Welcome to Rizzo Chiropractic Holistic Health and Wellness Center

Check the following services you are interested in:

____Chiropractic

____ Physical Rehabilitation and Graston Technique

____ Nutritional Analysis (Hair, Blood & Urine)

____ Detox (Sauna, Footbath, Nutritional 21 Day Detox)

____ Biofeedback (Spectra Vision/ Zyto Scan)

____ Neurofeedback (ADHD, Migraines, Memory, Focus)

____ Low Level Laser (Skin conditions, Wounds & Pain)

____ Normatec (Boot Compres.- Swollen Legs & runners)

Name _____MI_____ Birth date _____ Age _____

Address _____ Height _____'_____ Weight _____Sex_____

City, State, Zip _____ Social Security # _____

Emergency Contact_____Phone _____ Referred by? _____ Billboard [ ],

Home Phone _____Work # _____ Facebook [ ], Web Site [ ] , Physician [ ], Other _____

Cell Phone _____ Carrier _____ Occupation _____

Marital status-circle one [S M W D] Employer's Name _____

Spouse's name _____ No. of Children _____ Employer's Address _____

E-mail address: _____ Medical Doctor _____

(If you want to receive monthly E-Health Tips and specials)

Have you had Chiropractic Care Before? _____When? _____Where? _____

What is your current complaint (be specific)? _____

How long have you had today's problem? _____ Date Symptom's Appeared _____

Have you seen other doctors or had any tests taken for this condition? _____

Is this condition due to:

Auto Accident Work Injury
Unknown cause Illness
Other accident_____

_____

If Accident, Explain:

_____
_____
_____
_____
_____

Are Symptoms:
Improving
About the same
Getting worse

Have you had these symptoms before?

NO YES
When? _____
Doctor's seen:

_____
_____

_____

Type of Insurance: Circle one:
Medicare Aetna Cigna Highmark
UPMC Auto WC Other Cash
Group # _____
ID # _____

Check any activities which aggravate your condition:

Standing Lying
Twisting Walking
Bending Coughing
Sitting Lifting

List Surgeries, Hospitalizations, you have had and dates.
(i.e. tonsils, appendix, etc.

_____
_____
_____
_____
_____
_____

_____
_____
_____

List all previous accidents: (auto, accidents, falls, broken bones and work injuries) When and Where?

_____
_____
_____
_____
_____

List Illnesses/conditions currently being treated for and Dr's name

_____
_____
_____
_____
_____
_____
_____
_____

Continued to next page…

List all Prescription drugs you now take:

_____
_____
_____
_____
_____
_____
_____

List all Supplements/ Herbs and over the counter drug(s) you now take:

_____
_____
_____
_____
_____
_____

Do you?

Social Habits

[ ]Smoke [ ]Alcohol [ ]Coffee

Stress Levels

[ ] None/Slight [ ] Mild

[ ] Moderate [ ] Severe

Exercise Activity

[ ] None [ ] Light

[ ] Moderate [ ] Strenuous

Do you use Recreational Drugs?

How often? _____

Do you have a family history of…?

arthritis
diabetes
cancer
scoliosis
cardiovascular disease

Other

_____
_____
_____

List allergies:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Occupational Activity [ ] Sitting 50 % or more [ ] Light Labor [ ] Manual Labor [ ] Heavy Labor [ ] Repeated Motion

Please check any of the following you may have had:

[ ] High Blood Pressure [ ] Asthma [ ] Gastric Ulcers [ ] Joint Pains [ ] Heart Disease [ ] Bronchitis [ ] Scoliosis
[ ] Colitis/Spastic Colon [ ] Jaw Pain [ ] Heart Murmurs [ ] Acid Reflux [ ] Shoulder Pain [ ] Diabetes [ ] Abdominal Pain
[ ] Pulmonary Disease [ ] Emphysema [ ] Hiatal Hernia [ ] Numbness [ ] Headaches [M]or [T] [ ] Pneumonia [ ] Multiple Sclerosis
[ ] Hepatitis A B C [ ] HIV+/AIDS [ ] Premenstrual Pains [ ] Sinus/ Allergies [ ] Gas/ Bloating [ ] Kidney Stones [ ] Tinnitus-Dizziness

Would you like us to send a report to your Family doctor? [ ] Yes [ ] No

The above health information is true and accurate to the best of my knowledge.

Signature _____ Date _____

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone to you at home, at work, by E-mail, or by your cell phone and you are not at available; a message may be left on your answering machine, with your e-mail or with your employer.

You have the right to refuse to give us this information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may opt out of this service by signing below.

