The Pain Relief and Wellness Center of South Hadley
MICHAEL COLLINS, D.C.

Today's Date: _____
Patient Name: _____Nick name: _____
Address with zip code: _____
Home Phone: _____ Alternate phones: Work: _____Cell: _____
Birth date: _____ Marital Status: _____
Employer Name: _____ Employer Address: _____
_____

Who referred you to our office? (so we may thank them): _____
Primary care physician (name, address, phone): _____

Is this injury due to an: Auto accident? _____Workers Injury? _____
Personal Injury? _____None of the above? _____

We will need a copy of your Drivers License and Insurance Card for
billing *and* ***identification*** use ***only***!

If you are not the Policy holder, Please fill out the following three questions:

Name of person whom the insurance policy is under (if not self):_____
Birthdate of policy holder (if not self): _____
Employer of policy holder (if not self): _____

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary forms to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for any unpaid balance. I understand the limits of my insurance carrier and agree to pay for any services that are denied ad being "non-covered services, non-medically necessary or beyond the yearly benefit maximum".

Signature _____ Date _____
(parent or guardian if patient is a minor)

PATIENT'S NAME _____ **DATE** _____

CURRENT HEALTH CONDITION

Describe condition for which you made this appointment _____

_____

Date this condition began _____ **Was it caused by an accident?** ☐ **Yes** ☐ **No**

Are you currently being treated by another physician for this or any other condition? ☐ **Yes** ☐ **No**

NAME of your physician _____ **Phone** (____) _____

Other doctors seen for this condition _____

_____

Have you had X-rays re this condition? ☐ **Yes** ☐ **No** **Date of X-rays** _____

Where were X-rays done? _____

If you had surgery/this condition, Dr.'s Name _____ **at** _____ **Hospital**

Drugs you now take:

☐ **Pain Med.** ☐ **Muscle Relaxer** ☐ **Nerve Med.** ☐ **Blood Pressure Med.** ☐ **Insulin**

☐ **Other Medications** _____

PAST HEALTH HISTORY

Please describe, noting year, any of the following which you have ever had:

Surgeries: _____

_____

Broken Bones or Other Injuries: _____

_____

Other Serious Illness: _____

_____

Previous Chiropractic care by Dr. _____ **Date last seen** _____

List all medications you are taking and for what? _____
Include over the counter pain relievers

_____

Please circle conditions you may have had in past or present:

HIV/Aides Diabetes Cortisone in joints High Cholesterol High Blood Pressure Stroke
TIA Dizziness/Fainting Aortic Aneurysm Cancer/Tumors Osteoporosis Prostate
Epilepsy/Seizures Visual Disturbances Arthritis Osteo Arthritis Arthritis Other _____

Is there a family history of any of the above? Please list:

