JP NJNY Associates
D/B/A North Dover Chiropractic Wellness Centre
PLEASE READ AND FILL OUT ALL PAGES.

*Personal Information*

Name_____

Address_____

City_____ State:_____Zip Code_____

Telephone Number_____

Cellphone Number_____

Birthday_____/_____/_____

Age_____ Gender: Female/Male/Other Pronouns: he/him; her/she; they/them

Email_____

Referred By_____

Employer_____Full Time/Part Time/Retired/Unemployed/Disabled

Pick One: Married/Single/Widow/Separated

Emergency Contact Name & Number_____

Primary Health Insurance Name_____

Secondary Health Insurance Name_____

*Insurance Card Driver's License: Front Desk will make a copy.

Which answer best describes your own current ideas and values towards your health?

[ ] Treatment Only- I only consult a doctor when I have problems/symptoms and discontinue care as soon as the symptoms leave.

[ ] Early Detection- In addition to symptom relief, I see doctors occasionally to detect problems early before they become serious.

[ ] Prevention – I am conscious of my health, diet, exercise and actively pursue these because I feel and perform better.

[ ] Wellness- I actively inform myself about true health and I am concerned with the long-term effects of my he

*JP NINY ASSOCIATES : OFFICE POLICIES*

*PLEASE SIGN FOR EACH SECTION. (IF THE PRINT IS TOO SMALL PLEASE ASK FOR LARGER PRINT PAPERWORK.)*

*BY SIGNING YOU HAVE READ AND AGREED TO THE INFORMATION YOU PROVIDED.*

**3 SIGNATURES ARE NEEDED ON THIS PAGE.*

**Chiropractic Terms of Acceptance: Sign and Date**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the patient and our office to be working for the same objective. Chiropractic has one goal – Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method is by specific adjustment of the spine. Health: Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not claim to diagnosis or treat any disease or condition other than a vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will recommend that you seek the services for another health care provider. Regardless of what the disease is called we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I therefore, accept chiropractic care on this basis.

I have read and fully understand the above statements. All questions regarding Dr. Nicole A. Messeson's objective pertaining to my care in the office have been answered to my complete satisfaction.

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**Signature & Date**

**HIPAA Compliance Patient Consent Form Our Notice of Privacy: Sign and Date**

Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so you will be notified at your next visit to update your signature date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, your consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

The practice reserves the right to change the privacy policy as allowed by law.

The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent. May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____

Date: _____

**No Show Fee Office Policy: Sign and Date**

THERE IS A $50.00 CHARGE FOR MISSED NO-SHOW APPOINTMENTS. THEREFORE KINDLY CALL/TEXT 24 HOURS IN ADVANCE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT. IF YOU DON'T DO SO YOUR CREDIT CARD ON FILE WILL BE CHARGED THAT DAY OF YOUR APPOINTMENT.

IT'S A COURTESY THAT THE OFFICE TEXT/CALL YOU FOR YOUR APPOINTMENT, HOWEVER DO NOT RELY ON THE TEXT/CALL TO KEEP TRACK OF YOUR APPOINTMENT(S).

IF YOU DON'T SHOW FOR YOUR APPOINTMENT, YOU WILL BE CHARGED THE $50.00 NO – SHOW FEE. WE APOLOGIZE FOR THE INCONVENIENCE. THIS IS SO THE OFFICE CAN STAY ON TIME AND ON SCHEDULE.

Name: _____ Date: _____

# JP NJNY ASSOCIATES
# D/B/A NORTH DOVER CHIROPRACTIC WELLNESS CENTRE
# PAYMENT UPDATE FOR 2024 (PLEASE READ)
# ALL CO-PAYS/PAYMENTS ARE DUE BEFORE SERVICES ARE RENDERED

***Insurance Billing Procedures and Policies***

All first visit charges are payable when services are rendered. Each patient must pay their co-payment and any unsatisfied deductible at the time of service. Patients will not be seen if they have any outstanding balance.

