Concept Chiropractic
+ Regenerative Medicine
Renew Yourself

PATIENT REGISTRATION

PATIENT INFORMATION

Patient First Name:	Patient Middle Name:	Patient Last Name:

Street Address:	City:	State:	Zip:
Employer's Street Address:	City:	State:	Zip:

Home Phone:	Work Phone:	Cell Phone:	I authorize Concept Chiropractic and Regenerative Medicine to leave a message on all answering services.

Birth Date:	Marital Status: Single Married Divorced Widowed Other	Gender: Male Female

Email:	I authorize Concept Chiropractic and Regenerative Medicine to send me emails for reminders, e-statements/bills, and informational newsletters.
Occupation:	Employer's Name:

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Relationship:	Phone Number:

I authorize Concept Chiropractic and Regenerative Medicine to leave or give information to spouse, emergency contact or any member of household.

REFERRAL SOURCE AND PRIMARY CARE DOCTOR INFORMATION

How did you hear about us?	Primary Care Physician:

HEALTH INSURANCE INFORMATION

Is your injury related to an auto accident, other accident, or worker's compensation? Yes No

Primary Health Insurance Name:	Phone #:

Policyholder's Name (if not self):	Relationship:	Date of Birth:

Secondary Health Insurance Name:	Phone #:

Policyholder's Name (if not self):	Relationship:	Date of Birth:

If you would like to put a credit card on file check the box and fill in your Credit Card Information

I prefer to be charged automatically on my credit card for any out of pocket cost or balances relating to my care and treatment that are not covered By my insurance. With the signature at the bottom of the page I authorize Concept Chiropractic and Regenerative Medicine to charge any of these charges on the credit card listed below. I will present the card at the first visit. To protect my safety the complete credit card number cannot be kept on file:

VISA MC AMEX DISCOVER Last 4 Digits of CC#:______________ Exp Date:______________

By signing the bottom of this page I authorize that the information provided above is true to the best of my knowledge. I understand that I may be billed administrative and filing fees for withholding information as it relates to my medical history and insurance coverage.

Print Name ______________ Signature (Parent/Guardian if patient is a minor) ______________ Date ______________

INSURANCE AUTHORIZATION OF TREATMENT, INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ________________________________ and assign directly to Concept Chiropractic and Regenerative Medicine all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

FINANCIAL POLICY

1. I am ultimately responsible for full payment for any and all services rendered.
2. I am considered as a CASH patient until I have provided completed insurance forms, and that your office has qualified and accepted my coverage, otherwise I pay at the time of service.
3. I am responsible for any costs not covered by my insurance and therefore must pay deductibles, copays,coinsurance and one-time initial $5 medical supply/administrative/processing fee at the time of service.
4. Insurance Benefits quoted by my insurance company are NOT a guarantee of payment or coverage.
5. Concept Chiropractic and Regenerative Medicine makes every attempt to receive authorization of treatment from insurance companies for treatment received at our facility. However, there may be times when the insurance company does not provide this authorization in a timely manner. Concept Chiropractic and Regenerative Medicine will submit claims as a courtesy to me. If my insurance carrier has not paid a claim within the terms of the contract within 60 days of submission, Concept Chiropractic and Regenerative Medicine will submit an appeal one(1) time. If the claim is not paid within 30 days of the appeal I will be responsible for taking an active part in the recovery of my claim. After 90 days, I will be responsible for the balance and I authorize the use my credit card, (if supplied) to collect full payment, otherwise I must remit payment in full upon receipt of the bill.
6. In the event I discontinue my plan of care prior to the doctor's consent, I am responsible for any outstanding balance and the courtesy of insurance assignment is immediately discontinued.
7. I agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.
8. I agree that in order for Concept Chiropractic and Regenerative Medicine to service my account or to collect any amounts I may owe, Concept Chiropractic and Regenerative Medicine may contact me by telephone at any telephone number associated with my account. This includes wireless telephone numbers, which could result in charges to me. Concept Chiropractic and Regenerative Medicine may also contact me by sending text messages or e-mails, using any e-mail address I have provided to them. Methods of contact may include using pre-recorded/ artificial voice message and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that Concept Chiropractic and Regenerative Medicine or any agency working on behalf of Concept Chiropractic and Regenerative Medicine may contact me/us as described above.
9. I understand that I can be charged a **$75.00** NO SHOW fee for any appointment not rescheduled within the same week or same day(depending on availability) or canceled within 24hrs.

