



7000 Security Blvd. STE 108 Baltimore, MD 21244

Patient Information

Date _____

Healthcare for a Healthy Lifestyle

Patient Name _____
Last First MI
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Best time and place to reach you _____ Email _____
Age _____ Birth Date _____ Sex: F M Marital Status: M S D
of children _____ Spouse's Name _____ SS#: _____
Occupation _____ Name of Employer _____
Who may we thank for referring you? _____
Or Referred by: _____ Insurance Co. _____ Our Website _____ Phone Book _____ Your Doctor
Your Doctor's Name _____ Doctor's Tel. # _____
Are You Pregnant? ___ Yes ___ No Due Date _____

Emergency Contact

Name _____
Relationship _____
Tel.# _____
Alternate # _____

Accident Information

Is this condition due to an accident? ___ Yes ___ No
Date of Accident: _____
Type of Accident: ___ Auto ___ Work ___ Home
Other _____
To Whom Have You Reported Your Accident?
___ Auto Ins. ___ Employer ___ Workers Comp. ___ Attorney
Attorney's Name _____
Attorney's Tel. # _____

Present Condition

Reason for your visit _____
How long have you been suffering? _____
Is this condition getting progressively worse? ___ Yes ___ No ___ Unknown
Do you know what caused it? _____
Rate the severity of your pain on a scale of 1 (least pain) to 10 (most pain) _____
Please check all that apply to describe your pain:
___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Shooting ___ Squeezing
___ Burning ___ Tingling ___ Stiff ___ Aching ___ Cramps ___ Other _____
How often do you suffer from the above? _____
Is it constant or does it come and go? _____
How is it effecting your quality of life? Please check all that apply:
___ Work ___ School ___ Sleep ___ Walking ___ Sitting ___ Standing
___ Bending ___ Lying down ___ Eating ___ Mood ___ Energy ___ Relationships
___ Exercise ___ Daily Routine ___ Recreation, be specific _____
What have you already tried in order to resolve this problem?
___ Medication ___ Surgery ___ Physical Therapy ___ Massage ___ Chiropractic
___ Acupuncture ___ Nothing ___ Other _____

Health History

Please place a check next to all those that you have or have had in the past:

- | | | | |
|-------------------------------------------------|---------------------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraines / Headaches | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chemical
Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prosthesis | |
| | <input type="checkbox"/> Kidney Infection / Stone | <input type="checkbox"/> Psychiatric Care | |

Please list any surgeries or accidents that you have had and when _____

Medications

1. _____
2. _____
3. _____
4. _____
5. _____

Wellness Objectives

At the Silver Wellness Center, we are dedicated to helping you achieve all your health goals. Therefore, in order to serve you better please check all that apply that meet your health objectives:

<input type="checkbox"/> Symptom / Temporary Relief
<input type="checkbox"/> Maximum Correction <input type="checkbox"/> Restore Health
<input type="checkbox"/> Wellness & Prevention <input type="checkbox"/> Improved Performance

Habits

	Light	Mod.	Heavy
Alcohol	___	___	___
Coffee	___	___	___
Smoking	___	___	___
Drugs	___	___	___
Exercise	___	___	___
Sleep	___	___	___
Appetite	___	___	___
Soda	___	___	___
Water	___	___	___

Communication Channels

To help us better explain your Chiropractic condition and how we may be able to help you, please check the best answer:

- 1. I remember important things in my life by**
 What I see What I hear What I feel
- 2. The primary reason I brush my teeth is to**
 Avoid tooth decay and gum disease
 make sure I have healthy teeth and gums
- 3. When I make decisions I generally**
 Gather facts and weigh the evidence
 Make the right choice instantly
 Consult my family and friends
 Depend on how "I feel" about it

Insurance Information

Do you have health insurance ? Yes No If no please skip to Authorization

Primary Ins.

Carrier _____
Policy # _____
Group# _____
Policy Holder _____
Date of Birth _____
Social Security # _____
Relationship to Patient _____

Secondary Ins.

Carrier _____
Policy # _____
Group# _____
Policy Holder _____
Date of Birth _____
Social Security # _____
Relationship to Patient _____

Insurance Agreement

I understand and agree that health and accident insurance policies are a contract between an insurance carrier and a policy holder and that I am ultimately responsible for any services and/or treatment I receive at this office. Furthermore, I authorize this office to release any medical information and to complete any reports and forms to assist in collecting from my insurance carrier. I understand that any payments for services/treatments at this office will be credited to my account upon receipt of payments for said services/treatments. However, I clearly understand and agree that all services/treatments rendered to me are charged directly to me and that I am personally responsible for payments. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will immediately become due and payable.

I understand the insurance verification done by this office and quoted to me as provided by my insurance representative is not a promise or guarantee of payment by my insurance carrier and I will not hold this office responsible for discrepancies in the benefits quoted and the benefits actually paid.

