Paul M. Bizzaro, D.C.
81 South Main Street
Yardley, PA 19067

Telephone: 215.493.6589
Fax: 215.493.1022

Informed Consent:

I hereby request and consent to the performance of 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 for by the Doctor of Chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working for, or associated with, or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above, or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office clinic personnel regarding the nature and purpose of chiropractic adjustments and procedures.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, disc locations, and sprains. I do expect the doctor to exercise judgment during the course of the procedure which the doctor feels, at the time, based upon the facts known are administered in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to discuss or ask questions related to its content, and by signing below, I agree to the above named procedures and for any conditions in the future for which I seek treatment.

Patient Name (Print)____

Signature________________________________ Date____________________

Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements are made with in the office manager. How will you be paying for today's visit?
____Cash ____Check ____Credit Card

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information to process insurance claims. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my medical status.

Signature__________________________ Date__________________________

PATIENT LIABILITY AGREEMENT

I understand that I am financially responsible for all bills of Paul Bizzaro, D. C. In the event that my account is not paid, I shall be liable for any and all costs of collection, including, but not limited to an additional 33.33 % fee if my account is forwarded to WJG Collection Agency, Inc. for collection. In addition, I further understand that I will also be responsible for paying any reasonable attorney's fees plus court costs. Further, there will be a 2 % annual finance charge on all accounts past due at least 30 days.

By signing below, I hereby indicate that: 1) I have read this contract, 2) I understand the terms of this contract and 3) I agree to the terms of this contract.

____________________ date____________________

patient

PAUL M. BIZZARO, D.C.
81 SOUTH MAIN STREET
YARDLEY, PA 19067

TELEPHONE: (215) 493-6589
FAX: (215) 493-1022

General Information: **Today's Date:**____________

Name:____

Address:____

City:____________________ State:_______ Zip:__________

Home Phone:________________ Please call me at: ☐ Home

Work Phone:________________ Please call me at: ☐ Work

Cell Phone:________________ Please call me at: ☐ Cell

Email Address:____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other________

Birth Date:______________________ Current Age:________

Number of Children:____

Name of Nearest Relative:____________________ Phone:____________

Current Occupation:____

Employer Name:____

Employer Address:____

How were you referred to the office?

☐ Friend/Family Member- Name________________________

☐ Yellow Pages Ad ☐ Mail ☐ Website ☐ Passing By ☐ Other____________

Payment Information:

Responsible Party: ☐ Self ☐ Spouse ☐ Other________________________

Payment for Services: ☐ Insurance ☐ Self-Pay

If Insurance: ☐ HMO ☐ PPO ☐ POS ☐ EOP ☐ HAS/HSP ☐ Auto Insurance
☐ Worker's Compensation

Health Insurance Information:

Social Security #:______________________ (SS# is required to file any insurance claim)

Insurance ID#________________________

Group ID#:_________________________

Special ID#:_________________________

Primary/Auto Insurance Name:__________________ Phone#:__________ Fax#:__________

Primary/Auto Insurance Address:______________________________________

Secondary Insurance Name:____________________________________

Secondary Insurance Address:______________________________________

Additional "Auto/Worker's Compensation" Insurance Information:

Claim#:_____________________ Injury/Loss Date:__________________

Adjuster Name:____________________ Phone#:___________ Fax#:___________

Adjuster Address:____

Lawyers Name:____________________ Phone#:___________ Fax#___________

Lawyers Address:____

Additional Information:____

Chiropractic Information:

Have you had previous chiropractic care? ☐ Yes ☐ No If yes please answer the next few questions.

Date of last visit:_______________

Chiropractor's Name:_______________________________________

Chiropractor's Address:____

Response to care: ☐ No Results ☐ Positive Results ☐ Negative Results

Has anyone explained chiropractic to you? ☐ Yes ☐ No

Have you had spinal x-rays or MRI's preformed? ☐ Yes ☐ No If yes Mo/Yr Films Taken:________

Therapeutic Information:

Have you had previous Physical Therapy/Massage Care? ☐ Yes ☐ No If yes Mo/Yr of last visit:_____

Therapist Name and Location:____

Response to care? ☐ No Results ☐ Positive Results ☐ Negative Results

General Health History:

Do you feel as if you're in control of your life and health? ☐ Yes ☐ No

Please rate your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please describe your overall health situation: ☐ Improving ☐ No Change ☐ Worsening

Current Health Practices: __ Walking __Jogging __ Biking __Hiking __Supplements
__Homeopathy __Herbs __Aryuvedic __Circuit Training
__Weight Lifting __Aerobics __Swimming __Yoga/Pilates
__Stretching __Tai Chi __Chi Gong __Massage __Reflexology
__Medication __Biofeedback
__Special Diet:_______________________________________
__Supplements:_______________________________________
__Current Sports:_____________________________________
__Water Consumption:_________________________________

Family History: M=Mother/F=Father (Please check all appropriate lines for your parents)

M	F		M	F		M	F	
__	__	Deceased	__	__	Diabetes	__	__	Muscular Dystophy
__	__	Anemia	__	__	Epilepsy/Convulsions	__	__	Polio
__	__	Auto-Immune Diseases	__	__	Hepatitis	__	__	Spinal Problems
__	__	Bad Circulation	__	__	Heart Trouble	__	__	Multiple Sclerosis
__	__	Bladder Trouble	__	__	High Blood Pressure	__	__	Stroke or CVA's
__	__	Cancer	__	__	Kidney Disorder	__	__	Tuberculosis

