DiSalvatore Chiropractic
1956 West Prospect Road Ashtabula, Ohio 44004
(440) 992-0160 (440) 998-0121(Fax)
www.disalvatorechiropractic.com

WELCOME TO OUR OFFICE….

The doctors of DiSalvatore Chiropractic are committed to serving those people who desire conservative chiropractic treatment for their health care needs. This commitment begins with collecting enough information from the patient about their condition to arrive at a logical diagnosis. Without a logical diagnosis, treatment options are less effective. This wastes both time and money.

The following forms will provide us with much of the information that will help us help you. Some forms are long and many questions at first may seem irrelevant; however, each question may lead us closer to pinpointing your exact problem and/or aggravation of your complaint.

So please take the extra time to complete all forms to the best of your ability.

YOUR HEALTH DEPENDS ON IT.

Dr. Tom DiSalvatore and Staff

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CONFIDENTIAL PATIENT INFORMATION

Date:_____ **Please circle your preferred method of contact:**

Patients Name: _____ **Home Phone:** _____

Address: _____ **Cell Phone:** _____

City: _____**State:** _____**Zip:**_____ **Email:** _____

SS#:_____ **Marital Status:** S M D W

Date of Birth: _____**Age:**_____ **Spouse's Name:** _____

Occupation: _____ **Number of Children:** _____

Employer: _____ **Address**: _____

Person to contact in case of emergency (Name and Phone):_____

Have you ever been under Chiropractic care? ____ Yes ___ No If so, Who? _____

How did you hear about our office? _____

INSURANCE:
Insurance Company: _____**Insured Name (if different from patient):** _____

Relationship to Patient: _____ **Insured Date of Birth:** _____

SS#: _____ **Employer:** _____

Is your condition due to an auto accident or job related injury? _____ Yes _____No

OUR OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

I understand and agree that health and accident polices are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office of Thomas D. DiSalvatore, D.C. Inc. 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 Thomas D. DiSalvatore, D.C. Inc. 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 authorize the office of Thomas D. DiSalvatore, D.C. Inc. to release any medical information necessary to process my insurance claims. I further authorize payment by my insurance company to Thomas D. DiSalvatore, D.C. Inc. for services rendered by the doctors of Thomas D. DiSalvatore, D.C. Inc. if I have not paid for the services. Any overpayment by the insurance company will be returned to the patient or the insurance company. This authorization will continue in effect until I give written authorization not to release such information. I authorize payment of medical benefits to Thomas D. DiSalvatore, D.C., Inc. for services provided.

I will be paying today by: _____ Cash _____ Check _____ Credit Card

____MasterCard ____ Visa ____ Discover Card # _____ Exp. Date _____CVV_____

All accounts not paid within 60 days will automatically be put through on your credit card.

Signature: _____ Date_____

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CONFIDENTIAL HEALTH HISTORY

FAMILY HEALTH HISTORY

Check any of the following diseases that you, your mother, father, sister, brother, son or daughter have had. Please specify what type (if applicable) and who has had the diseases below:

_____ Cancer	_____ Kidney Disease	_____ Clotting Disorder
_____ Lung Disease	_____ Heart Disease	_____ Osteoporosis
_____ Diabetes	_____ Hypertension	_____ Psychological Disorder
_____ Septicemia	_____ Stroke/Brain Attack	_____ Gastrointestinal Disorder

YOUR PERSONAL HEALTH HISTORY

Check any of the following diseases that apply to just yourself:

____ Measles ____ Polio ____ Tuberculosis ____ Epilepsy ____ Anemia ____ Mumps ____ Small Pox ____Eczema
____ Chicken Pox ____ Arthritis ____ Whooping Cough____ Rheumatic Fever ____ Thyroid ____ HIV Positive

Exercise	**Work Activity**	**Habits**	
_____ None	_____ Sitting	_____ Smoking	Packs/Day _____
_____ Moderate	_____ Standing	_____ Alcohol	Drinks/Week _____
_____ Daily	_____ Light Labor	_____ Coffee/Caffeine	Cups/Day _____
_____ Heavy	_____ Heavy Labor	_____ High Stress Level	Reason _____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

Musculoskeletal
_____ Low Back Pain
_____ Pain Between Shoulders
_____ Neck pain
_____ Arm pain
_____ Joint Pain/Stiffness
_____ Walking Problems
_____ Difficulty Chewing/Clicking Jaw
_____ General Stiffness

Nervous System
_____ Nervous
_____ Numbness
_____ Paralysis
_____ Dizziness
_____ Forgetfulness
_____ Confusion/Depression
_____ Fainting
_____ Convulsions
_____ Cold/Tingling Extremities
_____ Stress

General
_____ Fatigue
_____ Allergies
_____ Loss of Sleep
_____ Fever
_____ Headaches

Gastro-intestinal
_____ Poor/Excessive Appetite
_____ Excessive Thirst
_____ Frequent Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Hemorrhoids
_____ Liver Problems
_____ Gall Bladder Problems
_____ Weight Trouble
_____ Abdominal Cramps
_____ Gas/Bloating after meals
_____ Heartburn
_____ Black/ Bloody Stool
_____ Colitis

Genito-Urinary
_____ Bladder Trouble
_____ Painful/Excessive Urination
_____ Discolored Urine

CVR
_____ Chest Pain
_____ Short Breath
_____ Blood pressure problems
_____ Irregular heartbeat

CVR Cont'd
_____ Heart Problems
_____ Lung Problems/Congestion
_____ Varicose Veins
_____ Ankle Swelling