Patient's Signature _____

Date _____

Parent's Signature (for a minor) _____

Date _____

Authorization

I hereby authorize Dr. Warren Silver to examine me, and after reviewing my findings with me, to treat my condition as he deems appropriate through the use of the various different techniques and modalities that fall under Chiropractic Health Care. I understand that I have the right to question Dr. Silver on the risks associated with any/all procedures being performed. Once my questions are answered I give authority for these procedures to be performed, assuming all risks. I also understand that at any time I have the right to deny any of the services.

I also affirm that the information I have provided on this health information form is true and accurate to the best of my knowledge. I also agree to report any changes to my health, name, address or other pertinent information to this office immediately of said changes.

Patient's Signature _____

Date _____

Parent's Signature (for a minor) _____

Date _____

OFFICE POLICY

Dear Patient:

We believe that a clear definition of our office policies will allow both you and us to concentrate on the big issue - REGAINING AND MAINTAINING YOUR HEALTH.

For Patients with no insurance:

1. **All payments are expected at the time of service or at the beginning of each week.** Patient balances may not exceed \$200 at any time, otherwise professional services may be terminated.

For patients with insurance:

1. That you are considered a cash patient, and therefore responsible for all charges, until you give us complete insurance information, and this office has had a chance to qualify and accept your coverage. Therefore, payment for today's initial visit is expected before you leave. For your convenience this office accepts cash, personal checks, and Visa/MasterCard. If you have insurance and it covers today's visit the payment will be credited to your deductible and/or co-payments.
2. Deductibles and co-payments are expected at the time of services or at the beginning of each week. Your co-insurance balance may not exceed \$200, otherwise professional services may be terminated.
3. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and that after 90 days you will be responsible for payment in full for any outstanding balance, on that claim.
4. After 90 days, you authorize us to use your credit card to collect full payment, on that claim.

Type _____ Credit Card # _____ Exp. Date _____

All Patients:

In an effort to continue to provide you with quality service, this office uses authorized automatic monthly credit card charges. This saves you time, decreases our paper work, and allows us to focus on your health.

5. Returned checks will be subject to an additional \$25 fee.
6. **Venue and Jurisdiction:** It is understood and agreed that any dispute arising out of the relationship shall be governed by the laws of the State of Maryland, and that Baltimore County shall have venue in any legal proceedings.
7. **Payment, Billing & Collection Expense:** Charges more than 30 days overdue will be subject to an Interest charge of 1.5% per month. In the event of non payment and the referral of the account to an attorney or third party for collection, an additional 33.3% of the balance owing (principle and interest) shall be assessed for collection and/or attorney's fees, in addition to any court costs associated with collection.
8. Charges may also be made for missed appointments and those cancelled without 24 hours notice.

We ask that you sign this form as acknowledgment that our policy was explained to you, that you understand it and that you accept full financial responsibility.

Patient's Name: _____ Patient's Signature: _____

Witness: _____ Date: _____

Silver Wellness Center
7000 Security Blvd. STE 108
Baltimore, MD 21244
(410) 298-3100

Many patients are under the mistaken impression that x-rays are their personal property. The law (section 29.2 of the regents rules on professional conduct) CLEARLY STIPULATES that such x-rays are the property of the treating doctor and requires all doctors taking or ordering such x-rays to maintain them in their files for a minimum period of three (3) years and to produce them upon demand of health department representatives. The same law does provide that consumers are entitled to receive the information contained in such records and x-rays. In no event should doctors allow original x-rays or records out of their office for any reason, however if you require a duplicate our office will be happy to have your x-rays copied for \$20.00.

PATIENT SIGNATURE_____

DATE_____

PLEASE READ AND SIGN BELOW IF APPLICABLE TO YOU

This statement asks if I am pregnant and my signature BELOW affirms that I am not pregnant at this time.

PATIENT SIGNATURE_____

DATE_____

Silver Wellness Center (SWC)
7000 Security Blvd. STE 108
Baltimore, MD 21244
410-298-3100

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at SWC we may use or disclose personal and health related information about you in the following ways:

- *Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- *Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- *Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it

will not affect the care provide to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- *If we are providing health care services to you based on the orders of another health care provider.
- *If we provide health care services to you in an emergency.
- *If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- *If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- *If we are ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the

status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in

effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

Dr. Warren M. Silver

If you would like further information about our privacy policies and practices please contact, Dr. Warren M. Silver

This notice is effective as of April 15, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please)

Signature

Date

If you are a minor, or if you are being represented by another party

Personal Representative Printed

Personal Representative Signature

Date

Description of the authority to act on behalf of the patient.

HIPAA HAPPENINGS

The Chiropractic Office of Silver Wellness Center (SWC)

Patient Authorization regarding chiropractic care being provided in an “open-door” adjusting environment

It is the desire of this office to provide chiropractic care in an “open-door” adjusting environment. An “open-door” approach involves the doctor moving from patient care area to patient care area and leaving the doors between patient care areas open. As a result patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related in an “open door” environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure and requesting your authorization.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. If you choose not to be adjusted in an open-door adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from SWC or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.