CONFIDENTIAL CASE HISTORY File #_____

Advanced Chiropractic and Wellness Center · 3840 Park Avenue, Suite D-108 · Edison, NJ 08820

1 PERSONAL INFORMATION

FIRST NAME:_____ MI _____
LAST NAME: _____
BIRTHDATE: ____/____/____ AGE: _____
SOCIAL SECURITY NO. _____
ADDRESS: _____Apt.____
TOWN: _____ ZIP _____
E-MAIL: _____

OCCUPATION: _____
EMPLOYER/SCHOOL: _____
ADDRESS: _____
TOWN: _____ ZIP _____

RACE: White Hispanic African American
Asian American Indian Other
Unknown Prefer not to answer

MARITAL STATUS: S M W D OTHER
NAME OF SPOUSE: _____
SPOUSE'S EMPLOYER: _____

2 INSURANCE INFORMATION

ARE YOU COVERED BY ANY **HEALTH** INSURANCE? YES NO
(If yes, please provide the receptionist with any and all insurance cards!
If no, please move to section 3)

NAME OF INSURED: _____
RELATIONSHIP TO YOU:

3 PHONE NUMBERS

HOME PHONE NO. (____) _____-_____
WORK PHONE NO. (____) _____-_____
CELL PHONE NO. (_____)_____-_____

In case of an **EMERGENCY**, who should we contact? NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: (____) _____-_____

4 PATIENT CONDITION

REASON FOR VISIT: _____ DATE OF LAST EXAMINATION ___/___/___

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS? YES NO

NAMES AND ADDRESSES OF DOCTORS YOU HAVE SEEN

_____ _____ _____
_____ _____ _____
_____ _____ _____

ANY SERIOUS ILLNESSES? (please specify) _____
ANY OPERATIONS? (please specify) _____
ARE YOU TAKING ANY MEDICATIONS? (please specify) _____

HAVE YOU **EVER** SUFFERED FROM ANY OF THE FOLLOWING? (PLEASE CHECK)

Dizziness ____	Arthritis ____	Anemia _____	Backaches_____	Headaches_____
Cancer_____	Neck Pain_____	Numbness_____	Sinusitis _____	Diabetes _____
Asthma _____	Digestive disorder _____		Neuritis _____	Heart trouble _____

I understand and agree that health and accident insurance policies are an agreement between the insurance company and myself. Furthermore, I understand that Dr. Norayr Ozbalik will prepare any necessary reports and forms needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Norayr Ozbalik will be credited to my account.

I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for payment. I hereby request and authorize the release of any medical records and information concerning diagnosis, care and treatments furnished, including all laboratory tests, x-ray reports, and findings. I also give permission to leave messages at the insurance companies' and/ or attorneys' phone numbers regarding my condition AND at the above home or work phone numbers regarding scheduling of appointments and care.

PATIENT SIGNATURE: (Guardian's signature if patient is a minor) _____

New Patient Consent to Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Advanced Chiropractic and Wellness Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or discloses to carry out treatment, payment, or health care operations

I understand that Advanced Chiropractic and Wellness Center is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Advanced Chiropractic and Wellness Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Advanced Chiropractic and Wellness Center change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.
I fully understand and accept the terms of this consent.

_____
Patient's Signature

_____
Date

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

Patient: _____
File #: _____
Employer: _____
Policy # or Group #: _____
SS#/ID#/ Claim #: _____

I hereby instruct and direct _____ Insurance Company to pay by check and make out and mailed to:

DR. NORAYR OZBALIK
ADVANCED CHIROPRACTIC AND WELLNESS CENTER
3840 PARK AVENUE
SUITE D-108
EDISON, NJ 08820

OR

If my current policy prohibits direct payment to the doctor, I hereby also instruct you to make out the check and mail it out to me as follows:

DR. NORAYR OZBALIK
ADVANCED CHIROPRACTIC AND WELLNESS CENTER
3840 PARK AVENUE
SUITE D-108
EDISON, NJ 08820

for the professional or medical expenses allowable and otherwise payable to me under current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said any professional service charges over and above this insurance payment. I understand that I am responsible for all co-payments, deductibles, and any other amount not covered by my insurance contract/plan.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also hereby authorize Dr. Ozbalik to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance company Commissioner or to assign benefits for any reason on my behalf.

Date: _____

_____ _____
Signature of Policyholder Signature of Witness

_____
Signature of Claimant, if other than Policyholder

ADVANCED CHIROPRACTIC AND WELLNESS CENTER

Dr. Norayr Ozbalik, D.C.

3840 Park Avenue
Suite D-108
Edison, NJ 08820
Tel: 732-902-2302
Fax: 732-902-2305

Acknowledgement of Office Procedures

By signing this consent, I am acknowledging that I understand the policies of Advanced Chiropractic and Wellness Center.

I am aware that:

- I am responsible for obtaining a PCP referral if my insurance requires so.
- If I do not obtain a referral, and my insurance requires one, I will be responsible for the full amount of the visit.
- I will pay my co-payment/ co-insurance per visit.
- I will pay my cash payment.

_____
Patient Signature

_____
Print Name

_____/_____/_____
Date

ADVANCED CHIROPRACTIC AND WELLNESS CENTER

Dr. Norayr Ozbalik, D.C.

3840 Park Avenue, Suite D-108
Edison, NJ 08820
Tel: 732-902-9302
Fax: 732-902-9302

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is impotent that each patient understands both the objective and the method that will be used to attain the objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and prevention of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interface to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by and **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments o the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	**Signature**	**Date**