EENT
_____ Vision Problems
_____ Dental Problems
_____ Sore Throat
_____ Ear Aches
_____ Hearing difficulty
_____ Stuffed Nose

Male/Female
_____ Menstrual Irregularity
_____ Menstrual Cramps
_____ Vaginal Pain/Infection
_____ Breast Pain/ Lumps
_____ Prostate

Females Only

When was your last period?_____
Are you pregnant? _____ Yes _____ No

Signature: _____ Date: _____

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CONFIDENTIAL HEALTH HISTORY

YOUR PERSONAL HEALTH HISTORY

Do you have a pacemaker? Y / N When was it implanted? _____

Have you ever had a knee, hip or shoulder replacement? (Please circle) Y / N

Which knee? (Please circle) right left

Which hip? (Please circle) right left

Which shoulder? (Please circle) right left

What medications or drugs are you taking? Please list below OR see medication list provided: (check here) _____

Medications/Doses::_____
_____
_____
_____
_____
_____
_____

What nutritional supplements are you taking?

Supplements/Doses:_____
_____
_____
_____
_____

Surgeries/operations and dates:
_____
_____
_____

Serious illness, accidents and infectious diseases and dates:
_____
_____
_____

Allergies:_____
_____
_____
_____

Signature: _____ Date: _____

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Financial Policy

Insurance Coverage

Welcome to **DiSalvatore Chiropractic.** Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year. Our clinic will verify your benefits online, however, we are not responsible for your insurer's final payment and benefit determinations.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)
A____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.
B____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.
Health Insurance: (please initial)
C____I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment.

Cancellation/No Show Policy
PLEASE READ CAREFULLY

In an effort to enhance each of your therapy visits, we strongly encourage regular attendance. Due to a recent increase in cancellations and no shows, we have had to establish the following CANCELLATION/NO SHOW policy.

A **$50.00** fee will be charged for all patients who cancel or do not show for their appointment. In the event of an unexpected conflict, morning appointments that must be cancelled should be phoned in by 8a.m. and afternoon appointments by 12:00pm to avoid the **$50.00** fee.

Each doctor has a limited amount of treatment spots available each day, so your cancellation notice allows us to place another patient in your cancelled appointment slot to receive needed treatment.

Certain accident claims adjusters and insurances expect regular attendance as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by our doctors to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

For patients who NO CALL/NO SHOW for three visits in a row, your treatment will be placed on hold and a follow-up appointment with the doctor will be scheduled to discuss your situation.

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Consent for Purposes of Treatment, Payment and Healthcare Operations (HIPAA)

I, _____ [Name of Individual] consent to DiSalvatore Chiropractic's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Print
Name_____Signature:_____Date:_____

Acknowledgement of Receipt of
Notice of Privacy Practices
This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of DiSalvatore Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by DiSalvatore Chiropractic and informs me of my rights with respect to my protected health information.

_____ _____
Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____
Today's Date *If Legal Representative, Indicate Relationship*

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INFORMED CONSENT

I understand that DiSalvatore Chiropractic performs manual therapy techniques, physical therapy procedures, exercise and acupuncture as part of its treatment protocol. Although chiropractic care is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that any form of treatment has potential risks and complications associated with it:

Risks of Chiropractic Treatment

Soreness	Like exercise, it is common to experience muscle soreness in the first few treatments.
Dizziness	Temporary symptoms like dizziness and nausea may occur, but are relatively rare.
Rib/Joint Injury	This may include rib fracture or rib cartilage sprain. Conditions like physical defects, osteoporosis, or arthritis may increase this risk. Treatment precautions are taken to minimize the risk.
Stroke	While strokes can happen from a multitude of factors, strokes from chiropractic adjustments are rare and no greater than the general medical population. Studies estimate the risk at 1:1 million to 1:5 million. *(Journal of the CCA Vol 27, No.2 June, 1993).* Risk is decreased by minimizing neck rotation. That is the protocol we utilize in our clinic.
Burns	Electric therapies generate heat and may cause a burn, resulting in a temporary increase of pain and possible blistering. Our machines are calibrated regularly, and individual patient pads are used.

Risks of Acupuncture & Dry Needling Treatment

Drowsiness	May occur after treatment (infrequently). If affected, you are advised not to drive
Minor bleeding Or bruising	May occur after acupuncture (~3% of patients) or during cosmetic procedures
Pain	During treatment may occur (~1% of patients)
Increased Symptoms	Worsening after treatment (< 3% of patients). You should tell your doctor about this, but it is usually a good sign that acupuncture will be beneficial
Fainting	Can occur in certain patients, particularly at the first treatment.
Pneumothorax	This may occur when treating points over the lung.
Infection	Rare. We use pre-sterilized, one-time-use, disposable needles to reduce this risk

Alternative Treatments Options & Risks

Non-treatment	Neglecting care can increase pain, accelerate degeneration, cause nerve damage, increase inflammation, and worsen pathology. This may complicate treatment, making it more difficult and less effective the longer it is postponed.
Rest or Exercise	Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed-rest contributes to weakened bones and joint stiffness. Exercises alone are of limited value, but do not correct injured nerve and joint tissues.
Medications	Can reduce pain or inflammation. Long-term use/overuse of drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Surgery	May be necessary for joint stability or serious disk rupture. Risks include pain, unsuccessful outcome, reaction to anesthesia, prolonged recovery, serious complications or death.

Treatment Results

I realize that the practice of medicine, including chiropractic, is not an exact science. I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to apply to all my present and future treatments at this clinic.

_____ _____ _____

Signature of Patient Date Staff Initials