Rivano Chiropractic
Health Center LLC
Sports & Family Care

135 Columbia Turnpike, Suite 301
Florham Park, NJ 07932
*T: (973) 845-6282 * F: (973) 845-6283*
drrivano@rivanochiropractic.com

Name_____Date_____

Social Security Number_____Date of Birth_____Age_____

Address_____

City, State, Zip Code_____Home Phone #_____

Cell Phone #_____Email Address_____

□ Married □ Single □ Divorced □ Widowed □ Engaged □ Domestic Partner

Children □ Yes □ No If yes, how many son(s)_____daughter(s)_____

Employer_____ Occupation_____

Employer's Address_____

City, State, Zip Code_____Work Phone #_____

Emergency Contact_____ Relationship_____

Home Phone #_____Cell Phone #_____Work#_____

Whom May We Thank For Referring You?:_____

If there is anyone you know that may benefit from our services kindly provide their name, phone number, and/or email so we may contact them.

_____

Insurance Information

Insurance Carrier_____

ID#_____Group #_____

Authorization for Release of Medical Records to Spouse, Parent, Guardian, or other (please specify)

I,_____give express written consent to the physician(s) and staff of this practice to disclose health information pertaining to my health and medical records to_____ who is spouse/friend/parent/guardian.

Assignment and Release:

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Rivano all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when treatment is no longer rendered at the office named above or one year from the date signed below.

_____Date:_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Name: **Date:**

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□ Male □ Female Hand Dominance □ Right □ Left Height_____Weight_____

What is the specific reason for today's visit (**Primary Chief Complaint**)_____

_____

_____

When did your symptoms initially begin and when was the most recent episode that you recall? **(Mark down the date of onset that these symptoms began)**:_____

Is there any other issue that you would like to discuss other than your chief complaint?_____

Was there a **specific mechanism of injury**? □ Yes □ No If Yes, please check off one of the following:

□ Trauma	□ Fall	□ Car Accident	□ Athletic Injury	□ Accident

What is the pain **frequency**?: □ Constant - 100% □ Frequent - 75% □ Intermittent - 50% □ Occasional - 25%

Is the **severity**: □ Mild □ Mild to Moderate □ Moderate □ Moderately Severe □Severe

Is the pain getting progressively worse? □ Yes □ No How long does the pain last?_____

Is the pain present **10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90% or 100%** of the **day?**

What makes the **pain worse**?_____

What makes the **pain better**?_____

If the pain **Radiates (travels)**, describe where it radiates to:_____

What **type of pain** are you experiencing? **(check all that apply)**

□ Aching	□ Boring	□ Burning	□ Cramping	□ Deep	□ Dull	□ Heaviness
□ Numbness	□ Pins & Needles	□ Radiating	□ Sharp	□ Shooting	□ Spasm	□ Stabbing
□ Stiffness	□ Swelling	□ Throbbing	□ Tingling	□ Weakness	□ Other	

Does it interfere with **(check all that apply):**

□ Daily Routine	□ Recreation	□ School	□ Sex Life	□ Sleep	□ Social Life	□ Work

Which **activities or movements are painful** to perform **(check all that apply)**?

□ Bending	□ Climbing Stairs	□ Coughing	□ Doing Housework	□ Doing Laundry
□ Doing Yard Work	□ Driving	□ Exercising	□ Getting Dressed	□ Getting In/Out of Vehicle
□ Lying on Back	□ Lying Down	□ Lying on Side	□ Lying on Stomach	□ Reaching Overhead
□ Sitting	□ Sleeping	□ Sneezing	□ Squatting	□ Standing
□ Turning Head While Driving	□ Using a Computer	□ Using the Bathroom	□ Walking	□ Other

Rate the severity of your pain on a numeric scale of **1 (least amount of pain) to 10 (severe pain):**_____

Name: Rivano Chiropractic Health Center LLC Sports & Family Care **Date:**

Is the pain worse in the: □ Morning □ Afternoon □ Night

List all **medication(s)** you are currently taking and what **dosages** if known?

Are you **allergic to any medications**? □ Y □ N If yes, which one(s) & what type of reaction occurred?

Please provide us with the **name and telephone number** of your **primary care doctor**:

Have you seen any **other healthcare provider** for this condition? Please provide their name and telephone number:

Past Medical History

Have you ever suffered from this type of **condition in the past**? □ Y □ N If yes, when did it occur last and what did you do for it?

