Jacob Klein DC, CCSP®
635 Madison Avenue, 19th Fl
New York, NY 10022

New Patient Intake Form

Patient Data **Date** _____

Title: (Check one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Other _____

First Name_____ **Middle Initial**____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City_____ **State**_____ **Zip Code** _____

Home Phone (____**)**_____-_____ **Work Phone (**____**)**_____-_____

Cell Phone (____**)**_____-_____ **Email** _____

Date of Birth_____/_____/_____ **Sex:** □ Male □ Female

Marital Status: □ Single □ Married □ Other

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other____

Primary Care _____

Name _____

Date of Last Visit_____ **Date of Last Blood Work**_____

Emergency Contact _____

Contact Name_____ **Relationship to Patient** _____

Contact Home Phone (____**)**_____-_____ **Cell Phone (**____**)**_____-_____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

□ Arthritis □ Cancer □ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder □ Stroke
□ Other_____

Surgeries: (Check all that apply to you)

□ Appendectomy □ Cardiovascular procedure □Cervical spine □ Hysterectomy
□ Joint Replacement □ Prostate □ Lumbar spine □ Gall Bladder
□ Brain □ Shoulder □ Thoracic spine □ Knee
□ Carpal Tunnel □ Gastro-intestinal □ Uro-genital □ Hernia
□ Other_____

Allergies: (Check all that apply to you)

□ Eggs □ Fish and Shellfish □ Milk or Lactose □ Peanuts
□ Soy □ Sulfites □ Wheat/Glutens □ Other _____

Social History: (Check all that apply to you)

Caffeine use: □ occasional □ often □ never
Drink Alcohol: □ occasional □ often □ never
Exercise: □ occasional □ often □ never
Chew Tobacco: □ occasional □ often □ never
Cigarettes: □<1 pack/day □ >1 pack/day □ never
Wear Seat Belts: □ occasional □ always □ never
Other_____

Family History: (Check all that apply)

Arthritis: □ Parent □ Sibling Cancer:
□ Parent □ Sibling
Diabetes: □ Parent □ SiblingHeart
Disease □ Parent □ Sibling
Hypertension □ Parent □ Sibling
Stroke □ Parent □ Sibling
Thyroid □ Parent □ Sibling
Other _____

Occupational Activities: (Check one that best describes your job description)

□ Administration □ Business Owner □ Clerical/Secretary □ Computer User
□ Heavy Equipment operator □ Daycare/Childcare □ Construction □ Health Care
□ Food Service Industry □ Medium Manual Labor □ Manufacturing □ Home Services
□ Heavy Manual Labor □ Light Manual Labor □ Executive/Legal □ Housekeeper
□ Other _____

How would you rate your happiness with your body? (least 1-10 most) _____

Over the **last 2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several Days	> half the days	Nearly every day
Little interest or pleasure in doing things:	_____	_____	_____	_____

Feeling down, depressed or hopeless: _____ _____ _____ _____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level								Flexibility			
Difficulty Sleeping											

Please list all current medications being taken: Check here if No Medications: _____.

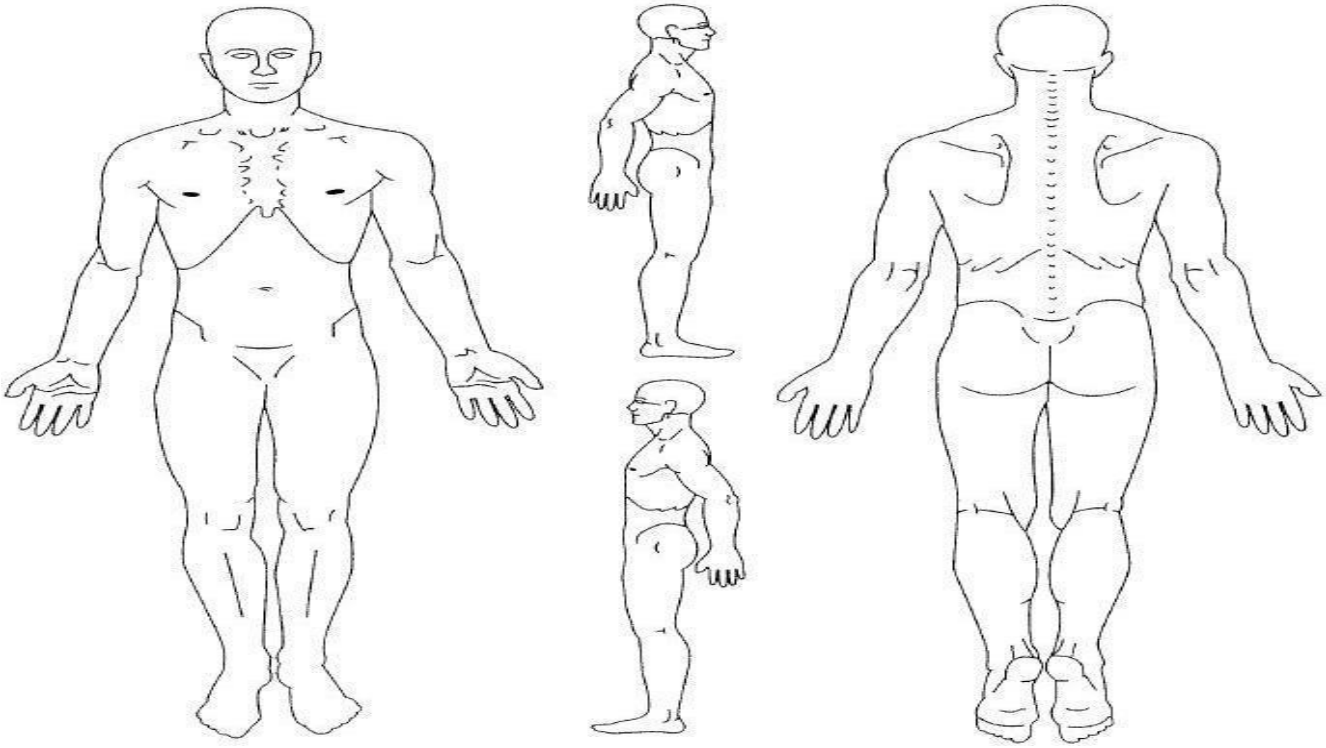
_____

_____

Are you pregnant? Yes_____No_____N/A_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? Month_____Day_____Year _____

