WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

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

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

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

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ ____/____

❑ Credit Card - Enter card # above (if accepted)

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

five 5

REASON FOR VISIT

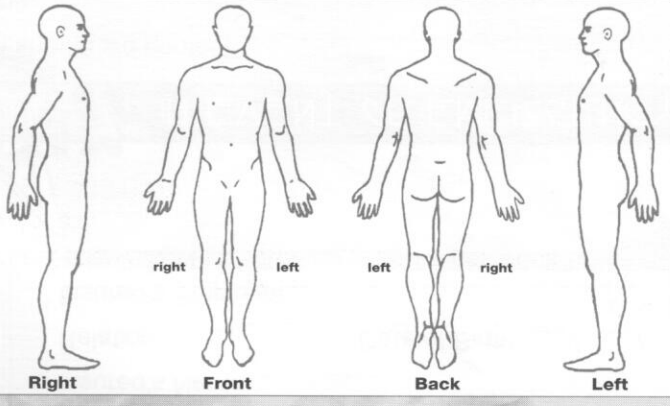
Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur? _____
Please explain what happened: _____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain: _____

Using the adjacent body charts, please circle all affected areas.

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? _____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name: _____
Clinic phone#: _____



six 6

HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History: _____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes ____ hours per week
Do you smoke? ❑ No ❑ Yes How much? _____ How long? _____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For woman: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of 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 financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other 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 to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials	Date
	___/___/___

Comments

Initials	Date
	___/___/___

Comments

Initials	Date
	___/___/___

Comments

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

BODY CHART

REASON FOR VISIT

Name: _____ Date: __/__/__ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Reason for visit: ❑ Work Accident ❑ Sports Injury ❑ Car Accident ❑ Trauma/Injury ❑ Chronic Pain ❑ Routine Adjustment

Explain what happened: _____

When did condition begin? __/__/__ Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine Have you had this or similar conditions in the past? ❑ Yes ❑ No

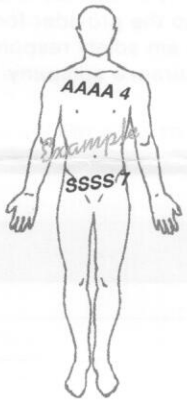
If so, please explain: _____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

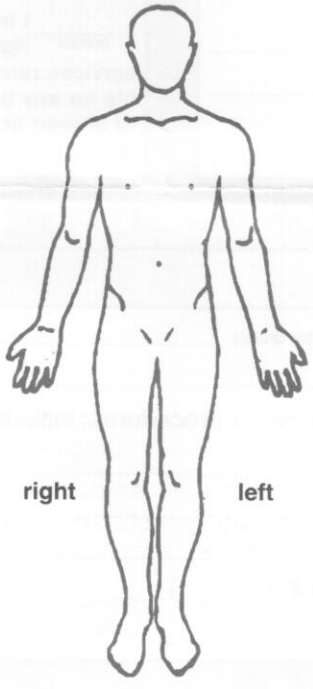
Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.

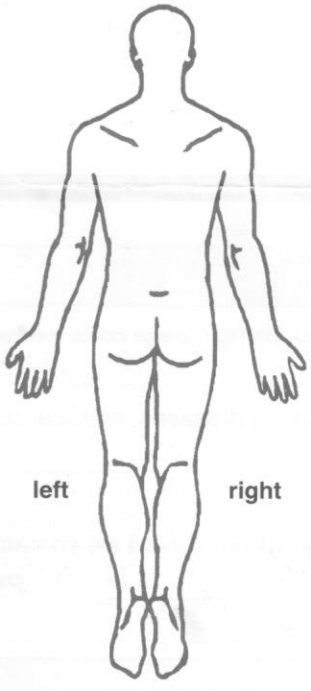


Example

Right



Front



Back

Left

DOCTOR'S NOTES

_____

_____

_____

_____

_____

WELCOME TO THE OFFICE OF DR. JOHN GIUGLIANO

Financial Policy

Thank you for choosing the office of Dr. John Giugliano as your health care provider. For our part, our primary goal is to provide you with the highest quality chiropractic care. Your part is to read and sign the following financial policy. This policy is to insure that there is no misunderstanding or confusion as to your financial responsibilities.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH AND PERSONAL CHECK

INSURANCE PATIENTS

If we are a participating in-network provider with your insurance company, all insurance copays and/or applicable deductibles are to be paid at the time of service.

