EQUILIBRIUM LLC

NEW PATIENT REGISTRATION

Personal Information

Name:_____ Date: _____

Address: _____

Phone #: Home: _____Cell: _____

Email: _____ DOB: _____ Sex: M/F

Height: _____ Weight**:** _____ Marital Status: Single / Married / Widowed / Other

Referring Physician: _____

Employment Information

Employer: _____

Employer Address: _____

Responsible Party: Self / Other Employer Phone: _____

Insurance Information

Name of Insured: _____

Insurance Carrier: _____

Phone: _____ Policy #: _____

Group #: _____

In Case of Emergency

Name: _____

Relationship: _____ Phone: _____

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PATIENT MEDICAL INFORMATION/HISTORY

Primary Care Physician _____

Other Practitioners involved in current care _____

Referring Physician/Source _____

Chief Complaint:

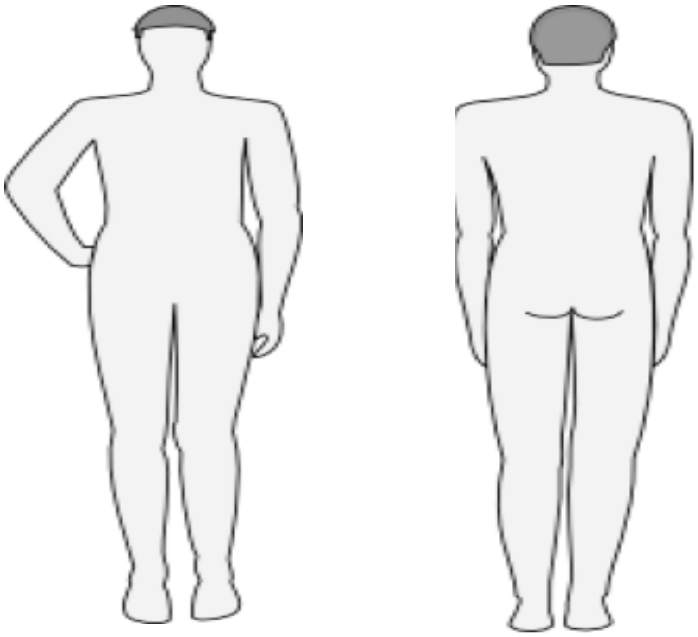
_____

_____

_____

From a scale of 0 (none) – 10 (worst/emergency), what is your current level of pain? _____

Please mark areas of pain/discomfort:



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When did this condition start?

Please describe the nature of your pain: (ie. Dull/Achy; Sharp; Radiating; Numbness, etc.)

_____

What activities make the pain worse?

_____

What activities make the pain better?

_____

Have you seen a physician or another healthcare provider regarding this condition? If "yes" please provide diagnosis and treatments provided.

_____

_____

Have you experienced any falls within the past year? If "yes" when? _____

Have you had any past hospitalizations, serious illnesses, surgeries or injuries?

Do you have any allergies (ie. Latex, medication, foods, seasonal, environmental, etc.)? If "yes" please list/describe

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Are you currently pregnant? Yes / No / Does not apply

Have you experienced any recent changes in your bowel/continence? Yes / No

Do you smoke? Yes / No

Do you drink alcohol? Yes / No
If "yes" how many a day? _____

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How many hours of uninterrupted sleep do you get per night? _____

What is your current emotional stress level? 0 (No stress) – 10 (Extremely Stressed) _____

Have you ever been diagnosed with any of the following conditions: Circle Yes or No
If Yes, please explain in the space provided below.

High Blood Pressure	Yes	No	Nausea/Vomiting	Yes	No
Heart Attack	Yes	No	Anemia	Yes	No
Pacemaker	Yes	No	Fever/Night Sweats	Yes	No
Heart Disease	Yes	No	Severe weight loss	Yes	No
Stroke/CVA	Yes	No	Numbness/Tingling	Yes	No
Deep Vein Thrombosis	Yes	No	Dizziness/Vertigo	Yes	No
Cancer	Yes	No	Pneumonia	Yes	No
Osteoporosis	Yes	No	Asthma	Yes	No
Metal Implants	Yes	No	Emphysema	Yes	No
Osteoarthritis	Yes	No	Migraines	Yes	No
Rheumatoid Arthritis	Yes	No	Tuberculosis	Yes	No
Thyroid Conditions	Yes	No	Hepatitis	Yes	No
Kidney Disease	Yes	No	HIV/AIDS	Yes	No
Diabetes	Yes	No	Other	Yes	No

Please describe YES answers:

_____

_____

Medications/Supplements:

_____

Please list tests that have already been conducted: (ie. XRAY, MRI, Blood Work, etc.)

_____

What are your goals and/or activities that you would like to return to or improve?

_____

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PATIENT PRIVACY INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The privacy of your information is important to us and the U.S. government regulators established privacy rule (HIPPA) governing protected health information. All the staff at Equilibrium LLC is responsible of privacy matters at our facility. You can contact us at: 201-461-9333. We are required by law to maintain the privacy of your protected health information and required to abide by the terms of this notice.

We want you to know how your Protected Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you online.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

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7. We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

a) Required by Law;
b) Required for public health purposes;
c) Required by law to report child abuse;
d) Required by law in judicial or administrative proceedings;
e) Required by law enforcement purposes by law enforcement official;
f) Required by medical examiner
g) Permitted by law to avert a serious threat to health or safety

8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the practitioner(s) at Equilibrium LLC has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature _____

Printed Name _____

Date _____

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PATIENT AGREEMENT

Thank you for choosing Equilibrium, LLC. Please review and sign the following agreement.

1. Payment of all fees is expected at time of service via credit card on file, check or cash. We will assist you in submitting claims to your insurance carrier; however, you are responsible for any deductible, co-insurance, co-payments, or claim denied by your insurance carrier.

2. I hereby authorize payment of medical benefits directly to Equilibrium, LLC for all services rendered.

3. I authorize Equilibrium LLC, having treated me, to release to government agencies, insurance carriers and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I understand that if at any point my insurance coverage changes, I am to notify administrative staff prior to my next visit. Failure to do so will result in me being responsible for the full amount of all services.

4. A scheduled appointment must be cancelled **at least 24 hours in advance**. Failure to reschedule in a 24-hour notice and/or a "no show" will be subject to our cancellation policy and will not be billable to your insurance.

Cancellation Policy:

First Late Cancel/No show:	**Fee waived**
2nd Late Cancel/No Show:	**$100 Fee**
➢ **3rd Late Cancel/No show:**	**$160 Fee**

We remain committed to providing the best care possible and we thank you for choosing Equilibrium LLC. Please sign to indicate that you have read and agree to the above terms.

_____ Date: _____

Signature of Patient

EQUILIBRIUM LLC

CREDIT CARD ON FILE (OPTIONAL)

In order to expedite billing, we keep a credit card on file. Your credit card will be billed weekly for any unpaid balance. You will receive a paid invoice and receipt via mail/email.

Name _____ Date _____

Credit Card Type: Visa Mastercard American Express Discover

Card #: _____ Exp: _____

I authorize Equilibrium LLC to charge this card for any unpaid balances on file.

_____ Date _____
Signature