_____
Patient Signature

_____
Date:

FINANCIAL POLICY

PATIENTS WITHOUT INSURANCE "Cash-Time of Service Discount" Our office offers discount pricing to patients that do not have insurance. This cash discount is only applicable **if paid at the time of service**. This discount reflects reduced administrative billing costs involved in processing cash payments compared to insurance payments. In order to get this discount, the patient must pay 100% of the charge at the time of the visit unless other arrangements have been pre-arranged and agreed upon. A payment plan can be established and must be in writing.

GROUP OR INDIVIDUAL INSURANCE When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment for any non-covered services, deductibles, coinsurances, or co-pays is payable at the time of service by you.

"ON THE JOB" INJURY (Worker's Compensation) If you are injured on the job, you will need to inform your employer of the accident and obtain the name & address of the carrier of their insurance company and get a Claim #. You must immediately pay for all accumulated costs and fees associated with your care at Rizzo Chiropractic should your employer not provide this information, or if a settlement has not been made within three months, or if you suspend or terminate care, unless other arrangements are made with Dr. Rizzo.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS Please notify your auto insurance carrier of your visit to our office immediately and notify us immediately if an attorney is representing you. You are ultimately responsible for your bill. Payment of all costs and fees of any services is due immediately upon settlement by an attorney or if you suspend or terminate care.

MEDICARE We do accept assignments from Medicare. Medicare pays our office directly. **Medicare will cover ONLY spinal manipulation for chiropractors**. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. If you have a secondary insurance, it may cover the remaining 20%.

MISSED APPOINTMENTS We reserve the right, at our discretion, to charge for missed appointments at the rate of $20/ office visit. Please keep scheduled appointments or cancel by calling 24 hours in advance.

ASSIGNMENT OF BENEFITS

1. Release of Information I authorize Dr. John M. Rizzo, D.C., to release any information he deems appropriate concerning my physical condition to my insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by Dr. John M. Rizzo, D.C., or any of his staff acting on his behalf.

Family and Friends Involved in Your Care – *If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved In your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim*

2. Payment Agreement I understand that there is no guarantee that my insurance company(s), will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for ***all remaining charges***. **All payments are due within 30 days of the monthly billing date. A service charge of 1.5% per month will be applied on any balance over 90 days.**

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and /or other insurances. If payment has not been received, the patient is in default and is responsible for collection, filing, court, or attorney fees incurred in attempting to collect this amount now or on any future outstanding account balances. I authorize that any insurance benefits or reimbursement for services rendered by you which amounts would otherwise be payable to me under any insurance plan, pre-paid health care plan, or Medicare be made payable directly to: Rizzo Chiropractic/ Dr. John M Rizzo, D.C. I also authorize the direct payment to you by my attorney out of the proceeds of any settlement of any claim based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, it is my understanding that I am responsible for your charges in full, and payment for services rendered will be made on a current basis and my account paid in full immediately.
4. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Signature of Patient: _____ Date: _____
Signature of Patient

Signature of Guardian/Representative: _____ Date: _____
(If Minor) Signature of Guardian/Representative

CHIROPRACTIC SPINAL MANIPULATION (ADJUSTING) AND SUPPORTIVE *CHIROPRACTIC CARE*
INFORMED CONSENT

I hereby request and consent to the performance of Chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by Dr. John M. Rizzo or his employees.

I have had an opportunity to discuss, or will have the opportunity to discuss, with the Doctor of Chiropractic and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.

The Chiropractic adjustment or other clinical procedures are usually beneficial and rarely cause any problems. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some rare risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, since they very seldom occur in the practice of Chiropractic, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

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 cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

X_____
Signature of Patient

Date Signed_____

To be completed by representative if necessary, (ex. if patient is a minor or unable physically or legally incapacitated).

_____
Print Patient's Name

_____
Print Name of Pt's Representative

X _____
Signature of Pt's Representative

Date Signed _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

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 applies to Protected Health Information associated with Group Health Plans provided by Rizzo Chiropractic to its patients. This Notice describes how Rizzo Chiropractic collectively, may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (**"HIPAA"**) to maintain the privacy of PHI and to provide with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be available in office.

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the following employee benefits that we provide to our employees, employee dependents and, as applicable, retired employees: [Insert the appropriate coverages you provide which might include major medical coverage, dental coverage, vision coverage, long-term care coverage and any other coverages that you provide that meet the definition of a health plan.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. Ex. we may be required to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department)
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

RIGHTS THAT YOU HAVE

Access to Your PHI

You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from [Insert company name] at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI

You have the right to request the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI

You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI

You have the right to request restrictions on certain uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications

You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of Notice

You have the right to a copy of this notice upon request by contacting us at the telephone number or address below.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

EFFECTIVE DATE

This Notice is effective _____ Office Personnel: _____

_____ _____

Patient Signature Date

Patient Representative: _____

Print Name

_____ Date: _____

Signature of Pt's Representative