Miniaci Chiropractic & Acupuncture Center, LLC
53 High Street, East Haven, CT 06512
Telephone (203) 469-5210
Fax (203) 468-8598

Acupuncture Questionnaire Form

Name:_____

Address:_____

City:_____

State:_____ Zip: _____

Social Security #:_____Sex: (M)___ (F)___

Date Of Birth:(Month, Day, Year)_____

Home Phone: _____ Work Phone: _____Ext._____

E-Mail: _____Cellular: _____

Employer:_____

Emergency Contact:_____

Phone:_____Relation: _____

Marital Status:(Single)____ (Married)____ (Widowed)____ (Divorced)____

Spouse Information (If Married)

Name:_____

Social Security #:_____Date Of Birth: _____

Employer:_____Work Phone: _____

Please fill out the following form with as much detail as possible. **Please print.**

Is any other member of your family being treated in this office? _____

Are you familiar with Acupuncture? _____

Are you interested in Acupuncture for: [] smoking cessation [] pain relief [] meridian balancing
[] other

If for pain relief, described your symptoms, other treatments and results:_____
_____

What are your goals for this Acupuncture series? _____
_____

Have you ever been treated with Acupuncture before? [] No [] Yes
If yes, for what? _____

Were the results satisfactory? _____

Family Physician (Name & Address):_____
_____

May we provide him/her with copies of your records [] Yes [] No

Medical History: Surgeries: _____

Prescriptions: _____

Serious Illness:_____

Habits: **(Please list or check)**

Vitamins	_____	Supplements	_____
Cigarettes	#_____/day____x_____years	Quantity	_____
Coffee/Tea	_____	Quantity	_____
Alcohol	_____	Quantity	_____
Hobbies	_____		

To: Miniaci Chiropractic & Acupuncture Center LLC
53 High St, East Haven, CT 06512

Fm: _____

Waiver of No Insurance

By affixing my signature below, I am indicating : EITHER: I have no health, auto or other insurance, including Medicaid or Medicare to submit my chiropractic bills through, and I further acknowledge that I am aware there is no Title 19/Medicaid coverage for chiropractic services rendered to persons over the age of 21, making any service rendered to Medicaid/Title 19/HuskyCharter Oak plan recipients the sole responsibility of the patient. ***Or:*** *I am seeking acupuncture treatments which will not be covered by Medicare/Medicaid/My Insurance and I will be responsible for paying the per visit fee of $50-$60; these visits will NOT be submitted to any carrier on my behalf.*

Signed: _____ *Dated:* _____

Witnessed: _____*Dated:* _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I _____ of _____ (town)
Do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissues. Physical therapy modalities and exercises may also be used. Although spinal manipulation is considered to be a safe and effective form of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with manipulation and therapy procedures as follows:

Chiropractic care is the science, philosophy and art of locating and correcting spinal subluxations (misalignments) and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this office. As with the practice of medicine, the practice of chiropractic is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgement and expertise in working with like cases. It is not reasonable to expect my chiropractor to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. An undesirable result, or side effect, does not necessarily indicate error in judgment or an improper treatment.

I understand that the chiropractor will use his/her hands or a mechanical device upon my body to a joint which may cause an audible "pop" or "click". As with any health care procedure there are certain complications which may arise during a chiropractic adjustment. Those complications include sprains/stains, soreness, dizziness, nausea, dislocations, fractures, disc injuries, or cerebral-vascular accidents (stroke). These complications are extremely rare occurrences. Rare complications of physical therapy treatments may include burns and or skin irritation/redness.

Reasonable alternatives to chiropractic care may include: over the counter analgesics, rest, medical care and prescription medication including pain medicine, anti-inflammatory, & muscle relaxers, or possibly surgery.

I hereby request and consent to the performance of chiropractic adjustments and other procedures by Dr. Miniaci and/or other licensed doctors of chiropractic who now or in the future may practice in, work or associate with, or be employed by Miniaci Chiropractic & Acupuncture LLC.

I have read the above consent, or had it read to me, have made my decision voluntarily and freely. To attest to my consent to these procedures I hereby affix my signature to this authorization for treatment.

_____ _____ _____
Patient's Name Printed Patient's Signature Date

Witness: _____ date_____

Patient Questions/Comments: _____
_____

COMPLETE FOLLOWING IF PATIENT IS A MINOR OR UNABLE TO CONSENT:

Patient name: _____ **Age:**_____
Name of person legally authorized to sign for patient: _____
Relationship: _____
Signature of authorized Person: _____ **Date:** _____

Miniaci Chiropractic & Acupuncture Center, L.L.C.
53 High Street
East Haven, CT 06512

By affixing my signature below, I am indicating that I understand and agree to the following policies of Miniaci Chiropractic & Acupuncture Center:

Health and accident policies are an agreement between an insurance carrier and myself. The chiropractic office will assist me in the completion of any forms needed to assist me in collection from the insurance carrier, however, any fee for service is ultimately my responsibility. The chiropractic office will check my chiropractic benefits for me, however benefit verification is never a guarantee of either payment or coverage, and it is ultimately my responsibility to know my coverage/policy. Should my insurance carrier require a referral of any type, I am responsible for obtaining the referral as well as for making sure that the chiropractic office has received the referral; further, I am responsible for making sure that updated referrals, if needed, are provided to the chiropractic office in a timely manner. If I fail to verify a referral or, should a referral not be present at the time of the service, I am accepting full financial liability for service rendered. I further acknowledge that my insurance carrier may not offer a benefit sufficient to cover all of the visits needed, or that they may disallow certain services for which I will be responsible. Co-pays, coinsurance and deductibles are due at the time of service. Acceptable methods of payment are: cash, personal check, money order, debit/ATM cards, Visa, MasterCard, American Express, and Discover Card; **co-pays not paid at the time of service are subject to a $5.00 per billing cycle fee.**

There is a $25.00 fee for appointments not cancelled with 24 hour notification.