By Signing below I agree to all statements in the Financial Policy, Insurance Assignment and Insurance Authorization and Release above.

____________________	____________________	____________________
Print Name	Signature (Parent/Guardian if patient is a minor)	Date

NOTICE OF PRIVACY PRACTICES AND PATIENT'S RIGHTS AND RESPONSIBILITIES

PLEASE CHECK THE BOX, SIGN, AND DATE below to acknowledge receipt of the HIPAA Privacy Practices and Patient Rights and Responsibilities:

☐ I have read and/or was offered a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities by Concept Chiropractic and Regenerative Medicine.

____________________	____________________	____________________
Print Name	Signature (Parent/Guardian if patient is a minor)	Date

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CONSENT TO EXAMINATION AND CARE

I hereby authorize Concept Chiropractic and Regenerative Medicine and its licensed doctors and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include spinal manipulation and other tests and procedures considered therapeutically appropriate. I also wish to rely on the Concept Chiropractic and Regenerative Medicine doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the examination and evaluation, the treatment and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction. By signing below I acknowledge my consent to be examined:

Patient's Print Name	Patient Signature (Parent/Guardian for minor)	Date

The specifics of the doctor's recommendation will be further explained during a Report of Findings following your examination and any subsequent examinations and significant changes in your diagnosis or treatment plan.

Based on current findings, Concept Chiropractic and Regenerative Medicine doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

To aid the understanding of my condition and the reasons for the proposed course of care, Concept Chiropractic and Regenerative Medicine doctors have answered my questions regarding the planned treatments and course of care that I will receive. Concept Chiropractic and Regenerative Medicine doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and that Concept Chiropractic and Regenerative Medicine doctors will advise me of any material risks in this regard.
2. That neither the physical therapy/chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.
4. Concept Chiropractic and Regenerative Medicine does not guarantee as to results with respect any course of care or treatment.
5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by Concept Chiropractic and Regenerative Medicine.

Patient's Print Name	Signature of Doctor	Date

Signature (Parent/Guardian if patient is a minor)	Date

Doctor's Notes:

Patient counseled by: ____________________ Discussion: ____________________

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CURRENT MEDICAL HISTORY

PATIENT INFORMATION

Patient Name:	Gender: Male Female
Current Symptoms (Be Specific):	
When did the symptoms first appear?	Rate your symptoms on a scale from 0-10:
What makes the symptoms worse or increase:	
What makes the symptoms better or decrease?	
Please identify three activities that you are unable to perform without symptoms due to this condition: 1. 2. 3.	
Have you seen another health care provider for this problem? Yes No If yes, who?	

SYMPTOMS

constant	mild	sharp	dull	achy
frequent	moderate	burning	stiffness	swelling
occasional	severe	numbness	tingling	other:

REVIEW OF CURRENT SYMPTOMS: DO YOU CURRENTLY HAVE ANY?

	YES	NO
Generalized symptoms: such as weakness, fatigue, fever, chills, night sweats, fainting, change in sleep pattern, unexplained weight loss/gain or others? (circle symptom if listed)		
Skin problems: such as rashes, itching, dryness, sores, changes in skin color, changes in moles, changes in hair, changes in fingernails, or others? (circle symptom if listed)		
Lung problems: such as coughing, phlegm, shortness of breath, difficulty breathing, wheezing, congestion, coughing blood, or others? (circle symptom if listed)		
Heart problems: such as a murmur, palpitations, rapid heartbeat, extremity swelling, chest pain, cold extremities, high/low blood pressure, or others? (circle symptom if listed)		
Gastrointestinal problems: such as stomach pain, nausea/vomiting, diarrhea, gas/bloating, constipation, rectal bleeding, change in appetite/thirst, change in stools or others? (circle symptom if listed)		
Genitourinary problems: such as painful urination, blood in urine, frequent urination, incontinence, urgency, change in urine appearance or others? (circle symptom if listed)		
Musculoskeletal problems: such as muscle pain, muscle weakness, muscle twitching, joint stiffness, joint pain, joint swelling, hot joints or others? (circle symptom if listed)		
Neurological problems: such as numbness, tingling, weakness, paralysis, loss of memory, loss of sensation, difficulty with coordination, dizziness, difficulty with speech or others? (circle symptom if listed)		
Psychiatric problems: such as depression, anxiousness, hallucination, drug addiction, suicidal thoughts, difficulty sleeping or others? (circle symptom if listed)		
Eye, nose or throat problems: such as blurred vision, double vision, eye pain, hearing loss, ringing in ear, vertigo, sinus problems, loss of smell, hoarseness, difficulty swallowing or others? (circle symptom if listed)		