Are your symptoms a result of: □ Motor Vehicle Accident □Work related Accident □ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day)
□ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day)
□ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp
□ Dull ache
□ Numb
□ Shooting
□ Burning
□ Tingling
□ Stabbing
□ Other _____

Payment/Insurance Information:

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp □ Auto Insur. □ Medicare □ Medicaid □ Other _____

Personal Health Insurance Carrier:_____Insur. Card ID # _____

Policy Holder's Name: _____Group # _____

Policy Holder's Date of Birth_____/_____/_____ Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □No Date:____/____/____Time:_____am / pm

ASSIGNMENT OF BENEFITS

I, [Patient Name], assign to you, my medical provider, all of my rights and benefits under my auto insurance policy and/or any employee welfare benefit plan for payment for services rendered to me, including but not limited to all of my rights and benefits under the Employee Retirement Income Security Act ("ERISA") applicable to the medical services at issue. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier/employee welfare benefit plan for any and all rights and benefits under ERISA or applicable statute/law, including but not limited to the claim for penalties and fees under ERISA for failure to provide Plan documents and other equitable relief. I authorize you to retain an attorney of your choice on my behalf for collection of your bills and/or to file insurance claims on my behalf for services rendered to me. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage and I specifically authorize you to pursue any administrative appeals conducted pursuant to ERISA.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

If you, my medical provider, initiates a collection proceeding against me, whether through litigation, arbitration or otherwise, in connection with any and all claims unreimbursed and/or under-reimbursed by my insurance carrier, I agree to pay any and all of my medical provider's attorneys' fees and court fees in connection with that proceeding.

PATIENT NAME:_____ DOB:_____

Patient's Signature: _____

Date:____/____/_____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, 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 source of information for applying my diagnosis and surgical information to my bill:
a means by which a third-party payer can verify that services billed were actually provided; and
a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for marketing purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:_____

_____

I authorize medical information to be released to my health insurance carrier including Medicare/CMS for payment of services rendered, to other treating or referring/referral physicians, my attorneys representing any potential claim, and my name, email address and telephone number for marketing purposes.

PATIENT NAME:_____ DOB:_____

Patient's Signature: _____

Date:____/____/_____

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HIPAA PRIVACY NOTICE

(effective 4/14/03)

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. In 1996, Congress as part of the (HIPAA) Health Insurance Portability and accountability Act, orders that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals, and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for bank accounts, credit cards, and even video rentals.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

By law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows, also for prescription to be called into your pharmacy and for scheduling of surgery in a hospital.

Additionally, none is needed in the course of carrying out health care operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.

However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent.

Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marketing a product to you.

Medical information about you may be released for research and public health uses, as long as you are not individually identified.

You are guaranteed access to review your medical record, and you may amend

the record if you believe it to be incomplete or inaccurate.

You have the right to review when and to whom your information was released.

You may suggest additional restrictions with regard to certain issues and disclosures, if you wish.

Portions of this notice may be modified, as long as you are notified.

Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.

The law requires that you acknowledge receipt of this notice; this has been included on the signature release on your registration form.

Acknowledgement:

Patient name: _____ Signature: _____

Relationship to patient: _____Date: _____

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Informed Consent -- Chiropractic Care

Jacob Klein DC 012684

Patient's Name:

Date of Care Plan:

Instructions: This document relates to your Informed Consent for care. Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

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X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name:_____

Patient's Signature:_____

Date of Signature: ___/___/____

Name of Parent / Guardian / Authorized Representative: _____

Signature:_____

Date of Signature: ___/___/____

--OFFICIAL--

CREDIT CARD AUTHORIZATION FORM

CREDIT CARDHOLDER INFORMATION										
NAME ON CREDIT CARD										
TYPE OF CREDIT CARD		VISA		MC		AMEX		DISCOVER		OTHER
CARD NUMBER										
EXPIRATION DATE	CVV:									

BILLING ADDRESS		Same as on file			
CITY		STATE		ZIP CODE	
PHONE		EMAIL			

AUTHORIZED USER OF CREDIT CARD	
NAME	
COMPANY	Klein Clinic
PHONE NUMBER	
EMAIL ADDRESS	
DRIVER'S LICENSE NUMBER	
RELATION TO OWNER	Office Manager
TYPE OF CHARGES	Medical Services
AUTHORIZED AMOUNT	Per Explaination of Benefits
DATE OF CHARGE	Per Dates of Service

AUTHORIZATION OF CARD USE

___ -- I certify that I am the authorized holder and signer of the credit card reference above. I certify that all information above is complete and accurate.

___ -- I hereby authorize collection of payment for all charges as indicated above. Charges may not exceed the amount listed above in the "AUTHORIZED AMOUNT" field. I understand this is only for up to this amount during the time period of "DATES OF CHARGES" referenced above. If additional charges are going to be authorized a new form will have to be completed.

CARDHOLDER NAME			
SIGNATURE		DATE	