PATIENT INFORMATION

NAME___________________________ HOME PHONE______________
EMAIL ADDRESS___________________ WORK PHONE______________
CELL PHONE______________

ADDRESS___________________________ CITY__________ STATE_____ ZIP______
BIRTHDATE__________ AGE___ MARITAL STATUS S – M – D – W NUMBER OF CHILDREN______
SOCIAL SECURITY # ___________________ OCCUPATION___________________
EMPLOYER___________________________ BUSINESS ADDRESS ______________

NAME OF EMERGENCY CONTACT______________ RELATIONSHIP______________
PHONE NUMBER______________

NAME OF SPOUSE______________________ OCCUPATION ______________
EMPLOYED BY________________________ PHONE NUMBER______________
BUSINESS ADDRESS____________________

INSURANCE

DO YOU HAVE HEALTH INSURANCE ___YES ___NO
PRIMARY HEALTH INSURANCE NAME______________ PHONE NUMBER______________
MEMBER / ID NUMBER______________ GROUP NUMBER______________
ADDRESS______________________________________
D0 YOU HAVE SECONDARY INSURANCE? ______YES ______NO
SECONDARY INSURANCE NAME______________ ID #______________
PRIMARY CARE DR.'s NAME:______________ PHONE #______________
ADDRESS______________________________________

BRIEFLY DESCRIBE YOUR SYMPTOMS

____
____

IS THIS VISIT DUE TO AN ACCIDENT? ___YES ___NO Auto Injury____Work Injury___ (Did you inform your employer?)
ATTORNEY______________ PHONE______________ ADDRESS______________
OTHER DOCTORS SEEN FOR THIS PROBLEM______________
IS THERE A PHYSICIAN OF WHICH YOU WOULD LIKE US TO COMMUNICATE?______________
HOSPITALIZED?___YES ___NO HOW MANY DAYS?______ NUMBER OF DAYS MISSED FORM WORK?______
PREVIOUS SURGERIES______________ WHEN?______________
HAVE YOU BEEN TREATED BY A PHYSICIAN IN THE LAST 12 MONTHS? ___YES ___NO WHEN?__________
CONDITION______________ DATE OF LAST PHYSICAL EXAM______________

ALLERGIES TO ANY MEDICATION ___YES ___NO
IF YES, PLEASE LIST______________________________________
ARE YOU CURRENTLY TAKING ANY MEDICATION ___YES ___NO
IF YES, PLEASE LIST______________________________________

PATIENT'S SIGNATURE______________________________ DATE__________
PRINT NAME______________________________________
SPOUSE OR GUARDIAN'S______________________________

PAST MEDICAL HISTORY AND PRESENT COMPLAINTS

Please check all that apply to you

Past	*Present*	
___	___	Accident/Injury
___	___	Dizziness
___	___	Back pain
___	___	Bleeding problem
___	___	Blood in urine
___	___	Breathing problem
___	___	Bone pain
___	___	Bruise easily
___	___	Burning
___	___	Calf pain
___	___	Cancer ______________
___	___	Cardiovascular problems
___	___	Chest symptoms
___	___	Pregnant
___	___	Chills
___	___	Fever
___	___	Headache
___	___	Nausea
___	___	Balance problem
___	___	Decrease range of motion
___	___	Diabetes Type______________
___	___	Difficulty getting out of chair
___	___	Difficulty exercising
___	___	Discharge
___	___	Difficulty controlling bladder
___	___	Endocrine related symptoms
___	___	Episodic weakness
___	___	Joint pain
___	___	GI systems
___	___	Gout attack
___	___	GU symptoms
___	___	Hand edema/swelling
___	___	Heel pain
___	___	Hip pain
___	___	Hives
___	___	Difficulty having bowel movement
___	___	Difficulty lifting foot
___	___	Spinal pain worse at night
___	___	Nausea

Past	*Present*	
___	___	Muscular symptoms
___	___	Eye or vision problems
___	___	Joint redness or swelling
___	___	Leg cramps
___	___	Leg pain
___	___	Leg swelling
___	___	Muscle pain/tenderness
___	___	Skin problems
___	___	Neurological problems
___	___	Numbness
___	___	Tingling/pins and needles
___	___	Psychiatric problems
___	___	Emotional problems
___	___	Rash
___	___	Night sweats
___	___	Sickle cell crisis
___	___	Rheumatologic condition
___	___	Seizures
___	___	Neck Pain
___	___	Stiffness in AM
___	___	Ear, nose, or mouth symptoms
___	___	Throat symptoms
___	___	Upper extremity edema
___	___	Fractures ______________
___	___	Weakness
___	___	Scoliosis
___	___	Mixed connective tissue disease (EDS-4)
___	___	Marfan's Syndrome
___	___	Polycystic kidney disease
___	___	Aortic Dilatation/heart arrhythmia
___	___	Hyperhomocysteinemia
___	___	Swollen groin lymph nodes
___	___	Prolonged corticosteroid use
___	___	Recent significant injury
___	___	Vertigo
___	___	High Blood Pressure
___	___	Duration of pain greater then 1 month
___	___	Recent bacterial or respiratory infection
___	___	Weight loss greater then 10lbs over 6 weeks
___	___	On anticoagulant therapy(Coumadin)
___	___	Other

