INTEGRATIVE HEALTH CARE ASSOCIATES

WELCOME TO OUR OFFICE!

Please PRINT in ink:

NAME:_____
FIRST MIDDLE LAST

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:__(___)-_____ CELL PHONE:__(____)-_____ WORK PHONE:_(____)_____

EMAIL:_____ REFERRED BY:_____

DATE OF BIRTH:_____ AGE:_____

YOUR OCCUPATION:_____EMPLOYER:_____

MARITAL STATUS:_____ SPOUSE'S NAME:_____NUMBER OF CHILDREN:_____

EMPLOYERS ADDRESS (If this is a workers comp accident)_____

CITY:_____STATE:_____ ZIP:_____ WORK #:_(___)-_____

SPOUSE'S EMPLOYER:_____WORK NUMBER: _(___)-_____

IF YOU HAVE INSURANCE, PLEASE GIVE YOUR CARD TO THE RECEPTIONIST TO COPY. WE DO NOT PARTICIPATE WITH MOST INSURANCE, BUT WE WILL SUBMIT YOUR VISIT FOR REIMBURSEMENT DIRECTLY TO YOU.

IF YOU ARE HERE BECAUSE OF AN AUTO INJURY OR OTHER PERSONAL INJURY, PLEASE LIST THE FOLLOWING:

DATE OF INJURY:_____STATE:_____CLAIM NUMBER:_____
NAME/ADDRESS OF INSURANCE COMPANY:_____

_____CITY:_____STATE:_____ZIP:_____

IF YOU ARE HERE BECAUSE OF A WORK-RELATED INJURY, PLEASE LIST THE FOLLOWING:
DATE OF INJURY:_____ CLAIM NUMBER:_____

NAME/ADDRESS OF INSURANCE COMPANY:_____

_____CITY:_____STATE:_____ZIP:_____

PLEASE READ CAREFULLY:

This memo is to prevent any misunderstanding regarding payment for services we provide. As a service to our patients, we will submit your claims to your insurance company so that you may be reimbursed, However, PAYMENT IS DUE AT THE TIME OF SERVICE.

SIGNATURE:_____DATE:_____

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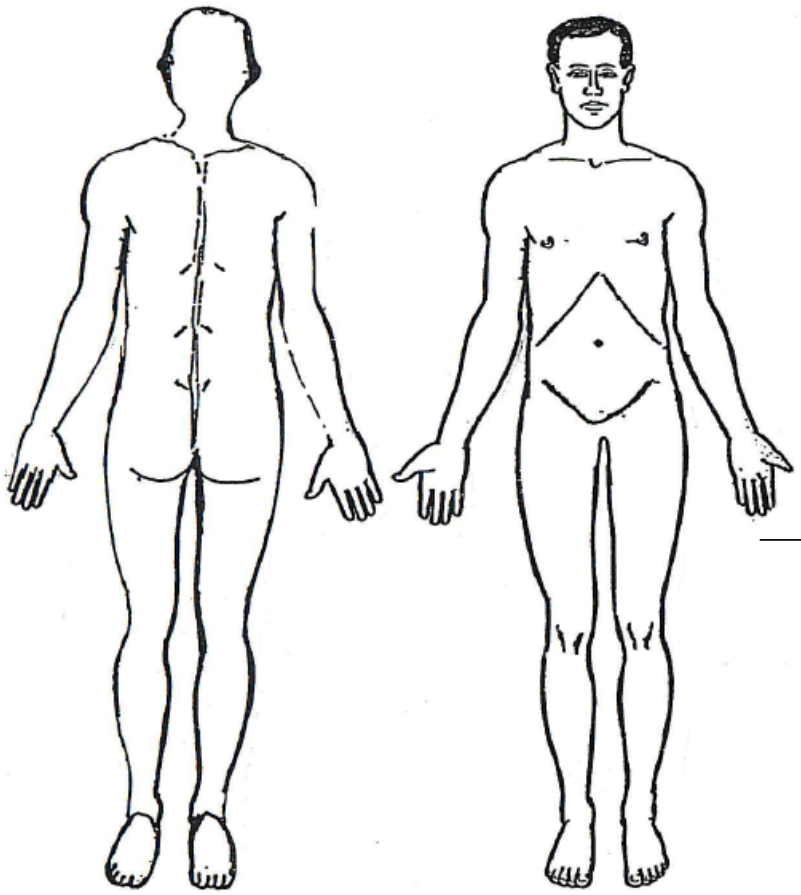
NAME:_____DATE:_____

Have you ever been to a chiropractor before?_____Who?_____
Why?_____

Please outline on the diagram below, the areas of your discomfort



Please list your major problems in order of their importance:_____
_____
_____

Describe the location and nature of your trouble:_____
_____
_____

When was the most recent occurrence of this difficulty?_____
_____
_____

Is it accident related?_____
If Yes, how did it occur?_____
_____

Have you been x-rayed in the last 6 months___
If yes, what type and where?_____
_____

What type of medications, vitamins, minerals etc, are you taking now?_____
_____
_____
_____

What methods have you tried to alleviate your problem?_____
_____
_____

Have you consulted another physician for this?
_____ Who?_____

Which of these factors affect your trouble? (please check)

	No Effect	Better	Worse		No Effect	Better	Worse
Movement				Toward end of day			
Sitting				During greatest activity			
Standing				While Resting			
Walking				Before Meals			
Lying Down				During Meals			
During the night				After Meals			