_____

_____

The Pain Relief & Wellness Center
Of South Hadley

130 College Street, Suite 50 • South Hadley, MA 01075 • Fax (413) 532-3466

Dr. Michael K. Collins
Chiropractic Physician

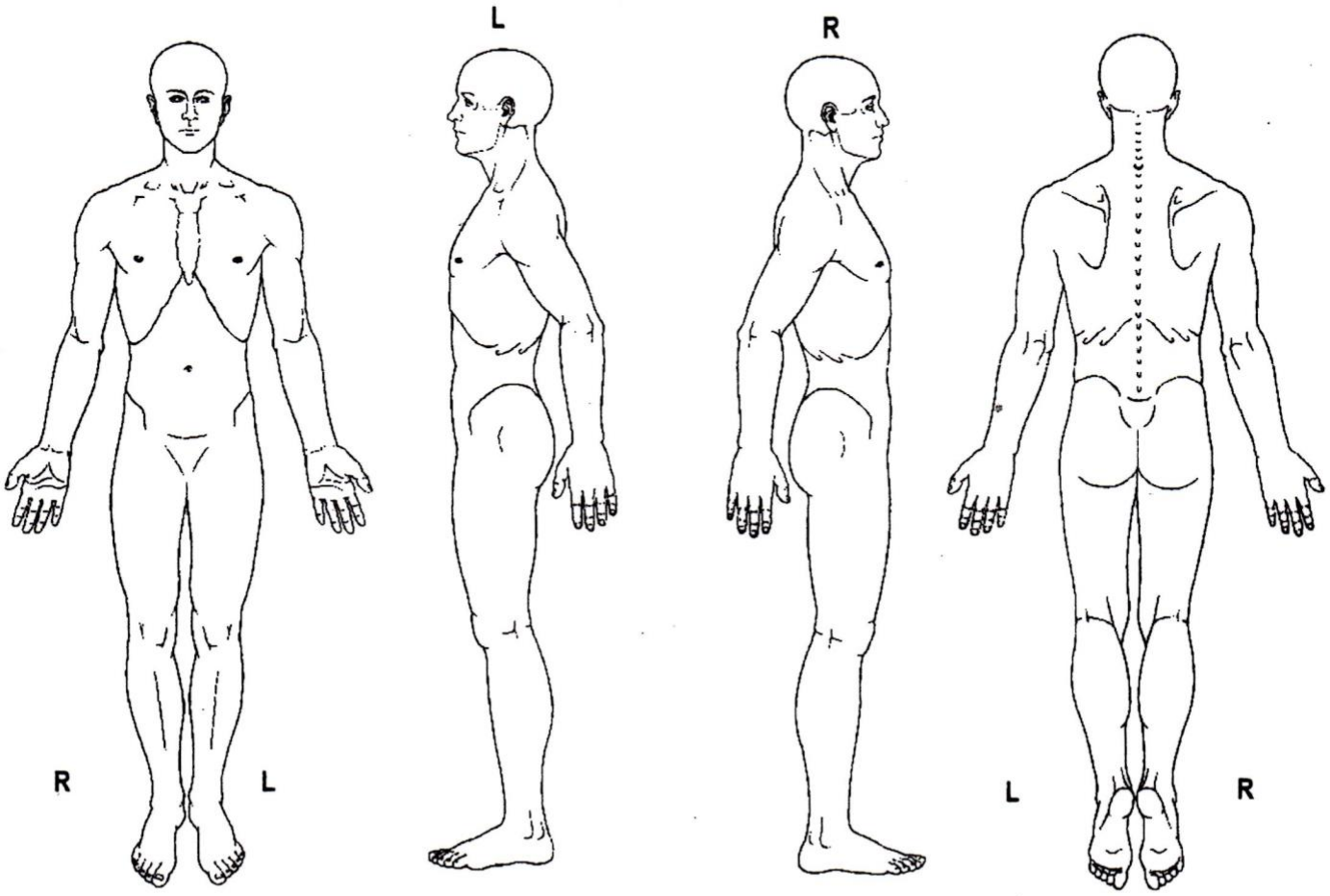
(413) 532-1177

Name:_____ Date:_____

Pain Diagram

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.
DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.

Numbness - - - - Pins & Needles oooo Burning xxxx Aching **** Stabbing ////



Please circle the number that best indicates the severity of your complaint right now.

Neck Pain	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worse Pain Imaginable
Low Back Pain	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worse Pain Imaginable
Other_____	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worse Pain Imaginable

AUTHORIZATION
PATIENT RECORD DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

PLEASE REVIEW CAREFULLY

I wish to be contacted in the following manner (check all that apply).

☐ **Home Telephone** (____)_____-_____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call-back number only.

☐ **Written Communication & Postcards**

- ☐ O.K. to mail to my home address.

☐ **Work Telephone** (____)_____-_____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call-back number only.

☐ **OK to Use Name on Referral Board**

☐ Other _____

_____

_____ _____

Patient's Signature Date

_____ _____

Print Name Date

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of, and requests to *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records to *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Record of Disclosures of Protected Health Information

Date	Disclosure to Whom	Purpose of Disclosure/Description of Disclosure	Initials

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Dr. Michael Collins Notice of Privacy Practices for Protected Health Information.

Patient's Name Printed _____ Date _____

Patient's Signature _____ Authorized Provider Representative _____

Personal Representative Printed _____ Personal Representative Signature _____

Description of personal representative's authority to act for the patient _____

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(413)532-1177 Fax: (413)532-3466

FINANCIAL POLICY

BUSINESS ARRANGEMENTS

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience. We offer several methods of payments for your chiropractic care in our office and you may choose the plan which you prefer. This information will enable us to better serve you and help us avoid possible misunderstanding in the future. If special arrangements are necessary, please consult with us during your initial consultation. Our main concern is your health and well being and we will do our best to help you.

A 24 hour notice is appreciated if you are unable to keep your appointment.

PLAN #1 CASH
All fees are to be paid at the time services are rendered, being either by cash or check.

PLAN #2 INSURANCE
If you have insurance that covers chiropractic services rendered at our office, we will bill your insurance company directly. However, you are responsible for your co-pay and co-insurance, which your policy may not cover. Co-insurance charges (if applicable) will be billed to you after your insurance has paid their portion.

PLAN #3 INDUSTRIAL INJURY (WORKMEN'S COMPENSATION)
If you have been hurt while working, this will be classified as an industrial injury. This office will get verbal authorization from your employer to begin treatment. You will then be responsible for assisting this office in obtaining information necessary to contact the worker's compensation insurance carrier. Once this authorization has been received, all WC insurance claims will be sent directly to the WC insurance carrier, the patient will not have to pay any portion while under care during this injury once treatment has been authorized.

PLAN #4 PERSONAL INJURY
This plan is for the convenience of those who need immediate care and are involved in legal work, which will delay payment for treatment. If you were in an accident with any type of personal injury suit, we will render care and send the claims to both the involved insurance company and your attorney. We will wait until settlement or other disposition of your claim before requiring payment for outstanding balances after insurance companies have paid. The following conditions apply:

1. If you have an attorney, an attorney's lien and/or assignment of benefits must be signed for direct payment of the bill. Any revocation of such a lien and/or assignment voids our agreement to wait in requiring payment.
2. The patient and the attorney must keep this office up to date as to any changes of condition in the case.
3. Any violation of the foregoing condition by you will entitle **Dr. Michael Collins** to immediate payment.

PLAN #5 SPECIAL ARRANGEMENT
If none of the above apply and you feel that your situation is unique, please feel free to discuss financial arrangement with our office manager.

I agree to use plan #_____ for the chiropractic care which I receive. If care is discontinued, the balance for care received up to the date is due in full in 60 days. Should this account proceed to collection, I hereby agree to pay any and all fees and cost incurred in the collection process including but not limited to attorney and/or collection agency fees of 25% of the unpaid balance and our costs. Accounts 60 days past due will be assessed at 1.5% monthly service charge.

Signature: _____

Date: _____

Michael K. Collins, D.C.

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130 College Street, Suite 50
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Consent for Use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.
There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of your privacy notices.

Your Right to Limit Uses or Disclosures
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke your Authorization
You may revoke your consent to us at any time; however, your evocation must be in writing. We will not be able to honor your evocation request if we have already released your information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to the terms. I am also acknowledging that I have received a copy of this notice.

Printed Name	Authorized Provider Representative
Signature	Date
Date	