I have been advised that the office will protect my personal health information in accordance with the HIPAA laws. I further acknowledge that I may receive a written copy of the office's HIPAA practices at any time, and that I acknowledge that my information, at times, will be shared with various other entities including but not limited to physicians, specialists, and insurance carriers for the purpose of coordinating care and collecting account balances.

My signature below further indicates: **I authorize the release of any medical or other information necessary to process my claims/bills. I also request payment of government benefits either to myself or the party who accepts assignment . I authorize payment of medical benefits to: Keith A. Miniaci, D.C., Miniaci Chiropractic & Acupuncture Center LLC.**

Signature_____ Date:_____

Miniaci Chiropractic & Acupuncture LLC * 53 High St* East Haven CT 06512 *203-469-5210

AUTHORIZATION TO OBTAIN AND/OR DISCLOSE HEALTH INFORMATION

I hereby authorize _____ to disclose and/or obtain my individually identifiable health information as described her to the person/organization named below. I understand that this authorization is voluntary and that it **may include information relating to AIDS, HIV, infection, behavioral health services, psychiatric care, treatment for alcohol and/or drug abuse.**

Patient name: _____ DOB: _____

Information to be disclosed/obtained:

Service dates: _____

[] Initial evaluation/examination [] Emergency room records [] Daily Treatment notes
[] Intake paperwork [] Laboratory tests/results
[] Consultation reports [] Radiology films/reports
[] Entire record (Consideration will be given in releasing entire record only when a subsection to the record will not serve the intended purpose of this disclosure.)
[] Other (Specify):_____

DO NOT release the following information: _____

Name of person(s) /organization(s) to whom the disclosure is to be made or from whom the information is to be obtained:_____

I am requesting the information be disclosed for the purpose of: (for example: legal reasons, continued care, insurance, another medical opinion, Worker's compensation, Employment, research, personal usage, Social Security):_____.

I understand this authorization may be revoked IN WRITING at any time except to the extent that the action has already been taken in reliance on this authorization. This authorization shall automatically expire in 1 year from the date of signature unless otherwise specified in the space provided here:

EXPIRATION DATE: _____.

I understand I may inspect and copy the information to be used and disclosed under this authorization and that I may receive a copy of this signed authorization form. There may be a fee associated with copying, not to exceed what is allowed by Connecticut State Law (45 cents per page, plus the cost, if any, of postage).

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information listed to the extent indicated and authorized herein.

I understand that this provider may not condition treatment on the provision of this authorization except in cases of research related treatment protocols or studies being conducted by outside third parties through this provider. In such cases specific authorization for the research related treatment protocols /studies will be signed as a condition of participation.

NOTICE TO RECIPIENTS: As the recipient of this information you may use the information only for the stated purpose. You may disclose this information to another party ONLY :

- With written authorization from the patient or his or her legal representative;
- As required by state and or federal law
- If needed for the patient's continued care

If this disclosure contains information regarding HIV behavioral health, psychiatric, alcohol or drug abuse education training, treatment rehabilitation or research the following shall apply:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

NOTICE TO THE INDIVIDUAL REQUESTING DISCLOSURE:

Your signature below indicates that you understand that if the organization authorized to receive the information is not a health care provider or health plan and the information disclosed is NOT protected by definition under current laws, then the released information may no longer be protected by the HIPAA Federal Privacy Regulations.

Patient/legal representative signature;_____ Date: _____

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PATIENT INFORMATION CONSENT TO DISCLOSURE

I, _____, a patient of Miniaci Chiropractic & Acupuncture LLC, do hereby attest that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

If there are any parties/businesses with whom my personal health information should not be disclosed, or if there are any restrictions I want placed on my information disclosure it is my responsibility to notify Miniaci Chiropractic & Acupuncture LLC in writing. (A form for this purpose is available from the chiropractic office upon request)

Signed: _____- Dated: _____-

Witnessed: _____- Dated: _____-

This form is part of a HIPAA compliance program.

Patient Information Consent to Disclosure.doc

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Patient Pregnancy Disclaimer

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having x-rays taken at this time and grant permission for this procedure. In doing so I release the doctor and clinic from potential damage arising from this procedure.

At the present time:

___ I am sure that I am not pregnant.

___ It is possible that I could be pregnant.

___ I am pregnant.

Date of LMP (Last Monthly Period): ___/___/___

Signature-Patient:_____ Dated:_____

Signature-Witness:_____ Dated:_____

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