

DR. SEAN P. MAHONEY
150 Water Tower Circle, STE 203
Colchester, VT 05446

New Patient Application

Name: _____ DOB: _____ Today's Date: _____

SS # : _____ Email: _____
SS# only necessary for MCR/Medicaid/VHAP Patients Email will be used for health information and schedule changes only.

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Job Duties: _____

Spouse: _____ Children _____

Emergency Contact Information: _____

Referred By: Family Friend Primary Care Doctor Other:

Which one of our patients shall we thank? _____

Reason you are here: _____

Other Doctors seen for this condition: _____

Who is your general health care practitioner: _____

Contact Information: _____

Do you mind if we send him/her updates on your care? _____

Previous Chiropractor: _____ Were you satisfied with their care?: YES NO

Circle any other symptoms you are experiencing or have experienced in the past:

Headaches	Asthma Allergies	Arthritis	Sinus Problems	
Neck Pain	Neck Stiffness	Stomach Pain	Chest Pain	Shoulder/Arm Pain
Sciatica	Numbness	Stress	Hip/Pelvis Pain	Wellness
Upper Back Pain	Middle Back Pain	Lower Back Pain	Other:	

My symptoms are due to (circle): Auto Accident Work Accident Home Accident
Sports Injury Gradual Onset

Are you Pregnant? Yes No Due Date: _____

List all surgeries in the last 5 years: _____

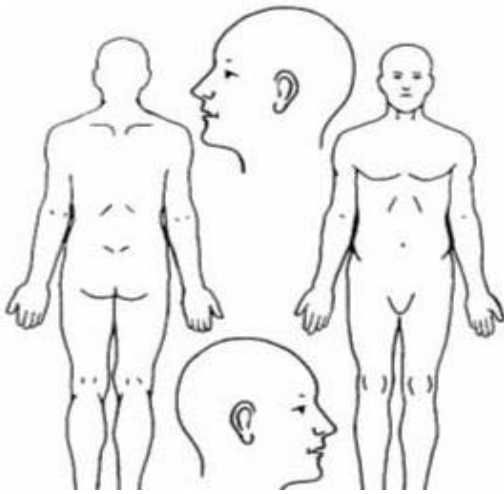
Have you ever had spinal surgery? YES NO

List any serious conditions/other health issues the doctor should be aware of: _____

Please list medication (OTC/Prescription) and supplements you are taking:

Present Health History

Please label the area(s) of today's symptoms:



When did your present condition begin?

Gradual Onset

Date: _____

What caused your present condition?

No specific injury

Home Accident

Work Accident

Auto Accident

What happened to cause your present symptoms?

Have you ever had these symptoms before?

No

Yes (date: _____)

What time of day are your symptoms better?

Morning

Afternoon

Evening

All of the above (constant pain)

What makes your symptoms better?

Rest

Ice Packs/Heating pads

Prescription Medications

OTC medications

Other (_____)

What makes your symptoms worse?

Activity (work, repetitive motions)

Ice packs/Heating pads

Driving (or riding) in car

Other (_____)

Patient Health History Worksheet

Significant Past History

Have you ever been hospitalized?

No

Yes (Year: _____ Reason: _____)

Have you had any surgeries?

No

Yes (Year: _____ Reason: _____)

Do you have any significant health problems?

No

Yes (_____)

Family Medical History

Does your father have any health problems?

No

Yes (_____)

Does your mother have any health problems?

No

Yes (_____)

Do your siblings have any health problems?

No

Yes (_____)

Do your grandparents have any health problems?

No

Yes (_____)

Personal History

Do you play any sports or exercise?

No

Yes (_____)

How many hours do you sleep at night? (_____)

How many hours a week do you work? (_____)

Do you drink alcohol?

No

Yes (How Many: _____)

Anything else the doctor should know?

No

Yes (_____)

Patient Name: _____ **Date:** _____

Please take several minutes to answer these questions so the Doctor can help you get better faster.

1. How have you taken care of your health in the past?

- | | | |
|--------------------|-------------------|-----------------|
| a. medications | d. exercise | g. vitamins |
| b. emergency room | e. nutrition/diet | h. chiropractic |
| c. routine medical | f. holistic care | other _____ |

2. How did that work out for you?

- | | | |
|------------------|-------------------------|-----------------|
| a. bad results | d. nothing changed | g. still trying |
| b. some results | e. didn't get worse | h. confused |
| c. great results | f. didn't work too long | other _____ |

3. How have others been affected by your health condition?

- | | |
|--------------------------------|---------------------------------|
| a. no one is affected | c. they tell me to do something |
| b. haven't noticed any problem | d. people avoid me |

4. What are you afraid this might be (or beginning) to affect? (or will affect)

- | | | |
|-------------------|----------------|-------------|
| a. job | d. marriage | g. time |
| b. kids | e. self esteem | h. finances |
| c. future ability | f. sleep | i. freedom |

5. Are there health conditions you're afraid this might turn into?

- | | | |
|---------------------------|-----------------|--------------------|
| a. family health problems | d. diabetes | g. depression |
| b. heart disease | e. arthritis | h. chronic fatigue |
| c. cancer | f. fibromyalgia | i. Need surgery |

How has this affected your job, relationships, finances, or family, other activities?

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc)?

What are you most concerned with regarding your problem?

Where do you picture yourself being in 1-2 years if this problem isn't taken care of? Be specific

What would be different/better without this problem? Be specific.

What result(s) do you most desire from working with us?

What's that worth to you?

