YORK ROAD CHIROPRACTIC
10153 York Road, Suite 105
(Phone) 410-628-2808 (Fax) 410-628-2818

Are you seeking treatment for an injury that is AUTO ACCIDENT or WORK RELATED? YES___ NO___
** **If you answered yes PLEASE INFORM THE FRONT DESK****
Patient's Last Name: _____ First: _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ___/___/___ SS#: _____ Sex: male/female Status: Single married divorced
Circle one circle one
Home Phone: _____ Cell Phone: _____ Employer: _____ Work Phone: _____
Email Address: _____ Primary Care Physician: _____ Phone: _____

Primary Insurance Coverage

Insurance Co: _____ Policy #: _____
Policy Holder's Name: _____ SS# _____ DOB: _____
Policy Holder's Employer: _____ Work Phone: _____

Relationship to Patient: spouse child other **Do you have any other insurance**? Yes No
Circle one circle one
Do you have HSA benefits with this plan? Circle one yes no
PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) TO MAKE COPIES.

Parent/Legal Guardian Information

Name: _____Date of Birth: _____/_____/_____
SS#: _____ Relationship: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Patient's Authorization

1. **My co pay is _____ and I will be making payment today by: Cash ____ Check ____ Credit Card ____**
2. I authorize York Road Chiropractic to apply for benefits on my behalf for services rendered by him/or staff. I request payment from my insurance company be made directly to York Road Chiropractic. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any other claim(s). I permit a copy of this authorization to be replaced by the originals. This authorization may be revoked by me at anytime in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical/chiropractic services provided.
3. **By my signature, I verify that treatment being sought at this office is not AUTO or WORK related.** I also understand, **It is my responsibility to notify this office, at the time of service, if this fact changes.**

4. **Acknowledgment and receipt of Notice of Privacy Practices (HIPPA)**
I understand and will be provided upon my request the Notice of the 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 my signing of this consent
The right to object of 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 disclosed to carry out treatment, payment or health care operations.

_____ ___/___/___ _____ ___/___/___
Signature of Subscriber or Beneficiary Today's Date Signature of Witness Today's Date

YORK ROAD CHIROPRACTIC

10153 York Road Suite 105 Cockeysville MD 21030

(Phone) 410- 410-628-2808 (Fax) 410-628-2818

Review of Systems

1. Is your condition due to an ❑ auto accident ❑ job related ❑ other _____

2. What is your major complaint? _____
describe briefly

3. Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following if you had:

❑ Pneumonia	❑ Mumps	❑ Influenza	❑ Eczema	❑ Small Pox	❑ Lumbago
❑ Pleurisy	❑ Measles	❑ Polio	❑ Arthritis	❑ Thyroid	❑ Anemia
❑ Diabetes	❑ Epilepsy	❑ Cancer	❑ Chicken Pox	❑ Rheumatic Fever	
❑ Heart Disease	❑ Tuberculosis	❑ Mental Disorder	❑ Whooping cough		

4. **Intake:** Do you consume any of these products?
If yes, please **check the box** and put in the approximate **amount consumed per week on the line.**

❑Coffee-cups_____ ❑Tea-cups/glasses_____ ❑Alcohol-glasses_____ ❑Cigarettes-packs_____

5. **Check** any of the following symptoms or conditions you have had in the last 6 months:

Musculoskeletal
- ❑Low Back Pain
- ❑Pain between shoulders
- ❑Neck Pain
- ❑Arm Pain
- ❑Joint Pain/Stiffness
- ❑Walking Problems
- ❑Difficulty Chewing/Clicking Jaw
- ❑General Stiffness
- ❑Gas/Bloating after meals
- ❑Black/Bloody Stool
- ❑Colitis

Nervous System
- ❑Nervousness
- ❑Numbness
- ❑Paralysis
- ❑Dizziness
- ❑Forgetfulness
- ❑Confusion/Depression
- ❑Fainting
- ❑Convulsions
- ❑Cold/Tingling Extremities
- ❑Stress

Gastro-Intestinal
- ❑Poor/Excessive Appetite
- ❑Excessive Thirst
- ❑Frequent Nausea
- ❑Vomiting
- ❑Diarrhea
- ❑Constipation
- ❑Liver Problem
- ❑Gallbladder Problem
- ❑Weight Trouble
- ❑Abdominal Cramps