Did it resolve on its own or did you see someone for the condition?

List any **surgeries** and the dates they were performed below:

Type of Surgery	Reason For Surgery	Date of Surgery

Have you ever been **hospitalized**? □ Y □ N If yes, when and why

Have you **broken any bones**? □ Y □ N If yes, which bones and when?

Have you ever experienced any **previous accidents**? If so, briefly explain

Do you suffer from any **pre-existing conditions** related or unrelated to your current complaint?

Have you suffered any **head injuries**?

Name: **Date:**

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***** Please check off any of the following conditions that you've had in the past or currently suffer with.*****
*****Indicate the date you were diagnosed with each condition on each line item*****

Date	*Date*	*Date*	*Date*
□ AIDS/HIV	□ Diabetes	□ Kidney Disease	□ Psychiatric Care
□ Alcoholism	□ Emphysema	□ Liver Disease	□ Rheumatoid Arthritis
□ Allergy Shots	□ Epilepsy	□ Lyme Disease	□ Rheumatic Fever
□ Anemia	□ Fractures	□ Measles	□ Scarlet Fever
□ Anorexia	□ GERD	□ Migraine Headaches	□ STD
□ Appendicitis	□ Glaucoma	□ Miscarriage	□ Stroke
□ Arthritis	□ Goiter	□ Mononucleosis	□ Suicide Attempt
□ Asthma	□ Gonorrhea	□ Multiple Sclerosis	□ Thyroid Condition
□ Bleeding Disorders	□ Gout	□ Mumps	□ Tonsillitis
□ Breast Lump	□ Heart Disease	□ Osteoporosis	□ Tuberculosis
□ Bronchitis	□ Hepatitis	□ Pacemaker	□ Tumors/Growths
□ Bulimia	□ Hernia	□ Parkinson's Disease	□ Typhoid Fever
□ Cancer	□ Herniated Disc	□ Pinched Nerve	□ Ulcers
□ Cataracts	□ Herpes	□ Pneumonia	□ Vaginal Infections
□ Chemical Dependency	□ High Blood Pressure	□ Polio	□ Whooping Cough
□ Chicken Pox	□ High Cholesterol	□ Prostate Condition	□ Other

Family History

Are both of your parents alive and well? □ Y □ N If not, what condition(s)/impairment(s) if any, did they suffer from?

_____

Has either of your parents suffered from the same or similar condition that you are suffering from today? □ Y □ N

Do you or does anyone in your family suffer from **diabetes, heart disease, lung disease, stroke, or cancer**? □ Y □ N

Social History

Exercise: How many times per week and for how long?_____

Do you use **free weights**?_____Do you do **cardio**?_____

List any **recreational activities** that you participate in:_____

Please list all **vitamins or supplements** you are currently taking?: _____

_____

Alcohol use: How many drinks per week?_____

Tobacco usage: How many packs per day?_____

Do you drink any **caffeinated beverages**? □ Y □ N, If yes, how many per day?_____

Have you ever used recreational drugs? □ Y □ N, If yes, which ones?_____

Name: **Date:**

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What are your **short term and long term goals** for receiving treatment at this office?_____

_____

What are you **unable to do now** because of your condition that you'd like to be able to do?_____

