



# TO THE New Patient

## OUTLINE OF PROCEDURES FOR CARE

### **STEP ONE:**

All new patients are requested to fill out this personal health history questionnaire.

### **STEP TWO:**

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

### **STEP THREE:**

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

### **STEP FOUR:**

The doctor will advise you if additional laboratory tests or x-rays are needed.

### **STEP FIVE:**

You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of

how our treatment works and what results can be obtained. You will also be advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

### **STEP SIX:**

Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

### **STEP SEVEN:**

An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

### **STEP EIGHT:**

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

DATE	I.D. NO.
------	----------

### PERSONAL HISTORY

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
Check One:  Married  Single  Widowed  Divorced  Separated  
Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Name of Spouse \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Type of Work \_\_\_\_\_ Name and Ages of Children \_\_\_\_\_  
Referred To This Office By: \_\_\_\_\_  
Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Who Is Responsible For Your Bill, You and  Spouse  Workers' Comp.  Auto Insurance  Medicare  Medicaid  
 Personal Health Insurance (Name) \_\_\_\_\_  Health Card # \_\_\_\_\_  
Insured Person's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### CURRENT HEALTH CONDITION

Unwanted Health Condition \_\_\_\_\_  
Other Doctors Seen For This Condition:  Yes  No \_\_\_\_\_ Who? \_\_\_\_\_  
Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_  
When Did This Condition Begin? \_\_\_\_\_ Has This Condition Occurred Before?  Yes  No  
Is Condition:  Job Related  Auto Accident  Home Injury  Fall  Other: \_\_\_\_\_  
Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_  
Have You Made A Report of Your Accident To Your Employer:  Yes  No  
Drugs You Now Take:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure Medicine  
 Insulin  Other \_\_\_\_\_  
Do You Wear A Shoe Lift?  Yes  No  
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? \_\_\_\_\_

### PAST HEALTH HISTORY

Please Check and Describe:  
Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  Back Surgery  
 Broken Bones  Other \_\_\_\_\_  
Major Accident or Falls: \_\_\_\_\_  
Hospitalization (Other Than Above): \_\_\_\_\_  
Previous Chiropractic Care:  None  Doctor's Name & Approximate Date of Last Visit \_\_\_\_\_

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        | <b>INTAKE</b>                        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Coffee      |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Tea         |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Alcohol     |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema           |                                      |

Have you been tested HIV positive?  Yes  No

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:**

**MUSCULO-SKELETAL CODE**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

**NERVOUS SYSTEM CODE**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

**GENERAL CODE**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

**GASTRO-INTESTINAL CODE**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

**GENITO-URINARY CODE**

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**C-V-R CODE**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

**EENT CODE**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

**MALE/FEMALE CODE**

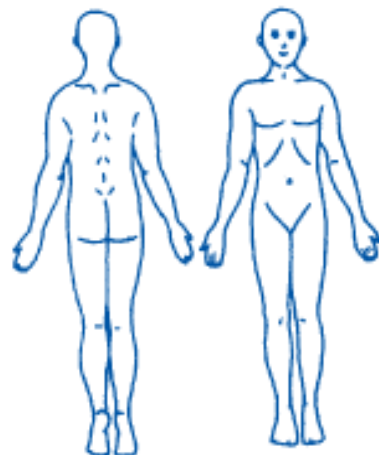
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FEMALES ONLY:**

When was your last period? \_\_\_\_\_

Are you pregnant?

- Yes  No  Not Sure



Please outline on the diagram the area of your discomfort

**FAMILY HISTORY**

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

**DO NOT WRITE BELOW THIS LINE**

ANALYSIS:

DIAGNOSIS:

Patient Accepted:  Yes  No  Referred

\_\_\_\_\_  
Doctor's Signature



Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

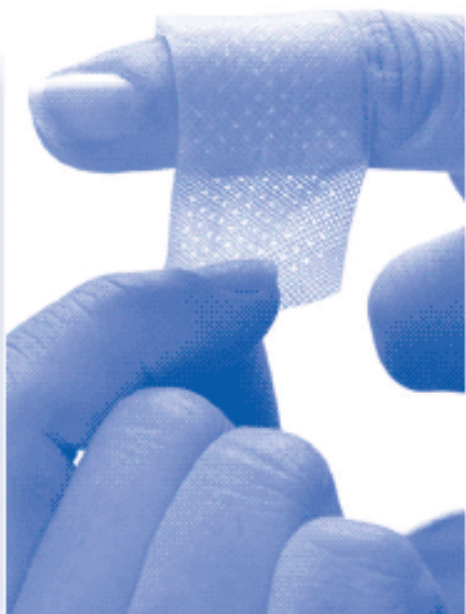
Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care     
  Corrective Care     
  Check here if you want the Doctor to select the type of care appropriate for your condition

Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_

If this is an accident related injury, please fill out the Accident Form. Thank You!