If we are accepting your insurance as an out-of-network provider, you will be responsible for any applicable deductibles and/or coinsurance to be paid at the time of service.

It is your responsibility to obtain any required referrals prior to your first visit. If a referral was required but not obtained, you will be fully responsible for all fees incurred.

Some insurance carriers require authorization for your initial visit and/or subsequent visits. This office will obtain any authorization required by your insurance carrier regarding your care. If during the course of treatment your insurance carrier denies authorization, you will be responsible for a set fee for non-covered services. We will always try to inform you if your insurance carrier has failed to authorize your treatment as soon as possible.

With regards to no-fault insurance, under New York State Law, a $200.00 deductible ***may*** be applicable to your treatment in this office.

NON-INSURANCE PATIENTS

Patients are responsible for initial exam fees and radiology (if applicable), and any subsequent visits. All payments are due at the time of service.

If you wish to request any financial arrangements, you may do so directly with our office manager, Deborah, not with the front desk staff or the doctor.

APPOINTMENT CANCELLATION

If for any reason you cannot keep your scheduled appointment, kindly notify our office within 24 hours.

* * * * * *

It is this office's pledge to assist you in understanding your insurance policy and how it affects your care. Please do not hesitate to ask for clarification of your coverage.

I have read, understand and agree to the financial policy as stated above.

_____ _____

Patient Signature or Responsible Party **Date**

WELCOME TO THE OFFICE OF DR. JOHN GIUGLIANO

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we begin any health care plan, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment and coordination of care.
2. I understand that the office of John Giugliano, D.C., P.C. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out my treatment, payment and coordination of care, such as appointment reminders, patient recall, insurance items and any call pertaining to my clinical care. I also understand that John Giugliano, D.C., P.C. may mail or email to my home or other designated location any items that assist the practice in carrying out my treatment plan, payment and coordination of care, such as appointment reminder cards and patient statements. My consent need only be obtained one time for all subsequent care rendered to me in this office.
3. If I was referred to this office by a third-party, I understand that a thank you letter may be sent to that individual.
4. I understand that my records will be kept on premise with the exception that they may be stored in an offsite facility or utilized by office personnel at another location. My records will never be left in an unsecured location or be used for any purpose other than what is stated above.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. By signing this form, I am consenting to John Giugliano, D.C., P.C.'s use and disclosure of my Patient Health Information in this manner.

Print Name_____ Date_____

Patient Signature_____

WELCOME TO THE OFFICE OF DR. JOHN GIUGLIANO

Physician Information Sheet

	Name / Address / Phone#
Primary Care Physician	
OB/GYN	
Specialist(s)	
Specialist(s)	

By signing below, I hereby acknowledge receipt of the HIPAA Notice Of Privacy Practices form from the office of Dr. John Giugliano.

Print Name_____ Date_____

Patient Signature_____ Date_____

John Giugliano, D.C., P.C.
NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003, Revised: January 2004. **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.**

John Giugliano, D.C., P.C. is required by law to protect the privacy of health information that may reveal your identity ("Prtected Health Information: or "PHI"), and to provide you with a copy of this Notice which describes the health information privacy practices John Giugliano, D.C., P.C. (including its staff)

When John Giugliano, D.C., P.C. uses or discloses PHI it is required to abide by this Notice (or amended Notice in effect at the time of the use or disclosure of PHI).

If you have any questions about this notice or would like further information or would like to discuss any privacy concerns you may have contact the Privacy Officer at 516-679-3100.

WHO WILL FOLLOW THIS NOTICE? The privacy practices described in this notice will be followed by:

- Any health care professional who treats you as an outpatient in this facility;
- Any business associates of John Giugliano, D.C., P.C. (as defined in this Notice).