**Method of payments accepted in the office for co-pays at the time of visit is:** Cash, Credit Card, Debit Card and Health Savings Account

**NO PERSONAL CHECKS ACCEPTED! (Non-Negotiable)**

**A Credit Card must be on file in order for services to be rendered. NO DEBIT CARD CAN BE ON FILE. If the credit card on file is declined, patient will be sent to collections right away, all costs of filing, outstanding bill(s), and obtaining a collection company is at all cost to the patient. NO EXCEPTIONS.**

**Credit Cards Accepted (please circle one): Master/Discover/American Express/Visa Card (MUST BE ON FILE AND BE ABLE TO CHARGE OUTSTANDING BALANANCE PER INSURANCE COMPANY/CASH PLAN.) At this time the office does not charge a credit card fee, however reserves the right to in the further charge 5% of the total (after or during the year of signature), which is allowed by the state. C/C INFORMATION WRITTEN IN YOUR HAND WRITTING.**

**Number:_____ Expiration Date:_____ CV: _____ (NEEDS TO BE ON FILE FOR SERVICES TO BE RENDERED FOR ALL PATIENTS EITHER INSURANCES/CASH PATIENTS. NO EXPECTIONS. OFFICE DOES NOT NEED TO CONTACT YOU FOR OUTSTANDING BALANCE YOU WILL RECEIVE AN EOB FROM YOUR INSURANCE COMPANY THAT WILL STATE IT IN BLACK AND WHITE FOR YOUR RECORDS.)**

As a courtesy to our patients, we will bill your insurance company for the treatment rendered. A patient assignment release must be signed in order for this office to bill your insurance company. Accepting assignment does not mean we accept full payment whatever the insurance company pays. Most insurance companies call for the patient to pay a deductible and/or a portion (co-pay) of the bill. Regardless of what is stated in the insurance policy, the patient portion is whatever the insurance company does not pay. The credit card on file will be charged with the outstanding balance that has occurred from services rendered in the office. **If for some reason the patient's credit card is declined or longer working patient is sent to collections at their expense immediately after declining of credit card. The office is not responsible for how many chiropractic visits your insurance allows/allot according to your insurance plan/coverage. Please make sure you understand your insurance. Your insurance is between you and your insurance.**

It is the patient's responsibility to keep his/her account current. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself, not between the doctor and the insurance company. The insurance company must legally answer the patient and is under no legal obligation to respond to this office. **Patient is current with insurance payments with insurance carrier. If patient lapse with their insurance payment, patient understands that are responsible to pay for the visit in full, if the insurance is re-instated and insurances pays patient will be credited back the difference. Office has the right to be paid for the services that are rendered. It is the patient's responsibility to make sure that any correspondence from the insurance carrier be given to us to make copies for our records.** Failure to notify this office of any insurance correspondence may jeopardize your claim and account standing with this office. Furthermore, I understand JP NJNY Associates (DBA: North Dover Chiropractic Wellness Centre) will prepare any necessary papers and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to JP NJNY Associates (DBA: North Dover Chiropractic Wellness Centre) will be credited to my account upon receipt. **However, I clearly understand and agree that all my services that are rendered to me are charged directly to me and that I am personally responsible for payment.**

**I understand I am responsible for the full amount rendered if payment by my insurance company is denied, or if my account becomes delinquent. If I am no longer under care at JP NJNY Associates (DBA: North Dover Chiropractic Wellness Centre). I understand that my remaining balance is to be paid in full. Should my account become due more than 90 days from billing, I acknowledge a monthly interest fee of 1.5% may be added to amount due for the APR 18%. Should my account be turned over for collection, I understand that I am liable for all attorney fees which amount to not less than one third of the total amount due, plus other collection and or court costs. I acknowledge I will be charged a one-time service fee of $50.00, in addition to the monthly interest fee of 1.5%. In addition, a fee of $50.00 is added for each missed appointment, no show, no call and no text, this is charged at the day of the no show call text. If credit card is declined patient will be sent straight to collections will an additional $50.00.**

***Signature On File***

-I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS

-I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPAINIES.

-I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILLS.

-I AUTHORZIE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY

-I AUTHORZIE PAYMENT DIRECT TO MY DOCTOR.

-I PERMIT A COPY OF THIS AUTHORZATION O BE USED IN PLACE OF THE ORGINAL

**We appreciate your cooperation. In signing this, I have read and understand this agreement and agree to all terms on this agreement.**

Patient's Signature_____

Date_____

Patient Intake Form

**Patients Name:**_____ **Date:** ____ / ____ /____

**1) Please choose the location(s) of your problem(s):**

| | | | |
|---|---|---|---|
| Headaches | Shoulder | Hand | Legs |
| Jaw | Arm | Mid back | Knee |
| Neck | Elbow | Low back | Ankle |
| Upper back | Wrist | Hip | Foot |

Other:_____

**2) What is your height?** _____ ft. _____ in.

**3) How much do you weight?** _____ lbs.

**4) DOB** _____ / _____ /_____

**5) Occupation:**

| | | | | |
|---|---|---|---|---|
| Trader | Professional/Executive | White Collar | Tradesperson | Retired |
| Laborer | Homemaker | Truck driver | Student | Unemployed |

