Peter J. Stein, DC •• Chiropractic and Rehabilitation Therapies

WELCOME!

In order to provide you with the best possible care, please provide the information below.

PAYMENT INFORMATION

Unless other arrangements have been made, payment would be appreciated at the time that services are rendered.

PATIENT IDENTIFICATION

Name	Occupation:
	Male [] Female []
Street	Date of Birth: Age:
City, State, and Zip	Medicare ID no
Contact numbers:	Other insurance co.: ID:
best #?	Who referred you to this office?
□ Work: ()	
☐ Mobile: ()	May we thank them? []yes []no
Email: Contact in case of emergency:	
Name:	
Telephone:()	
Name of parent/guardian of Minor Patier	nt:
your health needs. In the event that your nee provider, if appropriate. Your signature below services we perform. You are ultimately resp	history and physical examination will be conducted, to further determine ds cannot be met here, this office will refer you to another health care w will authorize payment to us by a third party, if applicable, for covered onsible for payment of expenses related to your care in this office. This ell as for cancellations less than 12 hours in advance of the appointment time
Please sign below to indicate your understan	ding of the above paragraph:
Signature	Date
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Name \sqcup Initial	$\square Re$ -evaluation
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Please indicate areas where you experience pain, using the body outlines below. Please mark the quality of the pain, using the suggested code letters, or other indicators you prefer.

A = ache

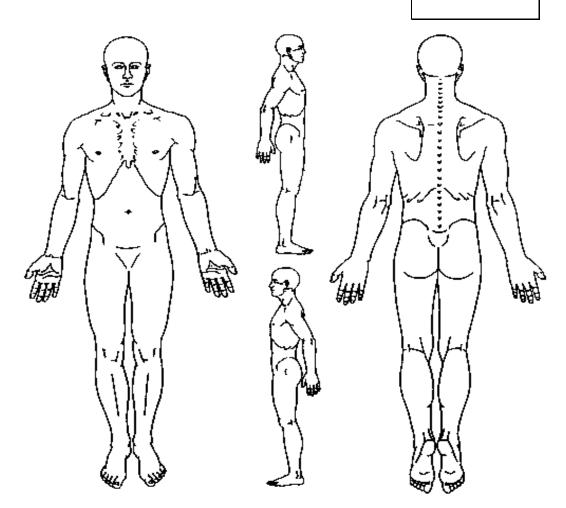
B = burning

N = numbness

P = pins and needles

 $S = \frac{1}{\text{sharp/stabbing}}$

X= other



Please mark your level of pain anywhere on the line below:

no worst possible pain pain

HEALTH HISTORY

This history form provides us with information to help us meet all your healthcare needs. This is a confidential part of your medical record. Today's date	PATIENT N	JAME			BIR	THDATE/	/			
Today's date	This history	form p	provides us wi	th information to help us	meet	all your healthca	are needs. This is a con	fidenti	al part of	
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Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

• I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.							
printed name	OR	authorized personal representative					
signature		date					
date							