SOCIAL HISTORY

Past	*Present*		*Past*	*Present*	
___	___	Alcohol Use	___	___	Tobacco use
		Number of drinks/week_______			Packs/day______ pack years________
___	___	Illegal drug use	___	___	Pregnant
					Date of last period ____________

Signature______________________ DATE ____/____/______

Patient Financial Policy

ACCEL-HEALTH has formulated this financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best care and minimizing administrative costs. This financial policy has been established to avoid any misunderstanding or disagreement concerning payment for professional services.

Patient Financial Policies:

- The professional services of Accel-Health are available to all persons. However, all patients must accept responsibility for payment.
- Patients are required to present a **valid insurance card** and a **driver's license** or **picture ID** at **every visit** at check-in and as needed throughout their care.
- **Please notify us if your insurance carrier or policy has changes.**
- If you fail to provide us with accurate insurance and identifying information, we will be unable to collect payment from a third party payer. In such event, you to assume full responsibility for services you received, and you may be charged a re-billing fee.

Your Co-Pay:

- If your insurance plan requires co-pay, we are **required** to collect it. **Please pay your co-pay when you check in.** We may reschedule your appointment if your co-pay is not paid at time of service.

Commercial Insurance Carriers:

- If we participate in your health insurance plan, our billing office will submit a claim for services rendered. All necessary insurance information, including special form, must be completed by you prior to leaving the office. You remain responsible to pay for the co-pay and deductible amounts required by your plan. We will expect your assistance in contacting your insurance carrier in the event of non-payment or discounted payments.
- If you're insurance plan will only pay for you to see physicians who are member of their network, please contact the plan to verify that we do participate. If we provide you with services and your insurance plan dos no pay because we are not participating you are responsible for full payment for our services.
- If you have an insurance plan in which we do not participate, we do not accept assignment of the claim-this means that you must pay for the services, and you obtain reimbursement directly from the plan payment in full is expected at time of service. Our office will complete a claim form so that you may submit it for reimbursement directly from the plan.
- It is your responsibility to pay any deductible or any portion of the charges as specified by the plan at the time of services.
- If we have a contract to participate with an insurance plan, we have agreed to a negotiated payment rate for each service. However, for the plans in which we do not participate, we charge you our regular fees. Insurance companies sometimes use the phrases "usual and customary" when discussing physician fees and decide what they think the "usual and customary" rate should be based on wide geographical area.

- The fees we charge differ and we do not write off balance based on the insurance company's reimbursement to you.
- Our staff is happy to help with insurance questions relating how a claim was filed, or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by your insurance company member services or your employer HR department.
- Your insurance company may require additional information to process your claim(s), such as accident details, co-ordination of benefits, or student status. Your insurance company will request this information from you in writing. It is very important that you provide your insurance with the information necessary to process your claims so that we may be reimbursed. If you fail to provide the information requested in a timely manner, we may not be paid by your plan. If this occurs, we will hold you responsible for the bill for serves we render.

Workers Compensation/Automobile Insurance:

- Workers compensation laws require the employee to report injuries to their employer. If your care involves a work-related injury, we must know the date, location and nature of the accident. The insurance company's name, telephone number of your adjuster, and the claim number assigned to your file. If you do not provide this information we cannot bill worker's compensation and you will be responsible for payment of the entire balance due, based on our normal fee schedule. We cannot bill your regular health insurance for a work-related injury.
- If you were involved in an automobile accident we need a coy of your Motor Vehicle Accident Insurance card. At the time of your visit you must provide us with Medical Provision Letter indicating medical coverage and the dollar amount of the coverage. If you are unable to produce this letter at the time scheduled visit, it will be necessary for you to complete a credit card release form in the event that the claim is denied by your motor vehicle insurance and/or your heal insurance. We cannot bill your regular health insurance, for motor vehicle accident related care, unless there is a no medical coverage available under your motor vehicle insurance plan. You are responsible for presenting a No Med Pay letter to our office on the first appointment.

Private Pay:

- Patien who do not have any health insurance coverage are expected to pay for professional services at the time of the visit, before treatment, unless prior arrangements have been made. We may require a deposit.
- Fianancial assistance is available for qualified patients. If you think you may qualify for assistance, the receptionist should be notified for a referral to our Practice Financial Counselor.

Methods of Payment:

- Payment for professional services may be made with cash, personal check, or credit cards (excluding American Express)
- We do not accept post dated check.

You agree to pay all costs of collecting amounts you owe us including but not limited to: billing fees, legal fees, court costs, and attorney fees. In the event your account is turned over to collection, you authorized Accel-Health to contact your employer for employment verification.