_____

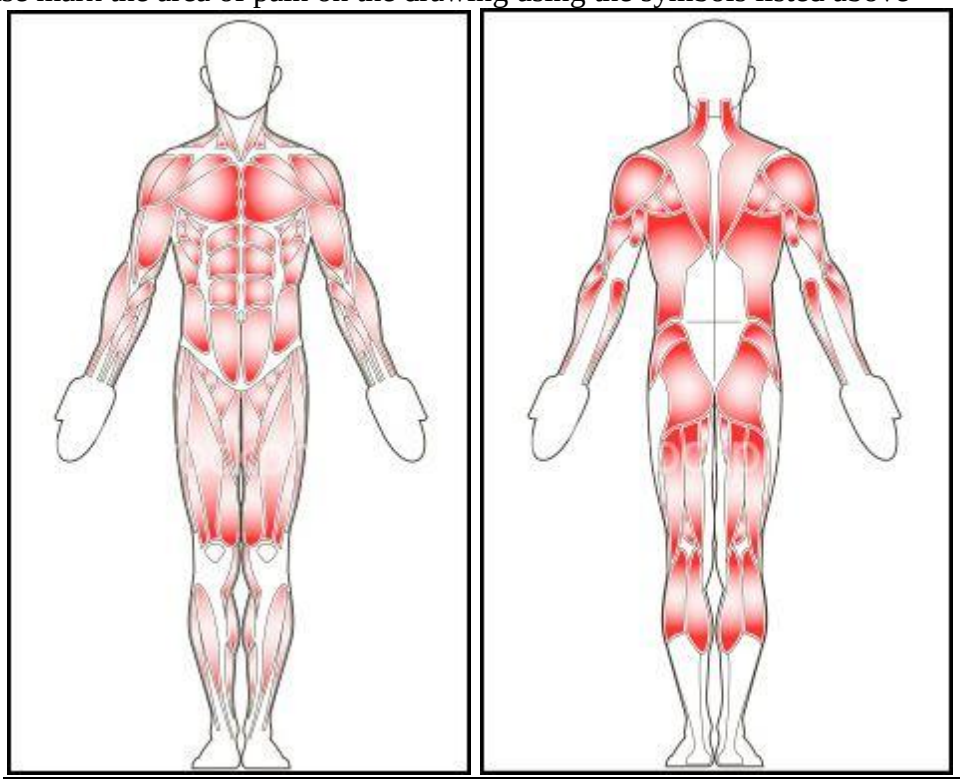
Circle severity number on diagram below. **(1 = least, 10 = greatest)**

Regions

Neck:	**1 2 3 4 5 6 7 8 9 10**
Mid Back:	**1 2 3 4 5 6 7 8 9 10**
Lower Back:	**1 2 3 4 5 6 7 8 9 10**
Hips:	**1 2 3 4 5 6 7 8 9 10**
Arms:	**1 2 3 4 5 6 7 8 9 10**
Legs:	**1 2 3 4 5 6 7 8 9 10**
Feet:	**1 2 3 4 5 6 7 8 9 10**

Mark Pain Region Using Symbols

Achy (AAA), Burning (+++), Constant (!!!), Dull (<<<), Pins & Needles (***), Sharp (###), Stabbing (XXX)
Please mark the area of pain on the drawing using the symbols listed above



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Review of Systems

Patient Name_____ **Date**_____

First Visit Please mark all symptoms that pertain to you in the last 30 days, or that you have received treatment for in the past, *(If no symptoms, please mark "None.")*

General

☐ Fevers ☐ Appetite Loss ☐ Fatigue ☐ Chills
☐ Weight Loss ☐ Sweats ☐ "Feeling sick" ☐ *None*

Eyes

☐ Vision loss, one eye ☐ Vision loss, both eyes ☐ Discharge
☐ Blurring ☐ "Halos" around lights ☐ Double vision
☐ Eye irritation ☐ Eye pain ☐ Light sensitivity ☐ *None*

Ears/Nose/Throat

☐ Ringing in ears ☐ Hoarseness ☐ Decreased hearing
☐ Earache ☐ Difficulty swallowing ☐ Nosebleeds
☐ Ear discharge ☐ Sore throat ☐ Nasal congestion ☐ *None*

Cardiovascular

☐ Difficulty breathing at night ☐ Near fainting ☐ Fatigue
☐ Shortness of breath with exertion ☐ Racing/skipping heartbeats ☐ Palpitations
☐ Difficulty breathing when lying down ☐ Lightheadedness ☐ Fainting
☐ Bluish color of lips or nails ☐ Chest pain of discomfort ☐ Weight gain
☐ Swelling of hands or feet ☐ Leg cramps with exertion ☐ *None*

Respiratory

☐ Sleep disturbances due to breathing ☐ Chest discomfort ☐ Cough
☐ Excessive snoring ☐ Coughing up blood ☐ Wheezing
☐ Shortness of breathe ☐ Excessive sputum ☐ *None*

Allergies/Immunologic

☐ Hives or rash ☐ HIV exposure ☐ Persistent infections ☐ *None*

Gastrointestinal

☐ Excessive appetite ☐ Bloody stools ☐ Vomiting blood
☐ Loss of appetite ☐ Yellowish skin color ☐ Nausea
☐ Abdominal bloating ☐ Vomiting ☐ Hemorrhoids
☐ Constipation ☐ Change in bowel habits ☐ Indigestion ☐ Gas
☐ Abdominal pain ☐ Diarrhea ☐ Dark, tarry stools ☐ *None*

