CONFIDENTIAL NEW PATIENT QUESTIONNAIRE DATE:

Referred By:_____ Email Address:_____

Last Name:_____First Name:_____MI_____

Address:_____ City:_____State:_____Zip:_____

Home #:( ) - Cell#: ( ) - Work#: ( ) -

Date of Birth:____/____/____ Age:_____ Sex: M F Soc.Sec. #:_____

Marital Status: S M D W Spouse's Name:_____

Type of Insurance: Auto Worker's Comp Personal Injury Private Health Medicare None

EMPLOYER INFORMATION

Occupation:_____

Employer:_____

Address:_____ City:_____State:_____Zip:_____

AUTO INJURY/WORK INJURY/PERSONAL INJURY DATA

Insurance Type: Auto Work Injury Private Lien Did you report the injury? YES NO

Patient's Relationship to Insured: Self Spouse Child To Whom?_____

Date of Injury:_____ Insurance Company:_____

How did the accident happen?_____

_____

Claim Number:_____ Policy Number:_____WC#:_____

Hospitalized? YES NO Where?_____ X-Rays Taken? YES NO

Where you working at time of injury? YES NO Dates Lost from Work:_____

What were you? DRIVER PASSENGER PEDESTRIAN Wore Seatbelt? YES NO Airbag Inflate? YES NO

Name of Attorney:_____Attny's Phone#:_____

PRIVATE HEALTH/ MEDICARE INSURANCE

Insured's Name:_____ Insured's Date of Birth:_____

Patient's Relationship to Insured: SELF SPOUSE CHILD OTHER:_____

Name of Insurance Company:_____ Policy#:_____

Insurance Phone:_____ Insurance Address:_____

SECONDARY INSURANCE Name of Insured:_____ DOB:_____

Name of Insurance Company:_____ Policy#:_____

PATIENT HEALTH INFORMATION

1. Major Health Complaint(s)_____

_____

2. Check Your Present and Past Symptoms

- ☐ Neck Pain
- ☐ Middle Back Pain
- ☐ Low Back Pain
- ☐ Headache
- ☐ Dizziness
- ☐ Convulsions
- ☐ Fainting, Visual Disturbances, Nausea
- ☐ Shoulder Pain
- ☐ Pain in Upper Arms or Elbows
- ☐ Hand Pain
- ☐ Pain in Upper Leg/ Hip
- ☐ Pain in Lower Leg/ Knee
- ☐ Pain in Ankle/Foot
- ☐ Swelling/ Stiffness of Joints
- ☐ Jaw Pain
- ☐ Tinnitus
- ☐ Rapid Heartbeat
- ☐ Chest Pain
- ☐ Loss of Appetite
- ☐ Blood Disorder

- ☐ Excessive Thirst
- ☐ Chronic Cough
- ☐ Chronic Sinusitis
- ☐ General Fatigue
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Abdominal Pain
- ☐ Difficulty Swallowing
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Angina
- ☐ Heart Attack
- ☐ Stroke
- ☐ Asthma
- ☐ Cancer
- ☐ Emphysema
- ☐ Arthritis
- ☐ Diabetes
- ☐ Ulcer
- ☐ Bladder Infection
- ☐ Colitis

3. Describe your current pain: ☐ Sharp/ Shooting ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness

☐ Throbbing/ Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/ Constricting ☐ Burning ☐ Tingling

4. Did your problem begin: ☐ Due to an accident ☐ Multiple Incidents ☐ Gradually ☐ No specific reason

☐ Other: _____

6. What treatment have you received for this present condition? ☐ Surgery ☐ Spinal Injections ☐ Physical Therapy

☐ Chiropractic ☐ Medicine ☐ X-Ray ☐ Acupuncture ☐ Occupational Therapy ☐ Other: _____

7. Have you been treated previously for the same condition? ☐ YES ☐ NO If yes, by: ☐ MD ☐ Chiropractor

☐ Physical Therapist ☐ Occupational Therapist ☐ Other: _____

8. What makes your problem better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Moving/ Exercise

☐ Inactivity/ Not Moving ☐ Other: _____

9. What makes your problem worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Moving/ Exercise

☐ In activity/ Not Moving ☐ Other: _____ 10. Do you work? ☐ YES ☐ NO

10. If Yes: ☐ Sitting more than 50% ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

CONTINUED

11. Are your complaints affecting your ability to work or otherwise be active?

☐ No effect ☐ Some physical restrictions (able to perform light duty housework and household tasks) ☐ Need limited assistance with everyday tasks ☐ Need assistance often ☐ Have a significant inability to function without assistance ☐Cannot care for self

12. Are you currently taking medication? ☐ YES ☐ NO If yes: _____

_____

13. Are you allergic to any drugs or medications? ☐ YES ☐ NO If yes: _____

_____

14. Do you smoke? ☐ YES ☐ NO **15. How many packs a day?** _____

16. Do you have allergies? ☐ YES ☐ NO If yes: _____

17. Have you had any surgery? ☐ YES ☐ NO If yes: _____

18. Women: Are you pregnant? ☐ YES ☐ NO ☐ NOT SURE **Patient Initials:** _____

FAMILY HISTORY

DIABETES: ☐ Mother ☐ Father ☐ Brother(s) ☐ Sister(s)

HEART: ☐ Mother ☐ Father ☐ Brother(s) ☐ Sister(s)

KIDNEY: ☐ Mother ☐ Father ☐ Brother(s) ☐ Sister(s)

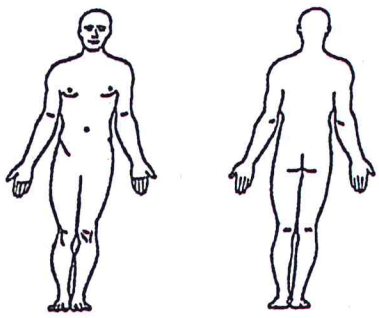
CANCER: ☐ Mother ☐ Father ☐ Brother(s) ☐ Sister(s)

BACK: ☐ Mother ☐ Father ☐ Brother(s) ☐ Sister(s)

OTHER: _____

PAIN/ SYMPTOMS PICTURE

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN/ SYMPTOMS, INCLUDE SYMPTOMS OF PAIN, NUMBNESS/ TINGLING.