Cancellation and Missed Appointment and Procedures:

- If you are **unable to keep a regular schedule appointment and fail to notify our office within 24 hours of your appointment, a $50.00 charge may be placed on your account.**
- If you are **unable to keep a procedure appointment such as, but not limited to, an EMG or Injection and fail to notify our office with in 24 hours of your appointment, a $100.00 charge may be placed on your account.**
- Once these cancellations and missed appointment fee charges are incurred we reserve the right to defer future appointment until the balance of these fees have been paid in full.

Disability and Insurance Forms:

- We will complete your disability or other insurance forms. WE ask that you turn in the forms as soon as possible. Please allow 5-7 business days for your forms to be completed. Please understand forms are completed in the order in which they are received. This is a **$15.00 charge** for completing these forms, payable in advanced.

Medical Records and X-Rays:

If you need a coy of your medical records sent to yourself or to someone else:

- You will be asked to sign a release of medical records before fulfilling the request.
- Medical records cannot be released with a telephone request; we must have signed authorization.
- Copy fees apply. Be sure to ask the amount when requesting records or x-rays.

Durable Medical Equipment:

- Your physician may prescribe a piece of medical equipment, i.e., cold therapy, walker boot, crutches, ect., to be used for a period of time to aid in your recovery. We can fit and dispense that product to you. Payment in full is required when requesting the equipment prescribed.

Minor Patient:

- Written permission from the parent or guardian is required prior to treatment.
- The adult accompanying a minor is responsible for payment at the time of service. For unaccompanied minors, non-elegant treatment will be rescheduled unless charges have been preauthorized and payments by cash, check, or credit card have been prearranged.

Schedule of Miscellaneous Fees:

o	**Missed Appointments:**	
	-Chiropractic Visit	$25.00
	-Office Visit	
	Physical Therapy	$50.00
	Medical Doctor/DO	$50.00
	-Medical Procedure	$100.00
o	**Disability Forms:**	$15.00
o	**Returned Check Fee:**	$30.00
o	**Statement Billing Fee:**	
	-Unpaid co pays	$25.00
o	**Medical Records,** by page:	$ .65
o	**Collection Fee:**	

- A collection charge is applied to all accounts unpaid after 60 days. The collection charge is computed by a periodic rate of 1.5% per month, which is the annual percentage rate of 18%. Minimum charge of $1.00.

Thank you for choosing Accel-Health for your Medical, Chiropractic and Physical therapy needs. We are here to help you. Our practice firmly believes that a good physician-patient relationship is based upon understanding a good communication. Questions about financial agreements should be directed to our Practice Financial Counselor.

I have read this financial policy and agree to abide by it.

Patient Name (printed): ______________________ Date of Birth: ______________

Patient Signature: ______________________ Date: ______________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVCY NOTICE

I have been presented with a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

Further, I permit a copy of this authorization to be used in a place of the original, and request payment of medical benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

*Patient Name (printed) ______________________________________

PATIEN EMAIL CONSENT

With this form, you authorized Accel-Health Professionals to communicate general information to you via email.

Obligations/Considerations when consenting email:

- Use email for general AH information email:
- Inform the clinic of any changes to your email address.
- Withdraw consent to email patient information through verbal/written communication to AH.
- AH uses reasonable means to protect the security and confidentiality of emails sent and received.
- AH will not engage in email communication that is unlawful.

PATIENT'S CERTIFICATION OF HIS/HER CONSENT FOR ACCEL-HEALTH EMAIL COMMUNICATION

***Patient Email Address:** ______________________________________

I acknowledge that I have read and fully understand this consent form. I understand and consent to the patient and Accel-Health obligations herein.

***Patient Signature:** ______________________________ **Date:** ______________

Internal use only:

If the patient or patient's representative refuses to sign the Acknowledgment of Receipt of Privacy Notice, and/or the Email Consent, please document the date and time the form was presented to the patient. Specify which consent they are not willing to sign and the employee who reviewed this form with the patient is to sign below.

Date Presented: ____________ ***Time:*** _________ ***Consent Denial:*** ________________

Presented By (print, sign, and date) ______________________________________

Patients Name: ______________________ Today's Date: ______________

Date of Birth: ____________________ Social Security # ________________

I hereby authorize to recipient of this letter to release my medical records, including but not limited to : emergency room records, laboratory results, X ray reports, MRI reports, doctors/nurses notes, all consents and other diagnostic test results that pertain to my treatment of Accel-Health, as well as copies of the bill for services rendered.

Date of Treatment: ____

Information to be Disclosed: ____

Purpose for Use of Information: _____________________________________

Information should be mailed to:

Accel-Health
970 Summer St.
Stamford, CT 06905

Or faxed to:
1-203-348-5678

If you have any question, you may call 1-203-348-0123

I acknowledge that I have carefully reviewed this Authorization and understand its provision:

_________________________________ ____________________

Patient Signature *Date*

I have been advised that my insurance company may accept an Assignment of Benefits and, therefore, I may receive payments directly form my insurance carrier for serviced rendered at Accel-Health. I have been instructed that if this occurs I should bring these checks directly to Accel-Health.

Signature: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________