



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 #: _____

Emergency Contact

Name: _____

Relationship: _____ Phone: _____



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PATIENT MEDICAL INFORMATION/HISTORY

Primary Care Physician _____

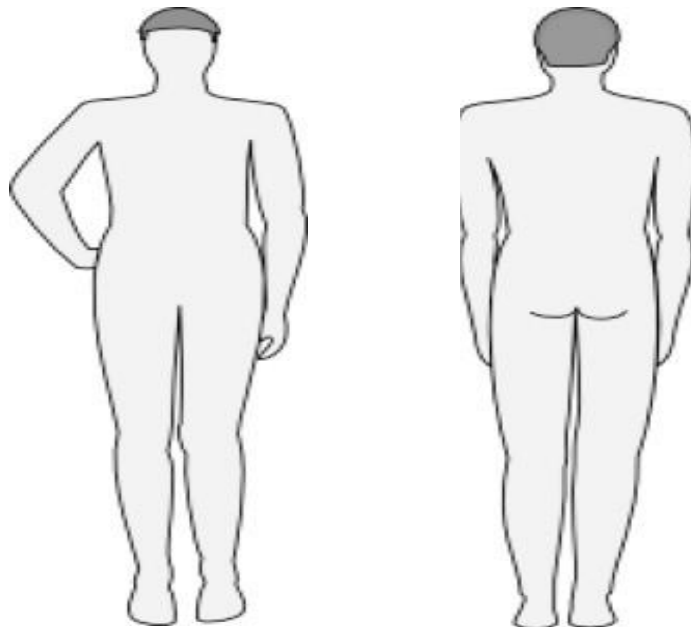
Other Practitioners involved in current care _____

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:





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

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

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



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Do you smoke? Yes / No

Do you drink alcohol? Yes / No

If "yes" how many a day? _____

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: Check if yes, and please explain in the space provided below.

High Blood Pressure: _____

Nausea/Vomiting: _____

Heart Attack: _____

Anemia: _____

Pacemaker: _____

Fever/Night Sweats: _____

Heart Disease: _____

Severe Weight Loss: _____

Stroke/CVA: _____

Numbness/Tingling: _____

Deep Vein Thrombosis: _____

Dizziness/Vertigo: _____

Cancer: _____

Pneumonia: _____

Osteoporosis: _____

Asthma: _____

Metal Implants: _____

Emphysema: _____

Osteoarthritis: _____

Migraines: _____

Rheumatoid Arthritis: _____

Tuberculosis: _____

Thyroid Conditions: _____

Hepatitis: _____

Kidney Disease: _____

HIV/AIDS: _____

Diabetes: _____

Other: _____

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?



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 _____



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

Subsequent Cancel/No Show: \$180 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



Credit Card on File (Optional)

Name: _____ Date: _____

Credit Card Type: Visa Mastercard Amex Discover

Card #: _____ Exp: _____

CVV Code# _____

By signing this document, I authorize Equilibrium LLC to save my credit card data on the EHR/EMR system. I authorize Equilibrium LLC to charge this card for any unpaid balances on file. All credit card data will be securely stored on a PCI-compliant server.

_____ Date: _____

Patient Signature