Welcome to:

activehealth
Chiropractic · Sports Medicine · Acupuncture

Please check the treatments you are here for:

- □ Chiropractic
- □ Acupuncture
- □ Sports Injury
- □ Therapy
- □ Active Release Techniques ®
- □ Graston Technique ®
- □ Custom Orthotics
- □ Motor Vechicle Accident
- □ Worker's Comp
- □ I'm Not Sure

activehealth
Chiropractic · Sports Medicine · Acupuncture

WELCOME the doctor and staff of ACTIVE HEALTH welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE
This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

PATIENT IDENTIFICATION

Name: _____ Nickname preferred:
Street: _____ _____
_____ Phone (Home) _____
City State & Zip (Cell) _____
Email: _____ (Work) _____
Social Security Number _____ Preferred number for contact: _____
Is it ok to leave messages? Yes ( ) No ( )

Male ( ) Female ( ) Married? Yes ( ) No ( ) Occupation: _____
Date of Birth: _____ Who referred you? _____

Primary Insurance Carrier _____ Member ID_____
Name of Insured _____

Secondary Insurance Carrier _____ Member ID_____
Name of Insured _____

Do you have an HSA/FSA? Yes ( ) No ( )

Is this a **Work Related Accident**? Yes ( ) No ( ) Was the injury reported to employer? Yes ( ) No ( )
Date of injury: _____ Has there been a claim assigned? Yes ( ) No ( )
Carrier Name: _____ Phone #: _____
Adjuster name: _____ Claim #: _____

Is this the result of an **Automobile Accident**? Yes ( ) No ( )
Date of accident: _____ Auto Insurance: _____
Do you have Medpay? Yes ( ) No ( ) Phone #: _____
Claim #: _____ Adjuster Name: _____
Do you have an Attorney representing you? Yes ( ) No ( ) Attorney Name: _____
Address: _____ Phone #: _____

Contact in case of emergency: _____ Phone #: _____

Name of Legal Guardian or parent (if applicable):_____

ACCEPTANCE AS PATIENT
I understand and agree that the doctors of ACTIVE HEALTH have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process if information gathering so that the doctor can determine whether to accept me as a patient.

Date: _____ Signature: _____

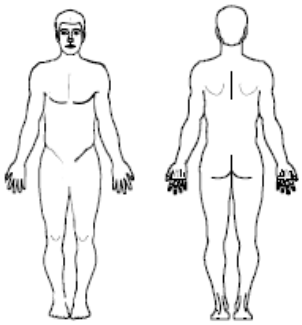
activehealth
Chiropractic · Sports Medicine · Acupuncture

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

activehealth
Chiropractic · Sports Medicine · Acupuncture

Medical History

Medical Care Information			
Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No If yes, Last Surgery Date: / / Reason:			

Present illness /Conditions:					
☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐
Other:					

Family History of illness:					
☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus
Other:					

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Social History:			
Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? _____ (circle one) Light / Moderate / Strenuous
Referred By:			

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

activehealth
Chiropractic · Sports Medicine · Acupuncture

Form: Consent for Purpose of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Dr. Michael C. Orefice for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Active Health & Wellness Center, LLC**.

I understand that diagnosis or treatment of me by the doctor may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. The doctor is not required to agree to the restrictions that I may request. However, if Dr. Michael C. Orefice agrees to a restriction that I may request, the restriction is binding on that doctor.

I have the right to revoke this consent in writing, at any time, except to the extent that the doctor has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me an created or received by my physician , another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the office's Notice of Privacy Practices prior to signing this document.

Active Health & Wellness Center, LLC Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations in the office.

The Notice of Privacy Practices also describes my rights and the duties of the doctor with respect to my protected health information.

Active Health & Wellness Center, LLC reserves the right to change the privacy practices that are described in the Notices of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment. The Notice of Privacy Practices for **Active Health & Wellness Center, LLC** is also provided at 255 Cherry Street, Suite A, Milford, CT 06460.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____/_____/_____
Date

_____
Description of Personal Representative's Authority

activehealth
Chiropractic · Sports Medicine · Acupuncture

Office Policy and Assignment of Payments

APPOINTMENTS:

- PLEASE SHOW UP FOR YOUR APPOINTMENTS ON TIME. WE MAINTAIN AN EXCEPTIONAL RECORD FOR RUNNING ON TIME, AND
  EXPECT THE SAME FROM YOU. IF YOU ARE LATE, YOU ARE CAUSING THE DOCTOR TO RUN LATE, AND THEN THE NEXT PATIENT
  HAS TO WAIT. PLEASE SHOW RESPECT FOR OTHER PATIENTS
  MISSED APPOINTMENTS:
- IF YOU NEED TO CANCEL YOUR APPOINTMENT, PLEASE GIVE US AT LEAST 24 HOURS NOTICE.
- AFTER THE FIRST "NO SHOW" YOU WILL BE GIVEN A PHONE CALL AND A REMINDER THAT THE OFFICE VISIT WAS MISSED.
- AFTER THE SECOND AND SUBSEQUENT MISSED APPOINTMENTS A "MISSED APPOINTMENT" CHARGE OF $25.00 WILL BE SENT
  TO THE PATIENT. THIS CHARGE IS NOT BILLABLE TO THE INSURANCE COMPANY.
- IN THE EVENT OF INCLEMENT WEATHER AND YOU DO NOT FEEL IT IS SAFE TO DRIVE HERE, PLEASE CALL US.
  PAYMENT POLICY:
- ANY REQUIRED PAYMENTS ARE EXPECTED AT THE TIME OF EACH VISIT.
- IF THE INSURANCE COMPANY DOES NOT PAY IN FULL, ACCORDING TO THE TERMS OF THE PATIENT'S POLICY, THE PATIENT WILL
  BE RESPONSIBLE FOR ALL UNPAID CHARGES.
- IT IS THE PATIENT'S RESPONSIBILITY TO KEEP TRACK OF THE DOLLAR AMOUNT LIMITS, NUMBER OF AUTHORIZED VISITS (IF
  NECESSARY), CHANGES FOR CO-PAYMENTS, DEDUCTIBLES, ETC. FOR THEIR INSURANCE POLICY.
- ACTIVE HEALTH & WELLNESS CENTER LLC WILL CALL TO VERIFY YOUR INSURANCE BENEFITS AT THE TIME OF YOUR
  INITIAL VISIT, HOWEVER, AS STATED BY YOUR INSURANCE COMPANY "THESE ARE AN ESTIMATE OF BENEFITS AND NOT A
  GUARANTEE OF PAYMENT".
- I ACKNOWLEDGE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF MY BILL AND ANY SERVICE CHARGES THAT ARE
  INCURRED IN COLLECTING PAYMENT FOR MY BILL INCLUDING ATTORNEY FEES, INTEREST AND COURT COSTS IF APPLICABLE.

HMO/POS/PPO Referrals/Authorization:

- If an insurance company requires a referral for the initial visit, this referral needs to be received by our office before the patient is seen. Obtaining this initial referral is the patient's sole responsibility and all charges incurred due to improper referral procurement will also be the patient's responsibility.
- If an insurance company requires an additional referral or authorization for further treatment, the Active Health & Wellness Center LLC will provide the patient with the necessary documentation, or we will fax it directly to the primary care doctor's office. However, it is ultimately the patient's responsibility to obtain the referral or authorization.

Copies of Records:

Active Health & Wellness Center LLC reserves the right to charge an administrative fee of 25 cents per page for the copying and/or sending of clinical records. We also reserve the right to charge 25 dollars for the initial page and 10 dollars per page thereafter for any written reports, requests or forms pertaining to the patient's condition. As a courtesy to our patients, we will submit medical claims to your primary and secondary insurance. In signing this form, you agree that we may bill your insurance company on your behalf, and you agree to ASSIGN PAYMENTS to the Active Health & Wellness Center LLC. This means that you give permission for the insurance payments to be made directly to us. If you do not agree to this, we require payment directly from you at the time of service, and we will then provide you with the necessary documentation to file your own insurance papers. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement of any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and claim and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with the doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expense.

I HAVE READ THE ABOVE AGREEMENT. I UNDERSTAND AND AGREE TO ALL OF THE POINTS DISCUSSED ABOVE.

NAME (PRINTED): _____

NAME (SIGNED): _____ DATE: _____

activehealth
Chiropractic · Sports Medicine · Acupuncture

Form: Notice of Privacy Practice Summary

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

The doctor will use health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes and to evaluate the quality of care that you receive.

The doctor will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires to do so.

The doctor may use your information to provide appointment reminders and information about alternatives or other health-related issues.

The doctor may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research health and safety, governmental function in order to comply with workers compensation laws and regulations a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health services.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Active Health & Wellness Center, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you make to communicate with health information by alternative means or by alternative locations to obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints please contact Active Health & Wellness Center, LLC at: 203-283-5404.

_____ _____/_____/_____

Signature Date