PROTECTED HEALTH INFORMATION OR PHI
John Giugliano, D.C., P.C. is committed to protecting the privacy of information gathered about you while providing health-related services. This includes any information that may identify you in connection with your health care. Some examples of Protected Health Information are:

- information about your health condition (such as medical conditions and test results you may have);
- information about your health care benefits under an insurance plan ;
- geographic information (such as where you live or work);
- demographic information (such as your race, gender, ethnicity, or marital status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number)

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Treatment, Payment And Health Care Operations

John Giugliano, D.C., P.C. its staff, other health care professionals and professional trainees may use your PHI or share it with others to the extent that such information is necessary in order to treat your medical condition, obtain payment for that treatment, and carry out our normal health care operations. Your PHI may also be shared with health care providers so that they may jointly perform certain treatment, payment activities and health care operations. It is our practice to request your written consent for disclosures to insurance companies that are responsible for your bill. Below are further examples of how your information may be used without your specific authorization.

Treatment. John Giugliano, D.C., P.C. may share your PHI with other medical professionals who are involved in your care, and they may in turn use that information or share it with others in order to diagnose or treat you. This office also may contact you to provide you with appointment reminders or information about treatment alternatives or other health care related benefits or services, which may be of interest to you. While we will take reasonable steps to safeguard the privacy of your PHI, certain disclosures of your PHI may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your PHI. For example, during the course of a treatment session other patients in the treatment area may see or overhear discussion of your PHI. These "incidental disclosures" are permissible.

Communication Barriers. John Giugliano,D.C., P.C. may use and disclose your health information if he is unable to obtain your consent because of substantial communication barriers, and believes you would want him to treat you if he could communicate with you.

Payment. John Giugliano,D.C., P.C may use your PHI or share it with others so that he can obtain payment for health care services he provides to you. For example, John Giugliano,D.C., P.C may share information about you with your health insurance company in order to obtain reimbursement after you have been treated. In some cases John Giugliano,D.C., P.C may share information about you with your health insurance company to determine whether it will cover your treatment. He might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment.

Family and Friends Involved In Your Care

John Giugliano,D.C., P.C may disclose your PHI to a family member, personal friend or any other person identified by you provided that you are present for, or otherwise available prior to the disclosure, you have the capacity to make your own health care decisions, you have been given an opportunity to object to the disclosure and have not done so. If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests, provided that we only disclose information that is directly relevant to the person's involvement with your health care or payment related to your health care.

As Permitted or Required By Law

John Giugliano,D.C., P.C may use your PHI and share it with others, as required by law. For example, John Giugliano,D.C., P.C will disclose information if required to do so pursuant to a court order.

Pursuant to a Court Order. John Giugliano,D.C., P.C may disclose your PHI pursuant to an order of a court of record requiring disclosure upon a finding by the court that the interest of justice significantly outweigh the need for confidentiality.

Public Health Activities

Public Health Activities. John Giugliano,D.C., P.C may disclose your PHI to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your PHI with government officials that are responsible for controlling disease, injury or disability. We may also disclose your PHI to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if the law permits it to do so.

Reports to Employers Regarding Work Related Illnesses or Injuries. John Giugliano,D.C., P.C may disclose relevant PHI to your employer if he provides health care services to you at the request of your employer related to medical surveillance of the workplace or to evaluate whether you have a work related illness or injury and the employer is required by law (such as Workers Compensation rules) to obtain such information.