Office Policies: If I am accepted as a patient at Mahoney Family Chiropractic, I agree to pay for all services, including services not covered by my insurance company. I also acknowledge, that when I am given explanation of my benefits from the practice, it is not a guarantee of payment.

Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

**MAHONEY FAMILY CHIROPRACTIC
COLCHESTER, VT / WAITSFIELD, VT
FINANCIAL AGREEMENT**

Thank you for choosing us as your health care provider. We are committed to your care being successful. Please understand that payment of your bill is considered a part of your care. **The following is a statement of our Financial Policy which we require you read and sign prior to any service.**

These policies apply only to the services actually performed, and in no way obligate you to continue the course of care recommended. If care is discontinued, any balances due for care received up to that date will become due immediately and payable in full, regardless of any claim submitted.

Payments are due at time of service.

We accept cash, checks, debit cards, Visa / Mastercard, Discover, and American Express

I have elected to use the following payment plan to finance my care at Mahoney Family Chiropractic:

z 1. CASH - I will pay for services as they are rendered.. **See us for pre-pay options to reduce fees .**

z 2. BC/BS of Vermont, CBA, United Healthcare, Great West or CIGNA (please circle appropriate carrier) - I will be a cash patient until I can furnish the necessary forms and information for billing. I authorize my insurance carrier to pay Dr. Mahoney directly, based on my plan. **I will pay my initial deductible in full and the percentage agreed upon at the time of each visit.** If my insurance carrier fails to pay it's share, I will pay my due balance in full. I understand it is my responsibility to call my physician for any referrals necessary according to my plan.

Policy Holders Name _____ **Policy Holders Date of Birth** _____

Policy Holders Address _____

z 3. OTHER INSURANCE - I have reimbursing insurance for which you are not a provider. **I will pay for services as they are rendered.** I will be given a receipt for each date of service and understand that I am responsible for my own billing.

z 4. MEDICARE - **I will pay for services as they are rendered, and understand that I will be reimbursed by Medicare. Please see staff for special rates and procedures.** I authorize Dr. Mahoney's office to bill my insurance carrier and provide any information needed to process my claim. I understand that any exam or x-ray fees are not covered by Medicare.

z 5. WORKER'S COMPENSATION - My employer has agreed to pay for services rendered by MFC. I will furnish the necessary information needed for billing. After verification is made, MFC will submit claims and await payment. I understand that I am responsible for any portion of this bill that my employer or its insurance carriers may refuse to pay.

z 6. PERSONAL INJURY - I have been injured due to an auto accident or personal injury. If all necessary documentation is provided and the case is approved, MFC will submit claims. See the Personal Injury Policy form for payment options, choose the option that applies to your situation and inform the front desk of your decision.

*** If my account balance should not be paid, and it is necessary for my account to be sent to a collections agency, I understand that I will be responsible for any recovery / collection fees.**

Print patient name: _____

Signature: _____ **Date:** _____

Mahoney Family Chiropractic

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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. Other than the uses and disclosures we describe below we will not sell or provide any of your health information to any outside marketing organization.

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

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.

Any Correspondence should be addressed to:

Attn: HIPAA Compliance Officer, Mahoney Family Chiropractic
150 Water Tower Circle, Suite 203, Colchester, VT 05446

USES AND DISCLOSURES

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

1. We may have to disclose your health information to another health care provider or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your condition.
2. We may have to disclose your examination and treatment records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use any information in your file for quality control purposes or any other administrative purposes to run our practice.
4. We may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information and treatment alternatives, or other health related information that may be of interest to you (i.e. test results). 164.520 (b)(1)(iii)(A). If you are not home to receive a appointment reminder, a message will be left on your answering machine and/or mailed.

You have the right to refuse to give us authorization to contact you regarding your case at this office. 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 including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives, etc.)

SPECIFIC PROCEDURES

1. This office uses an "open concept" adjusting area. For discussion with the doctor of specific health concerns there is a private office available upon request.
2. This office uses e-mail for the changes of the office schedule only. If you do not wish to receive this information in this way please inform our staff.

YOUR RIGHT TO LIMIT USES OF DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

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 the following circumstances.

1. We are providing health care services to you based on the orders (referral) of another health care provider.
2. We provide health care services to you in an emergency and we are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

REVOKING YOUR AUTHORIZATION

You may revoke your authorization to us at any time 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)(1)
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.

CONFIDENTIAL COMMUNICATION

We will attempt to accommodate any reasonable written request regarding how/where (i.e. mailing address or contact number) you would like to receive information about your health or the services that we provide.

AMENDING 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 a written request to amend your records that includes a valid reason to support the change. We have the right to refuse.

INSPECTING/COPYING YOUR HEALTH INFORMATION

You have the right to inspect the health information contained in your files while in our offices and/or have a copy made for you. The health information is available up to seven years from the date that the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/or have them copied. There will be a charge of \$.50 per page copied. Copies can be made of your x-rays for a charge of \$10.00 for each film. The original film is the property of this office because we are required by law to keep it in our records. Original films can only be released on referral to another physician.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your health information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- required for your treatment to obtain payment for services, to run our practice, and/or made to you.
- necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- for national security, intelligence purposes, or law enforcement officers.
- that were made prior to the effective date of the HIPAA privacy law (April 14, 2003)

We will provide the first accounting within a 12 month period without any charge, but any additional requests will be charged a fee. 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.

RE-DISCLOSURE

We cannot control the actions of others to whom we have released your information for treatment. Information that we use to disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

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. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Bldg, Washington, D.C. 20201

This notice is effective as of January 1, 2003. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

Name _____ Date _____