need special consideration, this can be addressed privately before you are treated. We hope your experience will be pleasant and we can help you with your health issue as quickly and as efficiently as we have for years. If you have any questions, please do not hesitate to ask us.

By signing this letter, I affirm that a representative of the Klein Chiropractic Institute, LLC has:

1) Discussed all prices before I was treated,
2) Advised me of my financial responsibility towards a co-payment and deductible,
3) Informed me that I may receive phone calls if I miss an appointment or to remind me of an appointment,
4) Informed me that I may receive mailings if I miss an appointment or to remind me of an appointment,
5) In the event that I need translation, I authorize a Staff Member to serve as my personal representative.
6) My physician has referred me for a series of X-Rays for diagnostic purposes. The procedure has been explained to me and I have informed them of any and all related medical conditions. I am not pregnant and consent to have the X-Ray study done. I have read and understand the above statements and consent to the examination as explained.
7) I understand that this is not a workers compensation case. I was not hurt or injured on the job.

## ACKNOWLEDGEMENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations. I acknowledge that the Klein Chiropractic Institute LLC., "Notice of Privacy Practices" has been provided to me. I understand I have a right to review Klein Chiropractic Institute LLC., "Notice of Privacy Practices" prior to signing this agreement. The Klein Chiropractic Institute LLC., "Notice of Privacy Practices" has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Klein Chiropractic Institute LLC. The Notice of Privacy Practices for the Klein Chiropractic Institute LLC., is also provided upon request at the front desk of this practice. The Notice of Privacy Practices also describes my right and the Klein Chiropractic Institute LLC. Duties with respect to my protected health information.

The Klein Chiropractic Institute LLC. Reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for on at the time of my next appointment.

**ASSIGNMENT OF INSURANCE BENEFITS** – I authorize and direct payment be made directly to:

Newton Klein, D.C.
1944 Corlies Avenue, Suite 101A
Neptune, NJ 07753

For any and all insurance benefits or reimbursements for services rendered which amounts would normally be payable to me under any insurance or pre-paid healthcare plan.

## PAYMENT AGREEMENT

I understand that coverage amounts quoted by an insurance carrier for services rendered by Klein Chiropractic Institute LLC., are not a guarantee of payment, and that the actual amount of my benefits may be less than expected. I also understand that unless precluded by a contractual and are not guarantee of payment, and that the actual amount of my benefits may be less than expected. I also understand that unless precluded by a contractual agreement between Klein Chiropractic Institute LLC., and the insurance company, I will be responsible for the full amount of the charges, less any amount paid by the insurance carrier.

_____ _____

Signature of Patient or Personal Representative Date

My signature above represents acceptance of the Assignment of Insurance benefits, Acknowledgement Form, Payment Agreement

_____ _____

Name of Patient or Personal Representative Description of Personal Representative's Authority

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**PRIVACY POLICY**

**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.**

**We are required by law to**:

- Maintain the privacy of your Personal Health Information;
- Provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information; and
- Follow the terms of this notice.

We protect your Personal Health information from inappropriate use or disclosure. Our employees, and those of companies that help us service your health care needs, are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services.

We will not disclose your Personal Health Information to another company for their use in marketing their products to you. However, as described below, we will not use and disclose Personal Health Information about you for business purposes relating to your Health Insurance coverage.

The main reasons for which we may use and may disclose your Personal Health Information are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health related benefits or services that may be of interest to you. The following describe these and other uses and disclosures, together with some examples.

**For Payment**: We may use and disclose Personal Health Information to pay for benefits under your Health Insurance coverage. For example, we may review Personal Health Information contained on claims to reimburse, for services rendered. We may also disclose Personal Health information to other insurance carriers to coordinate benefits with respect to a particular plan claim. Additionally, we may disclose Personal Health Information to a health plan or an administrator of an employee welfare benefit plan for various payment related functions, such as eligibility determination, and in review or to assist you with your inquiries or disputes.

