



# Milton Chiropractic & Rehabilitation, Inc.



# BAY STATE PHYSICAL THERAPY

## General Patient Intake Form

File Number (Office Use) \_\_\_\_\_

### Patient Information:

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

I prefer to be called \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sex **Male** **Female**

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

If minor, name of parent or guardian \_\_\_\_\_

Who should we contact in case of an emergency? \_\_\_\_\_

Relation \_\_\_\_\_

Address \_\_\_\_\_

Attorney \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

» Is He/She within Harvard Vanguard Medical Group **YES** **NO**

How did you hear about our office? \_\_\_\_\_

Have you ever been to a chiropractor / physical therapy before? **YES** **NO** Who? \_\_\_\_\_

\_\_\_\_\_

### Insurance Information:

Insurance Company \_\_\_\_\_

Ins Co. Address \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Relation \_\_\_\_\_ Date of Birth \_\_\_\_\_

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Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Social Security No. \_\_\_\_\_

Date of Birth \_\_\_\_\_

Height \_\_\_\_\_' \_\_\_\_\_" Weight \_\_\_\_\_ lbs

Marital Status \_\_\_\_\_

No of Children \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

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Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



# Milton Chiropractic & Rehabilitation, Inc.



# BAY STATE PHYSICAL THERAPY

## Health History

Are you taking any of the following medications?

<b>NERVE PILLS</b>	<b>PAIN KILLERS</b> (incl. aspirin)	<b>MUSCLE RELAXERS</b>	<b>STIMULANTS</b>
<b>BLOOD THINNERS</b>	<b>TRANQUILIZERS</b>	<b>INSULIN</b>	<b>OTHER</b> _____

Have you ever had any of the following diseases or conditions?

<b>HEART ATTACK/STROKE</b>	<b>HEART SURGERY/PACEMAKER</b>	<b>HEART MURMUR</b>
<b>CONGENITAL HEART DEFECT</b>	<b>MITRAL VALVE COLLAPSE</b>	<b>ARTIFICIAL VALVES</b>
<b>ALCOHOL/DRUG ABUSE</b>	<b>VENEREAL DISEASE</b>	<b>HEPATITIS</b>
<b>HIV+/AIDS</b>	<b>SHINGLES</b>	<b>CANCER</b>
<b>FREQUENT NECK PAIN</b>	<b>EMPHYSEMA/GLAUCOMA</b>	<b>ANEMIA</b>
<b>HIGH/LOW BLOOD PRESSURE</b>	<b>PSYCHIATRIC PROBLEMS</b>	<b>RHEUMATIC FEVER</b>
<b>SEVERE/FREQ. HEADACHES</b>	<b>KIDNEY PROBLEMS</b>	<b>ULCERS/COLONITIS</b>
<b>FAINTING/SEIZURE/EPILEPSY</b>	<b>SINUS PROBLEMS</b>	<b>ASTHMA</b>
<b>DIABETES/TUBERCULOSIS</b>	<b>DIFFICULTY BREATHING</b>	<b>CHEMOTHERAPY</b>
<b>LOWER BACK PROBLEMS</b>	<b>ARTIFICIAL BONES/JOINTS</b>	<b>ARTHRITIS</b>

Please list any other serious medical conditions that you have or have ever had. \_\_\_\_\_

Please list anything that you may be allergic to. \_\_\_\_\_

Please list previous surgeries/treatments with dates. \_\_\_\_\_

Please list any past serious accidents with dates. \_\_\_\_\_

Is there anything else about your family health history that you feel is important to share? \_\_\_\_\_

Do you: Take supplements or vitamins? **YES** **NO** Exercise? **YES** **NO**

Are you on a special diet? **YES** **NO** Since: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you smoke? **YES** **NO** How much? \_\_\_\_\_ How long? \_\_\_\_\_

Are you wearing: **HEEL LIFTS** **SOLE LIFTS** **INNER SOLES** **ARCH SUPPORTS** ?

