PATIENT INTRODUCTION CARD

{Please Print} Date: _____

Name: _____ Social Security No.: ____-____-____
(last) (first) (middle)

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Age: _____ ☐ Male ☐ Female No. of children: _____

Occupation: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employed by: _____ Business Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Spouse {or parent, if minor} _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Person responsible for account: _____

Address: _____ City: _____ State: _____ Zip: _____

Referred by: _____

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

☐ Temporary relief ☐ Control of immediate problem ☐ Total health care

☐ I prefer the doctor select the type of care he feels is best for me.

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE.

Have you had chiropractic care before? ☐ Yes ☐ No If so, when? _____

Do you have health insurance? ☐ Yes ☐ No What company? _____

Address: _____ Policy Number: _____

Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and policy to policy. Therefore, although we will fill out the insurance forms, the patient is personally responsible for payment of services rendered. We do accept certain insurance assignments, but all insurance arrangements must be approved in advance.

Check type of insurance coverage:

☐ Workers' Compensation ☐ Automobile Insurance Policy ☐ Group Policy

☐ Government Health Plan ☐ Personal Policy ☐ Other: _____

OUR PERSONAL CONCERN

Our professional and personal concern is with just two things, your health and our reputation. Therefore, we accept only those patients whom we sincerely believe we can help.

Revised 12/20/2023

CASE HISTORY RECORD

{Please Print}

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Office Phone: _____

Age: _____ **Date of Birth:** _____/_____/_____ **Sex:** ☐ Male ☐ Female **No. of children:** _____

Occupation: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Referred by: _____

Nearly all insurance covers chiropractic services, does yours? ☐ Yes ☐ No ☐ I don't know.

Name of insurance company: _____ **Policy #:** _____

Address: _____ City: _____ State: _____ Zip: _____

Major complaints and symptoms: _____

_____

Location and type of pain: _____

_____

When did you first notice this: _____

Has this happened before? ☐ Yes ☐ No **If so, when?** _____

Does this interfere with your normal living and work? ☐ Yes ☐ No ☐ Sometimes.

Any family history of this condition? ☐ Yes ☐ No ☐ I don't know.

Was it caused by a strain? _____ **Fall?** _____ **Accident?** _____

Automobile accident? ☐ Yes ☐ No If so, date? _____ Time? _____

Other accidents? _____

Attorney's name: _____ **Address:** _____

Have you had treatment by another doctor for this? ☐ Yes ☐ No

Name of doctor: _____ **Diagnosis:** _____

Treatment: _____ **X-rays:** _____

Length of care: _____ **Results:** _____

Drugs (Present): _____ **(Previous):** _____ **Vitamins:** _____

Questionnaire

{Please Print}
Name: _____

Have you had any difficulty with the following?

Head: Headaches_____ Dizziness_____ Sinus_____ Other _____

Eyes: Glasses/Contacts_____ Pain_____ Inflammation _____ Other _____

Nose: Smell _____ Hay Fever _____ Head Colds _____ Obstruction _____

Throat: Speech _____ Tightness _____ Pain _____ Thyroid _____ Tonsils _____

Neck: Stiffness _____ Pain_____ Tension _____ Other _____

Right Shoulder: Pain _____ Stiff _____ Bursitis _____ Other _____

Left Shoulder: Pain _____ Stiff _____ Bursitis _____ Other _____

Arms: R _____ L _____ **Elbows:** R _____ L _____ **Wrists:** R _____ L _____ **Hands:** R _____ L _____

Heart: Pain _____ Spasms _____ Palpation _____ Attack _____

High Blood Pressure: ☐ Yes ☐ No **Low Blood Pressure:** ☐ Yes ☐ No **When?** _____

Lungs: TB _____ Pain around chest _____ Intercostal Neuritis _____

Abdomen: Stomach _____ Liver _____ Gallbladder _____ Intestines _____

Digestion _____ **Gas** _____ **Constipation** _____ **Diarrhea** _____

Kidneys _____ **Hemorrhoids** _____ **Tenderness of Abdomen** _____

Menstruation: Pain _____ Cramping _____ Irregularity _____ Peri/Menopause _____

Do you have inner tension? _____ **Nervousness** _____

Diabetes _____ **Cancer** _____ **Rheumatism** _____ **Goiter** _____

Numbness in any body part _____ **Cramps** _____ **Swelling** _____

Anemia _____ **Fainting** _____ **Weakness** _____ **Painful joints** _____

Arthritis _____ **Pain in upper / lower dorsal area** _____

Pain in lower back _____

Pain In: Hips _____ R _____ L _____ Thigh _____ R _____ L _____ Knee _____ R _____ L _____

Pain In: Calf _____ R _____ L _____ Ankle _____ R _____ L _____ Foot _____ R _____ L _____

Comments: _____

_____

_____

_____

McCarrin Chiropractic Center
Dr. John E. McCarrin

MEDICAL INSURANCE DEDUCTIBLES

FOR YOUR INFORMATION, PLEASE NOTE:

A SEPARATE DEDUCTIBLE AMOUNT IS PAYABLE WITH RESPECT TO EACH CALENDAR YEAR IN WHICH COVERED MEDICAL EXPENSES ARE INCURRED.

PLEASE CHECK YOUR INSURANCE POLICY FOR THE AMOUNT OF YOUR DEDUCTIBLE.

EACH PATIENT IS RESPONSIBLE FOR THE PAYMENT OF THEIR ANNUAL DEDUCTIBLE.