**For Health Care Operations**: We may also use and disclose Personal Health Information for our insurance operations. These purposes include evaluating a request for Health Insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose Personal Health Information to Affiliates, and to business associates outside of Klein Chiropractic, LLC., if they need to receive Personal Health information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of Personal Health Information. Examples of business associates are: billing companies, data processing companies, or companies that provide general administrative services. Personal Health Information may be disclosed to reinsurers for underwriting, audit or claim review reasons. We may disclose your protected health information to chiropractic interns that see patients at our office. Communications between you and the doctor may be recorded to assist us in accurately capturing your responses. We may call you by name in the reception area when the doctor is ready to see you. We may disclose as needed your information for the purpose of contacting you to remind you of appointments. With your written authorization, we may use your name or your testimonial on a "New Patient Board", Patients Who Refer Board", in our monthly newsletter as a new patient, someone who referred a new patient, as "Success Story of the Month", or as "Patient of the Month".

Where Required by Law or for Public Health Activities: We disclose Personal Health Information when required by Federal, State or Local Law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing Personal Health Information to a governmental agency or regular with health care oversight responsibilities. We may also release Personal Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

**To Avert a Serious Threat to Health or Safety**: We may disclose Personal Health Information to avert a serious threat to someone's health or safety. We may also disclose Personal Health Information to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

**For Health-Related Benefits or Services**: We may use Personal Health Information to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about Health-related products or services that may be of interest to you.

For Law Enforcement or Specific Government Functions: We may disclose Personal Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**When Requested as Part of a Regulatory or Legal Proceeding**: If you or your estate are involved in a lawsuit or a dispute, we may disclose Personal Health Information about you in response to a court or administrative order. We may also disclose Personal Health Information about you in response to a subpoena, discovery request, or other lawful process by someone else involved I the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Personal Health Information requested. We may disclose Personal Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

**Other Uses of Personal Health Information**: Other uses and disclosures of Personal Health Information not covered by this notice and permitted by the laws that apply to use will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing.

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**INFORMED CONSENT**

**PLEASE READ AND SIGN BELOW:**

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this 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 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.*

*I hereby authorize this office to examine and treat my condition as them deem appropriate through the use of Chiropractic Health Care, and I give my authority for these procedures to be performed. It is understood and agreed that amount paid to our office for X-Rays is for examination only and the X-Ray negatives will remain property of this office, being or] file where they may be seen at anytime while I am an active patient in this office. I also agree that I am responsible for all bills incurred at this office and that this office will not be responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I understand that I may obtain copies of my medical file and any X-Rays taken upon request, and that copying fees may apply for these records.*

*In addition, my signature below acknowledges my Patient Consent for Use and Disclosure of Protected Health Information, and that I have been offered a copy of Klein Chiropractic Institute, LLC. Notice of Privacy Practices. I have had an opportunity to ask questions regarding its content, and by signing agree to the policies mentioned within those documents.*

**PATIENT (or Legal Guardian) Signature: _____ DATE: _____**

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**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE:**

*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 the patient named below, for whom I am legally responsible) by Dr. Newton H. Klein and/or other Licensed Doctors of Chiropractic and Physical Therapy who now or in the future treat me while employed by working or associated with, or serving as back-up for any Doctors of Klein Chiropractic Institute, LLC.*

*I have had an opportunity to discuss with the Doctor and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. 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 sprain. It is not responsible to expect the Doctor to be able to anticipate and explain all risks and complications of a given procedure or any particular visit, and I wish to rely on the Doctor to exercise judgement during the course of the procedure when the Doctor feels at the time, based upon the facts then known, is in my best interests.*

*Chiropractic Treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptoms, disease or condition as a result of treatment at this clinic. I understand that the Chiropractor will use his/her hands as a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the Doctor to exercise professional judgement during the course of any procedures, which he or she feels at the time to be in my best interest. Neither the*

*practice of Chiropractic or Medicine is an exact Science, but relies upon information related by the patient, information gathered during examination, and the Doctor's interpretation, thereof, as well as the Doctor's judgement and expertise in working with like cases.*

*I understand that as part of my Healthcare, this practice originates and maintains Health records describing my Health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other Health professionals who may contribute to my care, a source of information for applying my diagnosis and treatment information to my bill, and a means by which a third-party payer can verify that services billed were actually provided.*

*I have read, or have had read to me, the Office Policies, including the informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing 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 PRINTED NAME: _____**

**PATIENT (or Legal Guardian) SIGNATURE: _____ DATE:_____**

**ASSISTANT'S SIGNATURE: _____ DATE:_____**

**DOCTOR'S SIGNATURE: _____ DATE:_____**