Other:_____

**6) In general, how do you rate your overall health?**

| | | | | |
|---|---|---|---|---|
| Excellent | Very good | Good | Fair | Poor |

**7) What kind of exercise do you perform?**

| | | | |
|---|---|---|---|
| Strenuous | Moderate | Light | None |

**8) Do you have an immediate family member with any of the following?**

| | | |
|---|---|---|
| Rheumatoid arthritis | Heart problems | Diabetes |
| Cancer | Lupus | ALS |

Other:_____

**9) Please check all that apply to you in the appropriate column:**

| Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Headaches | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Neck Pain | ☐ | ☐ | Heart Attack | ☐ | ☐ | Excessive Thirst |
| ☐ | ☐ | Upper Back Pain | ☐ | ☐ | Chest Pains | ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Mid Back Pain | ☐ | ☐ | Stroke | ☐ | ☐ | Smoking/Tobacco Use |
| ☐ | ☐ | Low Back Pain | ☐ | ☐ | Angina | ☐ | ☐ | Drug/Alcohol Dependence |
| ☐ | ☐ | Shoulder Pain | ☐ | ☐ | Kidney Stones | ☐ | ☐ | Allergies |
| ☐ | ☐ | Elbow/Upper Arm Pain | ☐ | ☐ | Kidney Disorders | ☐ | ☐ | Depression |
| ☐ | ☐ | Wrist Pain | ☐ | ☐ | Bladder Infection | ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Hand Pain | ☐ | ☐ | Painful Urination | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Hip Pain | ☐ | ☐ | Loss of Bladder Control | ☐ | ☐ | Dermatitis/Eczema/Rash |
| ☐ | ☐ | Upper Leg Pain | ☐ | ☐ | Prostate Problems | ☐ | ☐ | HIV/AIDS |
| ☐ | ☐ | Knee Pain | ☐ | ☐ | Abnormal Weight Gain/Loss | | | |
| ☐ | ☐ | Ankle/Foot Pain | ☐ | ☐ | Loss of Appetite | | **For Females Only** | |
| ☐ | ☐ | Jaw Pain | ☐ | ☐ | Abdominal Pain | ☐ | ☐ | Birth Control Pills |
| ☐ | ☐ | Joint Pain/Stiffness | ☐ | ☐ | Ulcer | ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Hepatitis | ☐ | ☐ | Pregnancy |
| ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | Liver/Gall Bladder Disorder | | | |
| ☐ | ☐ | Cancer | ☐ | ☐ | General Fatigue | | | |
| ☐ | ☐ | Tumor | ☐ | ☐ | Muscular Incoordination | | | |
| ☐ | ☐ | Asthma | ☐ | ☐ | Visual Disturbances | | | |
| ☐ | ☐ | Chronic Sinusitis | ☐ | ☐ | Dizziness | | | |
| ☐ | ☐ | Other:_____ | | | | | | |

**10) Please list all prescription medications you are currently taking:**

**11) Please list all supplements you are currently taking:**

**12) Please list all surgical procedures you have had:**

**13) What do you do at work?**

| | | |
|---|---|---|
| Sits most of the day | Sits about half the day | Sits a little of the day |
| Stands most of the day | Stands about half the day | Stands a little of the day |
| Computer most of the day | Computer about half the day | Computer a little of the day |
| On the phone most of the day | On the phone about half the day | On the phone a little of the day |
| Drives most of the day | Drives about half the day | Drives a little of the day |
| Performs manual labor most of the day | Reads a lot about half the day | Travels frequently a little of the day |
| None | | |

Other: _____

**14) What do you do outside of work?**

| | | | | | |
|---|---|---|---|---|---|
| Aerobics | Skiing | Basketball | Soccer | Baseball | Softball |
| Bicycling | Swimming | Football | Tennis | Golf | Triathlons |
| Hiking | Volleyball | Ice hockey | Walking | Inline skating | Weight lifting |
| Jogging | Working out | Martial arts | Yoga | Rock climbing | Other |

**15) Have you had any hospitalizations?**

| | | |
|---|---|---|
| Yes | No | Previously mentioned |

**16) Have you seen a chiropractor before?**

| | |
|---|---|
| Yes | No |

**17) Have you had any significant past trauma?**

| | |
|---|---|
| Yes | No |

**18) Is there anything else you think I should know?**

| | |
|---|---|
| Yes | No |

**20) What did the patient score on the revised neck oswestry index?** _____

**21) What did the patient score on the revised lower back oswestry index?** _____