THANK YOU.
DR. McCARRIN

436 E Baltimore Ave
Media, PA 19063
(610)566-7424

McCarrin Chiropractic & Physical Therapy Center
436 East Baltimore Pike | Media, PA 19063
Office: (610) 566-7424 | Fax: (610) 892-0489

Re: X-ray Authorization

I hereby give authorization for McCarrin Chiropractic & Physical Therapy Center to take x-rays in this office.

_____ I am not pregnant.

_____ I am possibly pregnant.

_____ _____

Signature Date

McCarrin Chiropractic Center
Dr. John E. McCarrin

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT INCLUDING THE HISTORY OBTAINED, X-RAY, AND PHYSICAL FINDINGS, DIAGNOSIS, AND PROGNOSIS.

NAME _____ DATE _____

SOCIAL SECURITY NUMBER _____

SIGNATURE _____
(PLEASE SIGN TO AVOID DELAYS IN PROCESSING YOUR CLAIM)

450 E Baltimore Ave
Media, PA 19063
(610)566-7424

Appointment Reminders And Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. 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. In addition, 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.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you don 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.

This notice is effective as of _____. This authorization will expire seven years after the date which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed	Date
Patient Signature	Authorized Provider Representative
Personal Representative Printed	Personal Representative Signature

Description of personal representative's authority to act for the patient.

McCarrin Chiropractic Center

Dr. John E. McCarrin

I HEREBY ACKNOWLEDGE THAT I AM RECEIVING (OR ABOUT TO RECEIVE) HEALTHCARE SERVICES AT McCARRIN CHIROPRACTIC CENTER, AND THAT I HAVE BEEN ADVISTED THAT THE DOCTOR PROVIDING THE SERVICES IS WILLING TO WAIT FOR PAYMENT FOR THESE SERVICES PROVIDED THAT THERE CONTINUES TO BE A REASONABLE CHANCE THAT PAYMENT WILL BE MADE EITHER BY INSRUANCE PROCEEDS OR OUT OF THE SETTLEMENT OF A LIABILITY CLAIM.

I UNDERSTAND THAT IF IT IS DETERMINED EITHER:

A) THAT THERE IS NO INSURANCE COMPANY OBLIGATED TO PAY FOR THE SERVICES, OR IF THE INSURANCE COMPANY INVOLVED REFUSES TO ACKNOWLEDGE AN ASSIGNMENT TO THE DOCTOR OR MAKE OTHER PROVISIONS FOR THE PROTECTION OF THE INTEREST OF THE DOCTOR; OR

B) IF A LIABILITY CLIAM EXISTS, AND MY ATTORNEY REFUSED TO AGREE TO PROTECT THE INTEREST OF THE DOCTOR, OR IF I HAVE NOT ENGAGED THE SERVICES OF AN ATTORNEY;

THEN PAYMENT FOR SERVICES RENDERED BY THE DOCTOR AT THE McCARRIN CHIROPRACTIC CENTER WILL BE MADE ON A CURRENT BASIS AND MY BILL PAID IN FULL AS SOON AS MY LIABILITY CLAIM IS SETTLED OR THE PASSAGE OF SIX (6) MONTHS FROM MY LAST TREATMENT, WHICHEVER OCCURS FIRST.

DATED THE _____ DAY OF _____ 20_____

PATIENT'S SIGNATURE _____

436 E Baltimore Ave
Media, PA 19063
(610)566-7424

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

UNDER THE CIRCUMSTANCES DESCRIBED IN THE PRECEDING FIVE EXAMPLES, ANY OTHER USE OF DISCLOSURE OF YOUR HEALTH INFORMATION WILL ONLY BE MADEW WITH YOUR WRITTEN AUTHORIZATION.

YOUR RIGHT TO REVOKE 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
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 us at:

McCARRIN CHIROPRACTIC &

PHYSICAL THERAPY CENTER

436 E. BALTIMORE AVE

MEDIA, PA 19063

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 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 COMMINICATION REGARDING YOUR HEALTH INFORMATION

We normally provide information about your health to you in person at the time you receive chiropractic 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.

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 after 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 reason to support the change you are requesting us to make.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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 CAREFULLY.

USES AND DISCLOSURES

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

1) Your chiropractor or a staff member may have to disclose your health care 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/or your billing records to another part, such as an insurance carrier, an HMO/PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor 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 and members of the staff may need to use your name, address, phone number, and your clinical records to contact you or to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you.
    a. If you are not at home to receive an appointment reminder, a message will be left on your answering machine

You have a right to refuse to give us authorization or 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 or your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about 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 WEITHOUT 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.
3) We are permitted to use or disclose your health information if we provide health care services 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.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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. He accounting will include all disclosures except:

- Those disclosures required for your treatment, to obtain payment for services, or to run our practice.
- Those disclosures made to you.
- Those disclosures necessary to maintain a directory of the individuals in our facility or to the individuals involved with your care.
- Those disclosures for national security or intelligence purposes.
- Those disclosures made the correctional officers or law enforcement officers.
- Those disclosures 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 your 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 ill 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:

McCARRIN CHIROPRACTIC &

PHYSICAL THERAPY CENTER

436 E. BALTIMORE AVE

MEDIA, PA 19063

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

McCARRIN CHIROPRACTIC &

PHYSICAL THERAPY CENTER

436 E. BALTIMORE AVE

MEDIA, PA 19063

(610) 566-7424

This notice is effective as of _____. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

X _____ X _____

Patient Name Printed Date

X _____ X _____

Patient Signature Authorized Provider Representative

X _____ X _____

Personal Representative Printed Personal Representative Signature