I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNARIE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.

_____ _____

PATIENT/ LEGAL GUARDIAN SIGNATURE DATE

HIPAA Notice of Privacy Practices

Patient's Name _____

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatments, payment, or health care operations (TPO) 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, they may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician and therapist, 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, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to 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. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's and therapist's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician or therapist. We may also call you by name in the waiting room when your physician or therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, Public Health issues as required by law, Communicable diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors, and Organ Donation; Research; Criminal Activity; Military and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except that your physician or therapist or the physician's practice has taken as action in reliance on the use or disclosure indicated in the authorization.

II. Your Rights

Following is a statement of your rights with respect to your protected health information.

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 or therapist 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. You then have the right to use another Healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician and therapist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have a right to receive an accounting of certain disclosures we have made, if any, to your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any charges. You then have the right to object or withdraw as provided in this notice.

III. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signatures below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization and surgery. If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Allonardo and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name

_____

Signature

Dated: _____

Carmine Allonardo, D.C.

Doctor's Name

_____

Signature

POSTURE PERFECT CHIROPRACTIC, P.C.

405 Northfield Avenue
West Orange, N.J. 07052
(973) 324-9324 / Fax (973) 324-9339
Dr. Carmine Allonardo

ASSIGNMENT OF BENEFITS FORM

*PATIENT NAME:*_____

I IRREVOCABLY ASSIGN TO DR. CARMINE ALLONARDO ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY POSTURE PERFECT CHIROPRACTIC. I IRREVOCABLY AUTHORIZE DR. CARMINE ALLONARDO TO PURSUE ANY, AND ALL CLAIMS ARISING FROM MY CASE. I IRREVOCABLY AUTHORIZE DR. CARMINE ALLONARDO ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY DR. CARMINE ALLONARDO TO BE RELEASED TO POSTURE PERFECT CHIROPRACTIC. I IRREVOCABLY AUTHORIZE DR. CARMINE ALLONARDO TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I IRREVOCABLY AUTHORIZE POSTURE PERFECT CHIROPRACTIC TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES. THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION AND I UNDERSTAND ITS NATURE AND EFFECT.

*PATIENT SIGNATURE:*_____

*DATE:*_____

POSTURE PERFECT CHIROPRACTIC, P.C.

405 Northfield Ave
West Orange, N.J. 07052
(973) 324-9324 / Fax (973) 324-9339
Dr. Carmine Allonardo

To Our New Patients

We wish to welcome you to our office. We feel that mutual understanding and cooperation are a perquisite to a successful experience in our office. Therefore, We would like you to be aware of the following:

1. Our primary concerns are your health and our reputation. Therefore, we accept only those patients we feel we can help. If we feel that we are unable to take care of your condition, we will immediately refer to the appropriate health care professional.

2. Your only purpose for being here is to regain your health; our only purpose is to help you so do. We employ the most modern techniques that are continually improved and augmented by continuing education.

3. We recognize the value of time; yours and ours. We give everyone the time they require. If you must cancel your appointment, please allow 24 hours in advance so we can utilize that appointment for another patient. THERE WILL BE A $25.00 CHARGE FOR ALL MISSED APPOINTMENTS.

4. It is emphasized that your insurance contract is with you, not with this office. Therefore, you need to assign benefits to this office so payment is directed to this office and your only responsibility is co-pay and/ or deductible.

5. As a courtesy, we will complete your insurance forms, explain your benefit limits to you, and help you recover to the limits of your policy.

6. Please follow your recommended treatment schedule. It is the single most important key to regaining your health. Hit and miss treatment yields hit and miss results.

7. There are many people who need chiropractic care but unfortunately they are unaware of its benefits. Please help them by referring them to our office.

8. It is my responsibility to serve you in the best possible way, so if I've helped you, tell others; if I haven't, please tell me.

Signature:_____ Date:_____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Posture Perfect Chiropractic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Posture Perfect Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Posture Perfect Chiropractic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Posture Perfect Chiropractic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date

Name: Email: Phone #

Here at Posture Perfect Chiropractic, Dr. Allonardo would like to offer you even more support to reach your optimal wellness goals. Please answer the following questions so we can get started!

1. Do you currently take vitamins, supplements or protein shakes? YES / NO
   If yes, what are you taking?
2. What are your top concerns regarding your health that are most important to you?
   Circle all that apply:
   - Weight Management
   - Stress
   - Immunity
   - Allergies
   - Chronic pain
   - Fatigue
   - Headaches
   - Digestive
   - Blood pressure
   - Cholesterol
   - ADD/ADHD
   - Cancer
   - Other; Please Explain

3. Are you interested in learning how to cure, or improve the condition you circled? YES / NO
4. Are you interested in exploring natural alternatives for your health? YES / NO
5. Would you be interested in finding out how to use essential oils and other healthy ways of supporting your body? YES/ NO
6. Are you interested in learning how to clean your home without the use of toxic chemicals? YES/NO
7. Are you interested in learning how to cook and prepare foods with Essential Oils? YES / NO