**Relief Care**

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



**Corrective Care**

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

*I understand and agree that 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 reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.*

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature of Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_



CHIROPRACTIC AND SPORTS REHAB

601 Ewing Street, Suite C-3  
Princeton, NJ 08540  
609.921.1705 Office | 609.921.8871 Fax  
www.PrincetonChiropractor.com

# Medical Assignment of Benefits and Financial Policy

Please read this document in its entirety

## Financial Policy, Release of Information, Assignment of Benefits

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. We have varied plans to suit your financial position. If you are committed to getting your treatment then we will do everything we can to work out a payment plan for you that is comfortable and workable for your budget. If you have any questions, please discuss them with us prior to beginning therapy.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to us. In other words, you agree to have your insurance company pay us directly. If your insurance company does not pay us within a reasonable time period, we will have to look to you for payment of the outstanding balance.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for services are due at the time of service.
- You must inform our office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges that are denied.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian for payment.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment at the time of service. If you have a copay, you may either pay each time you come for your appointment or you may pay in advance to cover all visits for the week. Once the insurance company has begun to process our bills, if there is a balance due, we will send you a statement each month for the amount you owe – i.e. deductible, coinsurance, co-pay, until all claims have been processed. Payment is due upon receipt of our bill.
- All health plans are not the same and do not cover the same services. We will do our best to determine what services are covered by your insurance and let you know if there is a recommended treatment that is not a benefit of your insurance so that you may decide to proceed with the treatment or elect not to have the treatment performed. In the event your health plan determines a service to be “not covered” and we are unaware or you do not have authorization, you will be responsible for the complete charge.
- In today’s managed care system, insurance must be looked at as a supplement to your care not as the sole means to achieving it. They have a limit to what they will pay and will not pay for maintenance/wellness care.

## Payments and Patient Signature

- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.
- There is a \$20 service fee for all returned checks. Your insurance company does not cover this fee.
- A \$30 fee will be charged for all “No Shows” & Cancellations without a 24 hour notice. This fee is not reimbursable by insurance.
- I have read and understand the financial policy of Princeton Chiropractic, LLC and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by this office.
- I authorize the release of information necessary for treatment, payment & health care operations. I also authorize assignment of benefits for services rendered by Princeton Chiropractic, LLC.

Date: \_\_\_\_\_

Patient/Responsible Party Signature: \_\_\_\_\_



CHIROPRACTIC AND SPORTS REHAB

601 Ewing Street, Suite C-3  
Princeton, NJ 08540  
609.921.1705 Office | 609.921.8871 Fax  
www.PrincetonChiropractor.com

**HIPAA**

**Privacy Practices**

**Please read this document in its entirety**

## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

In the course of your care as a patient at Princeton Chiropractic, LLC we may use and disclose your personal and health related information for each of the following purposes:

- **TREATMENT** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would be sending medical information to the referring physician. Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment or to keep your Primary Care Physician abreast of your condition and progress while under care in this office.
- **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill and/or chart notes for your visit to your insurance company for payment.
- **HEALTH CARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be sending charts to an insurance network for quality assurance review.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, reschedule appointments or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.



CHIROPRACTIC AND SPORTS REHAB

601 Ewing Street, Suite C-3  
Princeton, NJ 08540  
609.921.1705 Office | 609.921.8871 Fax  
www.PrincetonChiropractor.com

**HIPAA**

## **Privacy Practices**

**Please read this document in its entirety**

---

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: Sandy Haegler

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information for as long as it remains in our files.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a copy of the revised Notice of Privacy Practices from this office. Any change in our privacy notice will apply for all of your health information in our files.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

**Please contact us for more information:**

Princeton Chiropractic, LLC  
601 Ewing, Street, Suite C-3  
Princeton, NJ 08540  
609-921-1705

**For more information about HIPAA or to file a complaint:**

The US Department of Health & Human Services  
Office of Civil Rights  
200 Independence Ave SW  
Washington, DC 20201  
Toll Free: 1-877-696-6775



CHIROPRACTIC AND SPORTS REHAB

601 Ewing Street, Suite C-3  
Princeton, NJ 08540  
609.921.1705 Office | 609.921.8871 Fax  
www.PrincetonChiropractor.com

# HIPPA

## Privacy Practices

Please read this document in its entirety

### Patient Information and Signature

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Patient Name (Printed) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

If you are a minor, or if you are being represented by another party:

Personal Representative Name (Printed) \_\_\_\_\_

Relationship to Patient and Description of the authority to act on behalf of the patient \_\_\_\_\_

Personal Representative Signature \_\_\_\_\_

Date \_\_\_\_\_

### Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason
------	----------	--------





**Edward V. Sofo, D.C., C.C.S.P.**  
*Certified Chiropractic Sports Physician*

*CHIROPRACTIC AND SPORTS REHAB*  
*Restore Function • Improve Health • Maintain Wellness*

*DrSofo@optonline.net*  
*www.PrincetonChiropractor.com*

---

Princeton Professional Park • 601 Ewing Street, Suite C-3 • Princeton, New Jersey 08540 • Telephone: (609) 921-1705

In order to complete our records and keep your file up to date please provide us with your Primary Care Physician or Family Physician Contact info. We may need to contact him or her in regards to a referral or medical records or to update your records on your current condition.

Thank you,

Dr. Sofo

Primary Care Doctor Name: \_\_\_\_\_

Primary Care Physician Group Name: \_\_\_\_\_

Primary Care Physician Address: \_\_\_\_\_

Primary Care Physician Address: \_\_\_\_\_

Primary Care Physician Phone : \_\_\_\_\_