What is the age of your mattress? \_\_\_\_\_ Is it comfortable? **YES** **NO**

*For women:* Are you taking birth control? **YES** **NO**

Are you pregnant? **YES** **NO** How long? \_\_\_\_\_ Nursing? **YES** **NO**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



# Milton Chiropractic & Rehabilitation, Inc.

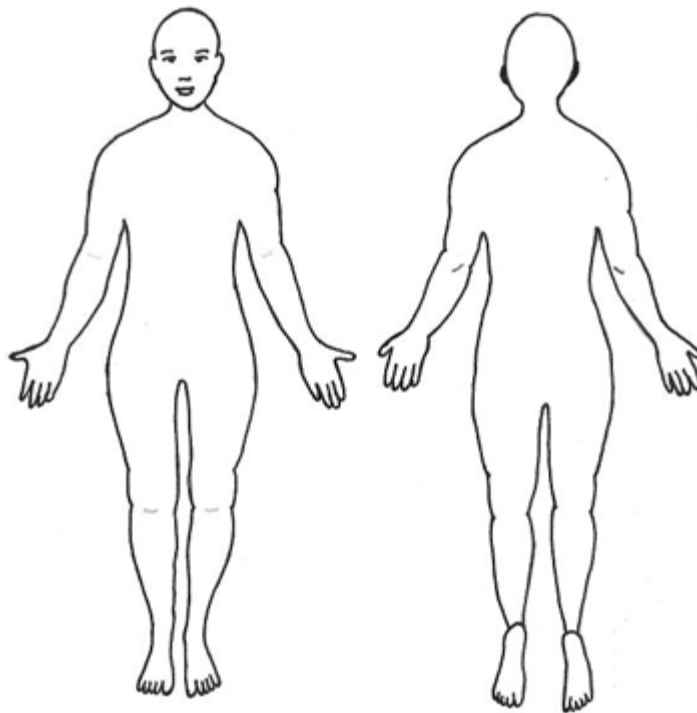


# BAY STATE PHYSICAL THERAPY

Test	Have you had this test?	Date performed	Did you bring copy today?
X-ray	Y or N		Y or N
MRI	Y or N		Y or N
CT Scan	Y or N		Y or N
Bone Scan	Y or N		Y or N
EMG	Y or N		Y or N
Other _____	Y or N		Y or N

Please mark these drawings to show the location of your symptoms and the type of symptoms you are experiencing.

**Sharp Pain** // // // // //    **Achy Pain** ^ ^ ^ ^ ^    **Burning Pain** X X X X X    **Numbness** 0 0 0 0



### Pain Scale

Please circle the number corresponding with the intensity of your symptoms. A "0" represents no pain where as a "10" represents the most severe pain imaginable.

Location: \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

Location: \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

Location: \_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Milton Chiropractic  
& Rehabilitation, Inc.**



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## Patient Information Consent Form

I understand that Milton Chiropractic / Bay State Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments, understand that have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Milton Chiropractic / Bay State Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

**I hereby consent to the use and disclosure of my personal health information for purposes as noted in Milton Chiropractic / Bay State Physical Therapy's Notice of information practices. I understand that I retain the right to revoke this consent by not signing the practice at any time.**

**Patient Name:** \_\_\_\_\_

**Signature :** \_\_\_\_\_

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



**Milton Chiropractic  
& Rehabilitation, Inc.**



**BAY STATE**  
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## Acknowledgement of Office Policies

The following are Milton Chiropractic and Bay State Physical Therapy's policies governing appointment scheduling, payment terms, and information release. Please read carefully and initial after each section before signing the bottom, and be sure to ask any questions you might have before signing the document.

**Appointment Scheduling.** We at Milton Chiropractic and Bay State Physical Therapy are glad to accept insurance assignment on your behalf in handling payment for the care you receive. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. This means that if you miss several appointments without notifying our office (emergencies considered), you may be dismissed from care and your file may be closed. *We only treat those patients who want to get well.*

**Consent for Treatment.** I, the undersigned, give Milton Chiropractic and Bay State Physical Therapy my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, my condition may worsen on rare occasions, or injury may occur (ie. muscle spasm, rib injury, etc). Risk of injury or complications from chiropractic treatments and physical therapy are substantially lower than that associated with many medical procedures or medications given for the same symptoms. I further understand that **no guarantee or promise** has been made to me concerning the results of treatment.