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Review of Systems

Genitourinary

☐ Urinary frequency	☐ Genital sores	☐ Trouble starting urination
☐ Night time urination	☐ Missed periods	☐ Abnormal vaginal bleeding
☐ Inability to control bladder	☐ Blood in urine	☐ Unusual urinary color
☐ Kidney pain	☐ Inability to empty bladder	☐ Lack of sex drive
☐ Excessively heavy periods	☐ Urinary urgency	☐ Painful urination
☐ Foul urinary discharge	☐ Pelvic pain	☐ *None*

Musculoskeletal

☐ Joint swelling	☐ Muscle weakness	☐ Back pain
☐ Loss of strength	☐ Arthritis	☐ Muscle aches
☐ Muscle cramps	☐ Presence of joint fluid	☐ *None*

Skin

☐ Suspicious lesions	☐ Poor wound healing	☐ Itching	
☐ Night sweats	☐ Excessive perspiration	☐ Rash	
☐ Changes in nail beds	☐ Unusual hair distribution	☐ Dryness	
☐ Skin cancer	☐ Changes in color of skin	☐ Flushing	☐ *None*

Psychiatric

☐ Thoughts of suicide	☐ Mental problems	☐ Thoughts of violence
☐ Frightening visions or sounds	☐ Anxiety	☐ Depression
☐ Sense of great danger	☐ *None*	

Neurologic

☐ Difficulty with concentration	☐ Headaches	☐ Disturbances in coordination
☐ Inability to speak	☐ Falling down	☐ Brief paralysis
☐ Visual distances	☐ Weakness	☐ Sensation of room spinning
☐ Excessive daytime sleeping	☐ Fainting	☐ Poor balance
☐ Numbness	☐ Tingling	☐ Seizures
☐ Tremors	☐ Memory loss	☐ *None*

Endocrine

☐ Cold intolerance	☐ Excessive hunger	☐ Excessive thirst	
☐ Weight change	☐ Excessive urination	☐ Heat intolerance	☐ *None*

Hematologic/Lymphatic

☐ Enlarged lymph nodes	☐ Bleeding	☐ Abnormal bruising
☐ Fevers	☐ Skin discoloration	☐ *None*

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PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)

I have reviewed the privacy practice notice (3 pages) for Rivano Chiropractic Health Center, LLC., and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Print the Patient Name

INFORMED CONSENT TO CHIROPRACTIC CARE

RIVANO CHIROPRACTIC HEALTH CENTER, L.L.C.
ANTHONY M. RIVANO, D.C.
135 Columbia Turnpike, Suite 301
Florham Park, N.J. 07932
Telephone (973) 845-6282
Fax (973) 845-6283

Patient Name_____ Birthdate _____

Please discuss any questions or concerns with Dr. Rivano before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy by Dr. Rivano.

I have had the opportunity to discuss with Dr. Rivano and/or other office personnel the purpose and benefits of the chiropractic adjustments and other treatments. Alternatives to chiropractic treatments will be reviewed following the initial consultation.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Doctor's Signature_____

Date

ATTENTION!

You as the patient may receive payments directly from your medical insurance carrier. Once you receive the check and explanation statement, you must endorse and mail the information to Rivano Chiropractic Health Center, LLC.

Please do the following when you receive a check and statement (explanation of benefits) from your insurance carrier:

1. **Sign the back of the check**
2. **Write "pay to the order of Rivano Chiropractic Health Center, L.L.C."**
3. **Make a copy of everything you are mailing, front & back**
4. **Mail the original <u>check and statement</u> to:**

Rivano Chiropractic Health Center, L.L.C.
135 Columbia Turnpike, Suite 301
Florham Park, NJ 07932

If you have any questions, please do not hesitate to call us.
We understand this is inconvenient for you, but please understand it is equally inconvenient for us. You can reach our billing office at 973-845-6282.

My signature below acknowledges that my insurance carrier may send payment for chiropractic services directly to me. I will not deposit this payment and will endorse it over to Rivano Chiropractic Health Center, L.L.C. and forward it along with any statements to Rivano Chiropractic Health Center, L.L.C. Furthermore, I acknowledge that if I deposit or cash this money, I will be held liable for additional payments and fees including the check amount.

_____Date_____
Signature

Rivano Chiropractic Health Center, L.L.C.
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billingdept@rivanochiropractic.com

FINANCIAL POLICY

We are committed to providing you the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibilities.