Cardiovascular/Respiratory
- ❑Chest Pain
- ❑Shortness of Breath
- ❑Blood Pressure Irregularities
- ❑Irregular Heart Beat
- ❑Heart Problems
- ❑Lung Problems/Congestion
- ❑Varicose Veins
- ❑Ankle Swelling
- ❑Stroke

Ent
- ❑Vision Problems
- ❑Earaches
- ❑Sore Throat
- ❑Hearing Difficulty
- ❑Dental Problems

General
- ❑Fatigue
- ❑Fever
- ❑Loss of Sleep
- ❑Headaches
- ❑Allergies

Genito-Urinary
- ❑Bladder Trouble
- ❑Painful/Excessive Urination
- ❑Discolored Urine

GU-Male
- ❑Prostate Sexual Dysfunction
- ❑Breast Pain/Lump

GU-FEMALE
- ❑Menstrual irregularity
- ❑Menstrual cramping
- ❑Breast Pain/Lump
- ❑Vaginal Pain/Infection

Last period ____/____/____
Are you pregnant?
❑ yes ❑ no ❑ not sure

Family History of:	**Diabetes**	**Cancer**	**Stroke**	**Heart Disease**	**Arthritis**
Mother	❑	❑	❑	❑	❑
Father	❑	❑	❑	❑	❑
Sibling	❑	❑	❑	❑	❑

Medications you are currently taking: (prescribed and over the counter):

York Road Chiropractic
Eugene Neddo JR D.C.
10153 York Road Ste. 105
Cockeysville, MD 21030
(410) 628-2808

Consent for Chiropractic Treatment

State law requires us to obtain your consent prior to your chiropractic treatment. What you are being asked to sign is simply a confirmation that we have discussed your contemplated treatment and that we have given you sufficient information upon which to make a decision whether to have the treatment and any choice as to the type of treatment of your own free will. We will discuss with you the common problems or undesired results that sometimes occur. We wish to inform you, not alarm you. If you wish, however, we can go into more elaborate details of more unlikely problems. If you do not, that is also your privilege. Please read the form carefully. Ask about anything that you do not understand. We will be pleased to explain it.
I hereby authorize and direct **Dr. Eugene Neddo**, with the associate(s) or assistant(s) of his choice to perform the following chiropractic procedures on

_____, my _____ as we have agreed upon.
Patient Name Relationship, if minor

☐ The nature and purpose of the treatment to be performed by the physician are: Chiropractic Adjustment/Therapy.
☐ These treatments are expected to accomplish: increase range of motion and decrease muscle spasms.
☐ The reasonably known risks of the treatments are: initial stiffness and discomfort.
☐ Details of this treatment and alternative methods of treatment have been explained to me. I have been advised that, although good results are expected, each situation/person reacts differently to the treatment; therefore, the Outcome of the treatment has no guarantee as expressed or implied.
☐ The doctor has explained to me the most likely complications that may occur from this treatment and I understand them. I have also been told the less likely complications, even if rare, that could occur.
☐ I hereby authorize Dr. Eugene Neddo and his associates/assistants to provide additional procedure(s) as they deem reasonable and necessary including, but not limited to, x-rays/therapy.
☐ I hereby affirm and state that I have read and understood this consent and that all blanks were filled in prior to my signature.

Date_____ Signature _____

The patient is unable to execute this consent for the following reason(s): _____

_____

Witness_____

I certify that I have personally reviewed all the blanks on this form and explained them to the patient or his/her representative before requesting the patient or his/her representative to sign this form.

Physician Signature: _____

Memo to our Patients Regarding HIPAA

As you may know, a new law has been passed that relates to how we may use your personal health information. We have always been in the forefront regarding patient confidentiality; and, for years, have been very careful with how we share your information with other people and have tried to protect your privacy. So, you will probably not notice that this law with affect our interaction that much.
We are required by law to have to sign a statement that you have received a copy of your rights under the law. This is called the "Notice of Privacy Practices".
Please sign and date this page indicating that you have been allowed to read the "Notice of Privacy Practices" and were offered a paper copy if so desired.

Print Patient Name_____

Signature of Patient or Guardian _____

Date_____

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FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize Dr. Eugene Neddo D.C. to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Eugene Neddo insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents.

If my account is assigned to a collection agency, I agree to pay 25% collection agency fees, court cost and attorney fees. I understand that all accounts with a balance over 30 days will be assessed at 1.5 percent late charge per month on the unpaid monthly balance.

_____ _____

SIGNED (PATIENT) DATE