**Assignment of Payment.** I hereby **authorize** my insurance company and/or my attorney to pay direct to Milton Chiropractic & Rehabilitation and Bay State Physical Therapy any monies due on my account for professional services rendered.

**Acknowledgement and Understanding.** It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office.

**Private Health Insurance.** I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.)

**Authorization to Release Information.** I **authorize** this office to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

**Patient Requests for Records.** I **authorize** the release of all medical, hospital, or surgical records pertinent to my care, including but not limited to, exams, special tests, x-rays, or lab results to this office.

**Ownership.** I understand that Milton Chiropractic, Bay State Physical Therapy and Massage Works! are all owned and operated by the same entity.

**I certify that I have read and understand all appointment and office policies listed above.**

Name (print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness (print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



**Milton Chiropractic  
& Rehabilitation, Inc.**



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## **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

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

### **Uses and Disclosures**

Here are some examples of how we might have to use or disclose your health care information:

- 1) Your chiropractor, physical therapist or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- 2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- 3) Your chiropractor, physical therapist and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
- 4) Your chiropractor, physical therapist and members of the practice staff may need to use your name, address, email, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520 (b)(1)(iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine. You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related 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 inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

### **Our Privacy Pledge**

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

### **Permitted uses and disclosures without your consent or authorization**

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- 1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
- 2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.



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- 3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- 4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
- 5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

Other than the circumstances described in the preceding five examples and under the **Uses and Disclosures** section above, any other use or disclosure of your health information will only be made with your written authorization.

### **Your right to revoke your authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

- 1) If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(i)
- 2) 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. If you wish to revoke your authorization please write to us at:

**Milton Chiropractic / Bay State Physical Therapy**  
**111 Willard Street Suite 2A**  
**Quincy, MA 02169**

### **Your right to limit uses or disclosures**

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

### **Your right to receive confidential communication regarding your health information**

We normally provide information about your health to you in person at the time you receive health-related services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.



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### **Your right to inspect and copy your health information**

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

### **Your right to amend your health information**

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

### **Your right to receive an accounting of the disclosures we have made of your records**

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request.

The accounting will include all disclosures except those disclosures:

- required for your treatment, to obtain payment for your services, or to run our practice.
- made to you.
- necessary to maintain a directory of the individuals in our facility
- to individuals involved with your care.
- for national security or intelligence purposes.
- made to correctional officers or law enforcement officers.
- that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

### **Your right to obtain a paper copy of this notice**

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

### **Our duties**

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

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

### **Re-disclosure**

Information that we use or disclose 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.

### **Your right to complain**

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

**Steven Windwer**  
**111 Willard Street Suite 2A**  
**Quincy, MA 02169**



## Milton Chiropractic & Rehabilitation, Inc.



**BAY STATE**  
PHYSICAL THERAPY

### To Contact Us

If you would like further information about our privacy policies and practices please contact:

**Steven Windwer**  
**111 Willard Street Suite 2A**  
**Quincy, MA 02169**  
**[drwindwer@miltonchiropractic.com](mailto:drwindwer@miltonchiropractic.com)**

This notice is effective as of April 14, 2003 or Date you signed the acknowledgement that you have received this notice. This notice will expire seven years after the date upon which the record was created.



**Milton Chiropractic  
& Rehabilitation, Inc.**



**BAY STATE**  
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## **Acknowledgement of Privacy Policy (HIPPA)**

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I acknowledge that I have received a copy of Milton Chiropractic & Rehabilitation and Bay State Physical Therapy's *Notice of Privacy Practices for Protected Health Information*.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature or Authorized Representative

\_\_\_\_\_  
Authorized Representative Name Printed and Relation to Patient