Social History: (Please check)

Tobacco Usage	__ None	__ Light	__ Moderate	__ Heavy
Alcohol Usage	__ None	__Light	__ Moderate	__ Heavy
Drug Usage	__None	__Light	__Moderate	__Heavy
Exercise	__Often/Routine	__Occasional	__Infrequent	__Rarely or None
Sleep	__Soundly	__Lightly	__Restlessly	__Barely

Weight__________ **Height**__________

Medical History:

Treated by Doctor and/or Therapist for any reason in the last year? __Yes __No

If yes, please describe:______________________________

Date of last visit:____________________

Date of Last Physical:____________________

Doctor Name & Location:______________________________ Phone#:______________

Current Medications: (Please include over the counter meds)

Name:____________________ ☐ OTC ☐ Prescribed Reason:____________________

Name:____________________ ☐ OTC ☐ Prescribed Reason:____________________

Name:____________________ ☐ OTC ☐ Prescribed Reason:____________________

Name:____________________ ☐ OTC ☐ Prescribed Reason:____________________

Name:____________________ ☐ OTC ☐ Prescribed Reason:____________________

Are you pregnant? __Yes __No If yes, what trimester? __________

Surgical History: (Previous Surgeries)

Please start with the most recent:

1.______________________________ Date:__________

2.______________________________ Date:__________

3.______________________________ Date:__________

4.______________________________ Date:__________

5.______________________________ Date:__________

Trauma History: (Previous Injuries)

Please start with the most recent:

__Fall __Auto __Sport __Other 1.______________________________ Date:__________

__Fall __Auto __Sport __Other 2.______________________________ Date:__________

__Fall __Auto __Sport __Other 3.______________________________ Date:__________

__Fall __Auto __Sport __Other 4.______________________________ Date:__________

__Fall __Auto __Sport __Other 5.______________________________ Date:__________

Present Complaints:

*Please rate your current complaints from 1 to 10. List the most severe first.

1.______________________________ Intensity___ Frequency___

2.______________________________ Intensity___ Frequency___

3.______________________________ Intensity___ Frequency___

4.______________________________ Intensity___ Frequency___

Out of all of your health problems, which one would you want to have fixed?____________________
When did you first notice this main problem?______________ Approximate or Exact Date:__________
In what manner did this problem begin? ___Suddenly ___Gradually
From what did this problem develop? ___Job Related Injury ___Auto Accident ___Home Injury
___Illness ___Unknown ___Other________________________
If known, briefly describe how the main problem occurred?______________________________
____
Have you ever had this main problem before? ___Yes ___No When?____________________
How have your symptoms been changing? ___Improving ___No Change ___Worsening
Have you had any radiating pain or numbness? ___Yes ___No Where?____________________
Have you had any changes in urination or defecation? ___Yes ___No How so?______________
Have you been seen by another Dr. or Therapist for the main problem? ___Yes ___No When?________
If yes, name/location:____Phone#____________

Please show the areas of discomfort in the diagrams below:

Area of Complaint - Front View

Right Side **Left Side**

*Figure 1- Shade **FRONT** Areas of in region of complaint and note the type of problem with identifying labels*

Identifying Labels

P = Pain
B = Burning
N = Numbness
S = Sharp
A = Ache
T = Tension
H = Hot
C = Cold

Area of Complaint - Back View

Left Side **Right Side**

*Figure 2- Shade **BACK** Areas of in region of complaint and note the type of problem with identifying labels*

Please check all activities that **AGGRAVATE/WORSEN** your main complaint:
___Bending ___Reaching ___Straining @ stool ___Coughing/Sneezing ___Sitting
___Standing ___Lifting ___Turning head ___Lying down/Sleeping ___Walking

Please check all activities that **RELIEVE/IMPORVE** your main complaint:
___Bending ___Reaching ___Straining @ stool ___Coughing/Sneezing ___Sitting
___Standing ___Lifting ___Turning head ___Lying down/Sleeping ___Walking

Patient's Signature:__________________________________ Date:______________

CREDIT CARD ON FILE POLICY

To Our Patients:

We have implemented a credit card on file policy. You will be asked for credit card information at the time you check in. This information will be held securely as your insurance processes your claim and notifies us of the patient responsibility amount due to any applicable co-insurance or deductibles. At that time, any remaining balances due as the patient's responsibility will be charged to your credit card. A copy of the credit card charge and a receipt will be mailed to you. You will already be aware of this charge amount because your insurance companies mail an Explanation of Benefits to the patient before they send payment to us.

This will be an advantage to you, since you will no longer have to write out and mail a check to us. This process will benefit everyone in helping to keep the cost of health care down. As a practice, we have struggled to find creative ways to keep our costs and fees down in an environment where the costs of healthcare continue to rise.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. You may continue to pay your co-pay due at the time of your visit or any outstanding balances via cash, check, or credit card.

This authorization will remain in effect until rescinded by the cardholder.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely,

Paul Bizzaro, D.C.

I authorize Paul Bizzaro, D.C. to charge outstanding balances on my account and the accounts of members of my family listed below to the following credit card (please check and add expiration date):

VISA ______ MASTERCARD ______ DISCOVER __________ AMEX ______ Card Exp. Date: ________ Sec. Code ______

CC# ________________________________ Print Name: ______________________ Date: ________________

Signed: ______________ (Signature)

____ Medical Record Number: ________________________

(Print Patient Name If Different)

Family Members to Be Included: ____