If you answered Yes to any question above please explain:

If Female, What was the date of your last menstrual period? ____________________

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PAST MEDICAL HISTORY

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Please check to indicate if you have had any of the following:

AIDS/HIV	Breast Lump	Gonorrhea	Liver Disease	Shingles
Alcoholism	Bulimia	Gout	Migraines	Stroke
Anemia	Cancer	Heart Disease	Multiple Sclerosis	Suicide Attempt
Anorexia	Diabetes	Hepatitis	Osteoporosis	Thyroid Problems
Appendicitis	Drug Abuse	Hernia	Pacemaker	Tuberculosis
Arthritis	Emphysema	Herpes	Polio/Post-Polio	Tumors
Asthma	Epilepsy	High Cholesterol	Psychiatric Care	Ulcers
Blood Disorders	Glaucoma	Kidney Disease	Rheumatoid Arthritis	Venereal Disease

PLEASE LIST ANY MAJOR ILLNESSES, INJURIES, FRACTURES, OR SURGERIES YOU HAVE HAD

ILLNESS, INJURY, FRACTURE, SURGERY	DATE	TREATMENT

Please list any allergies you have:

Please list any medications you are currently taking:

Please list any vitamins/nutritional supplements you are taking:

FAMILY HISTORY - List any diseases that run in your family

BLOOD RELATIVE	MAJOR ILLNESS
Father	
Mother	
Brother(s):	
Sister(s):	
Other Relative:	

SOCIAL HISTORY

Please check all that apply.

SMOKING	EXERCISE	ALCOHOL	CAFFEINE
Never Smoked	Exercise None	No Alcohol	No Caffeine
Previously Smoked	Light Exercise	Presently Drink Alcohol	Yes Caffeine
Presently Smoked	Moderated Exercise	# Drinks/Week	#Cups/day
#Pack/Wk: Years:	Heavy Exercise	(Includes beer, wine, liquor)	(Includes coffee, tea, soda)

THIS CONFIDENTIAL HISTORY WILL BE A PART OF YOUR PERMANENT RECORDS

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NOTICE OF PRIVACY PRACTICES

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.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us compliance@chiroregenmed.com. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care; Share information in a disaster relief situation; Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: Marketing purposes; Sale of your information; Most sharing of psychotherapy notes

In the case of fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways.

Treat you - We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization - We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services - We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues - We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medication; Reporting suspected abuse, neglect, or domestic violence; and Preventing or reducing a serious threat to anyone's health or safety

Do research - We can use or share your information for health research.

Comply with the law - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests - We can share health information about you with organ procurement organizations.

NOTICE OF PRIVACY PRACTICES

Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests - We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html
View online at www.chiroregenmed.com

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PATIENT RIGHTS AND RESPONSIBILITIES

YOU THE PATIENT HAVE THE RIGHT TO:

- Be treated with dignity and respect
- Confidentiality
- Participate in the assessment and care planning process
- Be provided service in a timely manner
- Be notified in advance of types of treatment and frequency of treatment being provided
- Be notified of any changes in your plan of care and treatment
- Receive an explanation of the billing process and an explanation of charges
- Express grievance without fear of reprisal or discrimination
- Refuse or discontinue

YOU THE PATIENT ARE RESPONSIBLE FOR:

- Providing information when services are rendered
- Notifying practice when you will not be available for treatment or will be late for treatment
- Rescheduling any missed treatment in order to keep on schedule as outlined in your treatment plan
- Notifying the practice of any change in your condition, physician orders, attending physician, or attorney
- Notifying the practice of any incident involving the staff or equipment
- Payment of all co-payment or deductible applicable per the insurance plan of your choice

PATIENT EMPOWERMENT CHECKLIST!

1. **COMMUNICATION** - If your condition worsens, please contact us immediately. We are required to give you the dr's cell phone number, their email or both.
2. **FOLLOW UP** - Follow up with all of your doctor's self-care advice, such as:
   - Performing all of your home exercise instructions. If you have any problems doing your home exercises, inform Dr. Hegazi immediately.
   - Follow up with your icing instructions.
   - Watch your ergonomics. Take time to evaluate your work station and how you perform your home related activities and ensure you are always in the "good posture position."
3. **UNDERSTANDING** - Ensure you understand all of your available treatment options, both inside and outside of this office, which Dr. Hegazi has discussed with you.