Victims Of Abuse, Neglect Or Domestic Violence. John Giugliano,D.C., P.C may release your PHI to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if I reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. John Giugliano,D.C., P.C may release your PHI to government agencies authorized to conduct audits, investigations, and inspections of the facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Judicial and Administrative Proceedings. John Giugliano,D.C., P.C may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement. John Giugliano,D.C., P.C may disclose your PHI to law enforcement officials for the following reasons:

- To comply with a court order, grand jury subpoena or administrative subpoena that is legally enforceable;
- To report certain types of wounds or physical injuries if required to do so by law;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person, provided that only limited PHI will be disclosed;
- You are the victim of a crime and: (1) John Giugliano,D.C., P.C has been unable to obtain your consent because of an emergency or your incapacity; (2) law enforcement officials represent that they need this information immediately to carry out their law enforcement duties; and (3) in the doctor's professional judgment disclosure to these officers is in your best interests;
- In the event of your death, if the doctor suspects that your death resulted from criminal conduct;
- It is necessary to report a crime that occurred on our property; or
- It is necessary to report a crime discovered by the doctor when providing offsite emergency medical care.

National Security And Intelligence Activities Or Protective Services. John Giugliano,D.C., P.C, may disclose your PHI to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Workers' Compensation. John Giugliano,D.C., P.C may disclose your PHI to the extent legally required for workers' compensation or similar programs that provide benefits for work-related injuries.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR PHI

Right To Inspect And Receive Copies of Records

You, or your legally authorized representative, have the right to inspect and obtain a copy of any medical records that are used to make decisions about your care and treatment, and any billing records, for as long as John Giugliano,D.C., P.C maintains this information. To inspect or obtain a copy of any of these records, you must submit a request in writing to this office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The fee, at the time of the publication of this Notice, is $0.75 per page and must generally be paid before or at the time we give the copies to you. A waiver of the fee may be given in certain circumstances, upon the approval of the office manager.

Right To Amend Records

If you believe that the health information John Giugliano,D.C., P.C has about you is incorrect or incomplete, you may ask John Giugliano,D.C., P.C to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to this office. Your request should include the reasons why you think we should make the amendment.

If John Giugliano,D.C., P.C denies part of or your entire request, we will provide a written notice that explains the reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.

Right To An Accounting Of Disclosures

You have a right to request an "accounting of disclosures" made within the last 6 years but not prior to April 14, 2003, which is a list with information about certain disclosures of your PHI that John Giugliano,D.C., P.C has made to others. An accounting of disclosures will not include:

- Disclosures John Giugliano,D.C., P.C made to you or to your personal representative;
- Disclosures made pursuant to your written authorization;
- Disclosures we made in order to provide you with treatment, obtain payment for that treatment, or conduct our its normal business operations made for treatment, payment or health care operations;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your PHI;
- Disclosures that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers; or
- Disclosures made before April 14, 2003.

The accounting of disclosures may be obtained by writing to this office. Your request must state a time period for the disclosures you want included. We may charge you for the cost of providing more than one accounting of disclosures in any 12-month period. We will notify you of any such charge prior to fulfilling your request.

Right To Request Additional Privacy Protections

You have the right to request that John Giugliano,D.C., P.C restrict its use and disclose of your PHI for purposes related to treatment, payment or health care operations. You may also request that we limit how it discloses information about you to family or friends involved in your care or payment for your care

John Giugliano,D.C., P.C is not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, we do agree, we will be bound by its agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases we will need your permission before we can revoke the restriction.

Right To Request Confidential Communications

You have the right to request that you receive PHI by alternative means of communication or at alternative locations. For example, you may ask that we contact you at work instead of at home. Such requests must be in writing. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

6. How to File a Privacy Complaint

You may register a privacy complaint with John Giugliano,D.C., P.C. Complaints to John Giugliano,D.C., P.C must be in writing and submitted to: 2429 Merrick Road, Bellmore, New York 11710. ATTN: Privacy Officer. You will not be retaliated against or denied any health services if you file a complaint. If you require further assistance, please send your complaint to either the Office for Civil Rights ("OCR") regional office listed below that has jurisdiction over Nassau County, or to the OCR headquarters. The addresses are:

OCR Headquarters, Robinsue Frohboese, Acting Director, Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W.Room 509F, HHH Building, Washington, D.C. 20201

Region II: New York, Michael Carter, Regional Manager, Jacob Javits Federal Building,26 Federal Plaza, Suite 3312, New York, NY 10278, Telephone: 212-264-3313, Fax: 212-264-3039, TDD: 213-264-2355