There's no time to be side-lined….
I'll get you back in the game.

Dr. Joe De Carlo

Certified Chiropractic Sports Physician
829 Second St. Pike, Richboro, PA 18954

PATIENT INFORMATION

Date _____ Name _____ DOB _____ Marital Status S M D W SEP

Address _____ City/State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Name of Employer _____ Occupation _____

Whom may we thank for referring you? _____

May we contact you via e-mail? No Yes _____

May we text you to confirm your appointments? No Yes

INSURANCE INFORMATION

Primary Insurance Co. Name & Address _____

_____ Insurance Co. Telephone Number _____

ID # _____ Group # _____ **Co-Pay Amt. $**_____

Name of Insured _____ Insured's DOB _____

Insured's Employer _____ Relation to patient _____

Insured's Address (if different from **patient's**) _____

ACCIDENT INFORMATION

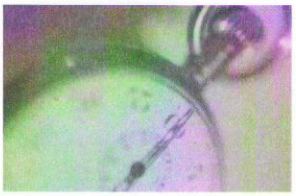
Claim Number: _____ Adjuster Name: _____

Insurance Company: _____ Insurance Phone: _____

Claim mailing address: _____

Date of accident: _____ Brief description of accident: _____

_____



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REASON FOR VISIT

Please describe your major complaints/symptoms: _____

Caused by a strain? ____ Stress? ____Fall? ____ Overuse? _____Exercise? _____ Work Related?

_____ Auto Accident? _____ Unknown? ____When did this occur? _____ Reoccurring?

What activities/movements/positions make your symptoms better or worse?

Worse: _____

Better: _____

How often do you experience your symptoms? ☐ Constantly (76-100% of day) ☐ Frequently (51-75% of day) ☐ Occasionally (26-50% of day) ☐ Intermittently (0-25% of day)

Describe the nature of your symptoms. ☐ Dull Ache ☐ Shooting ☐ Sharp ☐ Burning ☐ Numb ☐ Tingling

Have you been treated by another Dr. for this condition? ___M.D. ___D.O. ___D.C. ___Other

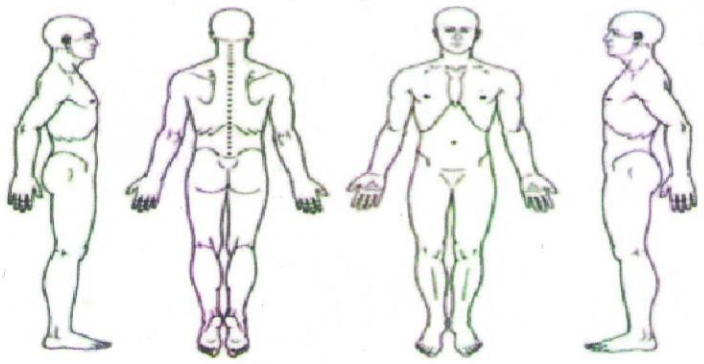
Name of Dr. _____ Treatment _____

Were X-rays/MRI taken and when? _____ Results _____

PLEASE RATE YOUR PAIN LEVELS

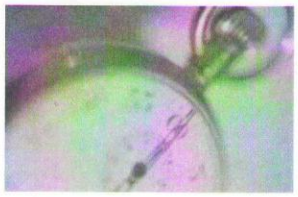
	None					Moderate					Unbearable
At Best	0	1	2	3	4	5	6	7	8	9	10
At Worst	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10

Please indicate all areas where you have pain and/or other symptoms with an X.



Patient Signature _____ Date _____

Doctor's Notes: _____



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FINANCIAL RESPONSIBILITY

I understand that the physician's billing staff will file all claims for services rendered to my current insurance carrier. I, however, acknowledge that I am responsible throughout the course of treatment for all co-payments, co-insurance charges, unmet yearly deductible amounts, as well as non-covered service fees. Furthermore, I acknowledge that I am also responsible for any balances that may be due to the physician due to:

1. Out of network charges
2. Terminated/changed coverage
3. Exhausted automobile accident benefits
4. Denied worker's compensation claim
5. Lack of insurance coverage
6. Denied payment due to lack of referral obtained from primary physician
7. Failure on the part of the patient to respond to insurance carrier correspondence
8. Failure on the part of the patient to respond to coordination of benefits inquiry
9. Misquoted benefits/network inclusion by insurance company
10. Non-payment/delay in payment from insurance company beyond 60 days
11. any other reason not already mentioned for non-payment of claims.

I understand that failure to meet my financial responsibility will result in collection agency action.

I acknowledge that it is my responsibility to revoke or revise this permission by written notice as needed.

Patient's name: _____ Patient Signature: _____ Date: _____

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE

I authorize Dr. Joe De Carlo to furnish my insurance company with medical information they may request regarding my condition or treatment. Furthermore, I authorize my referring healthcare provider to release any diagnostic reports and/or surgery reports to Dr. Joe De Carlo.

I certify that I have read and understood the above policies and financial obligations. I agree to be responsible for payment of all service rendered on my behalf or my dependents according to the above terms.

Your signature is necessary before any treatment or advice is rendered.
I certify that I am 18 years of age and/or the legal guardian/guarantor of the patient named below.

Printed Name of Patient _____ Date _____

Signature of Patient and/or legal Guardian _____

NOTICES OF PRIVACY PRACTICES

A federal regulation, known as the "HIPAA Privacy Rule", requires that we provide detailed notice in writing of our privacy practices. This describes how medical information about you may be used and disclosed. (HIPAA – Health Insurance Portability and Accountability Act)

If you have any questions about this Notice please contact our office staff at 215-364-1331

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent You will be asked by your medical professional to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your medical professional will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your medical professional, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the medical professional's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the medical professional's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician from whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physical medical professional may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physical medical professional shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or

disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

2. Your Rights Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

3. Complaints

Complaints about your Privacy rights, or how we have handled your health information should be directed to Joe De Carlo, DC, CCSP by calling this office. 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 Bldg., Washington, DC 20201

This notice is effective as of ____/____/____

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

By the way of my signature, I provide Dr. De Carlo with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

_____
Patient's Name (PRINT)

_____ _____
Patient's Signature Date