MISSED APPOINTMENT(S):
Unless cancelled at least 24 hours in advance or filled by another patient, our policy is to charge ***$85.00*** per missed appointment. Our office operates by Appointment Only and that time slot is yours alone. We understand that extenuating circumstances arise in our personal lives. We respect your time and generally run on schedule at our office so if you know that you will not be able to make your appointment it is very important to inform the office. We will not file, nor will insurance plans pay for this charge, so please help us serve you and our other patients better by keeping scheduled appointments or canceling in advance. We appreciate your cooperation.

In order to comply with your recommended care plan, it is advised to reschedule any missed appointments within 24 hours of your original appointment time.

UPDATING PERSONAL INFORMATION
You need to update your personal information on file every time your information changes so we can keep your data as current as possible. We also need to be able to keep in contact with you in the event that the office hours change, the office moves to another location, adds another provider, or makes any other changes.

REFERRALS - If your plan requires a referral from your primary care physician it is **Your** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, **You Will Be Responsible For All Charges Up To The Date Of The Referral**. It is then your responsibility to provide us with the referral as soon as possible.

DEDUCTIBLES & CO-PAYMENTS/CO-INSURANCE - By law we MUST collect your carrier designated co-payment/co-insurance at the time of service. *Please be prepared to pay deductible or co-payment/co-insurance at each visit.* If payment is made with a personal check and returned due to insufficient funds you are responsible for immediate remittance of the balance as well as a $50.00 returned check fee made payable directly to our office.

NON-COVERED THERAPIES - In the event that your policy does not cover the cost for therapeutic modalities (i.e. muscle stimulation, ultrasound, etc.) you will be responsible for the cost of those services if they are chosen to be used. We will always do our best to let you know if something is not going to be covered in advance based on the insurance verification provided by your carrier.

We cannot guarantee payment as we are not the insurance carrier. However, as a courtesy we will verify your coverage. However, misinformation occurs regularly when verifying health benefits and cannot be a guarantee of coverage. It is ultimately YOUR responsibility to understand your coverage. If claims are delayed by more than 90 days, we require you to reimburse our office in full for services rendered. **The Patient Is Liable For Any And All Expenses Incurred In This Office.**

PATIENTS WITHOUT INSURANCE COVERAGE - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE - We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the exam, therapies, deductible and 20% co-insurance which can be billed to secondary insurance if you have one.

X- Ray's if needed will be done at an imaging center that is convenient for you. A prescription will be provided for you to take with you to your appointment.

THIS APPLIES TO TODAY'S VISIT AND ALL FUTURE VISITS.
OUR OFFICE ACCEPTS CASH, CHECKS, MASTERCARD AND VISA

IN CONSIDERATION OF YOUR UNDERTAKING TO TREAT ME, I AGREE TO THE FOLLOWING:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

BENEFITS ASSIGNED

I hereby authorize payment directly to **Rivano Chiropractic Health Center, LLC and/or Dr. Anthony Rivano, D.C.** for professional services rendered and I shall be personally responsible for any unpaid balance to the Doctor. I hereby authorize the attending Doctor to release any information concerning my examination or treatment to your insurance carrier if requested.

DELINQUENT ACCOUNTS
In the event that a patient stops making payment on his/her outstanding balance for longer than 45 days, he/she will be considered as having a delinquent account and may be dismissed from the practice. These patients will be given sufficient opportunity to find another provider. Before patients with delinquent accounts will be allowed to return for care, they must pay their entire balance in full. Patients who have had delinquent accounts in the past may be required to pay for future visits "up-front," either in cash or by credit card. Patients with outstanding balances may have their account(s) forwarded to a collection agency after 90 days of non-payment.

Collections of Past Due Balances - Any past due balance not paid **within 90 days** will be sent over to an attorney or agency for collections. You will be responsible for all charges related to this collection process. Please keep your account current to avoid any action. Statements are sent out on a monthly schedule for patients who have balances. The due dates are clearly posted on the statement. If payment is not received by the due date then a 10% late fee will be assessed and applied to your balance.

FINANCIAL HARDSHIP
In certain instances if you are unable to afford your care special arrangements can be made to provide you with a payment plan that will allow you to continue your care.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions.
I have read, understand and agree to this Financial Policy in its entirety.

SIGN_____**DATE**_____