First thing in morning				2-4 hr after meals			

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NAME:_____

WEIGHT:_____ GAIN / LOSS IN THE LAST 10 YEARS:_____

FAMILY HISTORY: MOTHER LIVING / DECEASED FATHER LIVING / DECEASED

Please answer the following: Mother / Father / Sister / Brother - if they have any of these problems:

_____Diabetes _____High Blood Pressure _____Cancer _____TB

_____Heart Disease _____Low Blood Pressure _____Hypoglycemia

_____Other:_____

List any MAJOR car accident, falls, injuries or other related accidents (and date):_____

_____

_____

List any DISEASES you have:_____

_____

_____

List ANY type of surgery you have had (and date):_____

_____

_____

List any type of MAJOR dental work you have had (and date):_____

_____

_____

Right handed or Left handed

Do you have any sexually related problems? _____Yes _____No

Number of times you urinate during: Day_____ Night_____

How often do you have a bowel movement?_____

Are you under emotional stress? _____Yes _____No

Do you have sufficient energy for your normal activities? _____Yes _____No

For our female patients:

Date of last menstrual period_____ How many days do you menstruate?_____

Number of days from beginning of period until beginning of next period_____

List any menstrual discomfort_____

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INTEGRATIVE HEALTH CARE ASSOCIATES
1315 WEST COLLEGE AVE; SUITE 200 - STATE COLLEGE, PA 16801
(814)-237-5559

PAYMENT POLICY

Payment is due at the time of service. We accept cash, check, Mastercard, Visa, American Express, and Discover. If you use a debit card, it will go through our system as a credit card. As a courtesy, we will submit claims to your insurance company for direct reimbursement to you. Managed care and HMO plans, such as Geisinger HealthPlan-DO NOT cover any services.

WORKERS COMPENSATION AND PERSONAL INJURY CASES

If workers compensation, auto or other personal insurance (NOT health insurance) is going to pay for your treatment, please inform us before your initial exam begins. We will submit these claims for you, providing you have provided us with the claim number, insurance company name and address and have completed any additional forms required. If the claim is denied by the insurance, saying that is it not work or auto related, you WILL be responsible for the amount due.

A finance charge of 1 1/2% (18% per year) will be added to any balances unpaid after 30 days.

I have read, understand and agree with the above payment policy

NAME (print):_____

SIGNATURE:_____DATE:_____

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Verification of Receiving and Understanding Your Rights and Responsibilities

Integrative Health Care Associates is required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information.

I, the undersigned, verify with my signature that I have received, read and understand:

- **Integrative Health Care Associates responsibility to privacy**
- **My rights as a patient**
- **My responsibilities as a patient**
- **My financial responsibilities and the payment policies of Integrative Health Care Associates**
- **The physician's policy against any legal case involvement**

My signature below indicates that I am of the age of majority, legal representative of the patient or parent or legal guardian of a minor child, or I am an emancipated minor. My signature also authorizes Integrative Health Care Associates to release my information contained within my Medical Record to anyone that is involved in my course of treatment. This may include, but not limited to: other physicians, hospitals, or medical facilities, insurance companies (health and/or disability) and case managers. I understand that this information may be transferred orally, electronically or in writing. I understand that I will be required to update this information as requested by this office.

SIGNATURE:_____DATE:_____

INTEGRATIVE HEALTH CARE ASSOCIATES
1315 W COLLEGE AVE; SUITE 200 - STATE COLLEGE, PA 16801

NOTICE OF PRIVACY PRACTICES

PATIENT'S RIGHTS AND RESPONSIBILITIES TO PRIVACY

Dr John Corneal, DC, DIBAK, Dr. Jeff Scipione, DC, and Karen Stoner, LMT and staff respect your privacy and will do everything possible to protect your privacy. This Notice of Privacy Practices describe how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PHI

Your protected health information may be used and disclosed by your physician, the office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information (PHI), as necessary, to a home health agent that provides care to your or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your PHI will be used, as needed, to obtain payment for your health care services.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your PHI, in order to support the business activities or your physician's practice. These activities include, but are not limited to: quality assessment activities, employee review activities, training of chiropractic students, licensing, etc. For example, we may disclose your PHI to a chiropractic student that may see patients in our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI as necessary, to contact you to remind you of an appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include: As Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroner, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates-required uses and disclosures. Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance of Section 164.500

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: Will be made with your consent, authorization or opportunity to object unless required by law. **You may revoke this authorization, at any time,** in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. There is a charge for copying. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation, or use in a civil, criminal or administrative action or proceeding, and the PHI that is subject to laws that prohibit access to the PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also require that any part of your PHI not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another health care professional. We however, do not release your medical information without your prior knowledge in any way other than for your continued care or billing purposes. If so, we would have you sign an additional form.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your PHI. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer. **We will not retaliate against you for filing a complaint.**

Legal

Our primary responsibility is to provide quality, responsive patient care. Due to the time consuming demands resulting from legal care involvement, it is the polity of **Integrative Health Care Associates** to not accept the care of patients requiring this assistance. Patients who require clinical advise for legal purposes will be referred to physicians who are prepared to provide litigation support.

PATIENT FINANCIAL LIABILITY AND PAYMENT POLICY

You, the patient or responsibility party, agree to make payment for services provided by John Corneal, DC, DIBAK, Jeff Scipione, DC, or Karen Stoner, LMT at the time of such services, with the exception of Personal Injury or Worker's Compensation as provided by law. We will submit claims to Medicare, and other insurances as a courtesy to our patients. However, payment is still expected at the time of service. Patients are directly responsible for any medical supplies or supplements.

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