Dr. Jaclyn Borza Maher, D.C.

122 West Court St., Suite 102

Ithaca, NY 14850

607-288-2904

www.jmaherchiropractic.com

New Client Information

Please allow our staff to photocopy your health insurance details.

All information you supply is confidential. We comply with all federal privacy standards.

Patient Name: _____ Today's Date: _____
First MI Last (MM/DD/YYYY)

Person Completing Form: Self Other: _____
Name, Relation

Address: _____
Street City, State Zip

Telephone No. _____
Home Cell Work

Email Address: _____ Date of Birth: _____

Marital Status: _____ Gender: _____ How did you hear about us? _____

Employer Name: _____ Occupation: _____

Employer Address: _____
Street City, State Zip

Emergency Contact: _____ Relation: _____ Phone: _____

Insurance Information

Primary Insurance Company: _____

Name of Primary Insured: _____ Gender: _____ DOB: _____
First MI Last

Address of Primary Insured: _____
Street City, State Zip

Patient's Relationship to Primary Insured (Circle one): SELF SPOUSE CHILD OTHER: _____

Employer of Primary Insured: _____

Employer Address: _____
Street City, State Zip

Authorization of Examination and Treatment:

I request and authorize Dr. Jaclyn Borza Maher, D.C. to evaluate and examine me, and provide treatment for the conditions I indicate. (Signing allows us to perform an examination and to provide treatment/services)

Signature: _____ Date: _____

** 24 HOUR CANCELLATION POLICY **

MISSED OR CANCELLED APPOINTMENTS WITH LESS THAN 24 HOURS NOTICE WILL INCUR A $95 FEE.

Initials: _____ Date: _____

Waiver and Financial Agreement:

I hereby agree to reimburse Dr. Jaclyn Borza Maher, D.C. for all evaluations and treatments provided at the time of service, even those not covered by insurance. I acknowledge that some forms of evaluations and treatment may not be covered by my insurance (if applicable).

Signature: _____ Date: _____

Name: _____ Date: _____
Last MI First

Patient Health Questionnaire - Current Condition

Briefly describe what brought you to our office and what you are seeking treatment for: _____

How long have you been experiencing your symptoms or had concerns regarding this matter? _____

Are your symptoms a result of: ☐ An accident or injury ☐ Work ☐ Auto ☐ Other _____
☐ A worsening long-term problem _____
☐ Other _____

How often do you experience your symptoms? ☐ Constant ☐ Comes and goes. How often? _____

How intense are your symptoms? (Please circle a number): 0 --- 1 ---2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10
Absent Uncomfortable Agonizing

What do the symptoms feel like?

☐ Numbness	☐ Aching	☐ Shooting
☐ Tingling	☐ Nagging	☐ Throbbing
☐ Stiffness	☐ Sharp	☐ Stabbing
☐ Dull	☐ Burning	☐ Other _____

Where have you felt and/or are you currently feeling your symptoms? _____

Do the symptoms affect other areas of your body? To what areas does the pain radiate or travel? _____

What makes the condition better or worse? (Such as time of day, movements, certain activities, etc)

What worsens the problem? _____

What lessens the problem? _____

What other treatments have you received in the past or are currently receiving as a means to deal with these concerns?

Prior intervention	Date received	Prior Intervention	Date received
☐ Presciption medication		☐ Chiropractic	
☐ Over-the-counter drugs		☐ Massage	
☐ Surgery		☐ Ice	
☐ Homeopathic remedies		☐ Heat	
☐ Physical therapy		☐ Other	
☐ Acupuncture		☐ Other	

Are any of your daily activities restricted or avoided due to your symptoms or concerns? If so, what are they and for how long have they been restricted? _____

Other comments you would like to share with the doctor that might assist in your care? _____

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Name: _____ Date: _____
Last MI First

Patient Health Questionnaire: Health History

Name and practice of primary care physician: _____

Date last seen and reason? _____

List all prescription and over-the-counter medications and supplements you are taking and specify for what condition:

_____

_____

List all surgical procedures and serious illnesses you have had and the number of times you have been hospitalized:

_____

_____

Injuries: Have you ever….

- ☐ Had a fracture or broken bone
- ☐ Had a spine or nerve disorder
- ☐ Been knocked unconscious
- ☐ Used a crutch or other support
- ☐ Used neck or back bracing
- ☐ Been injured in an accident

If you checked a box above, please explain: _____

Indicate below if you have had any of the conditions in the past or if you currently have the condition.

Past	Present		Past	Present		Past	Present	
☐	☐	Headache	☐	☐	Heart Attack	☐	☐	Thyroid issues
☐	☐	Neck Pain	☐	☐	Irritable Bowel (IBS)	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Constipation	☐	☐	Hypoglycemia
☐	☐	Mid-Back Pain	☐	☐	Diarrhea	☐	☐	Type 1 Diabetes
☐	☐	Lower Back Pain	☐	☐	Food sensitivities	☐	☐	Type 2 Diabetes
☐	☐	Shoulder Pain	☐	☐	Bedwetting	☐	☐	Frequent Urination
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Stones	☐	☐	Drug Addiciton
☐	☐	Wrist or Hand Pain	☐	☐	Kidney Disorder	☐	☐	Alcohol Addiction
☐	☐	Hip/Upper Leg Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Knee/Lower Leg Pain	☐	☐	Painful Urination	☐	☐	Mood Disorder
☐	☐	Ankle/Foot Pain	☐	☐	Incontinence	☐	☐	Anxiety Disorder
☐	☐	Jaw Pain	☐	☐	Infertility	☐	☐	Multiple Sclerosis
☐	☐	Joint Swelling/Stiffness	☐	☐	PMS symptoms	☐	☐	Systemic Lupus
☐	☐	Arthritis (Osteo)	☐	☐	Prostate Issues	☐	☐	Epilepsy
☐	☐	Rheumatoid Arthritis	☐	☐	Sudden Weight Change	☐	☐	Dermatitis/Rash
☐	☐	General Fatigue	☐	☐	Loss of Appetite	☐	☐	Eczema
☐	☐	Muscular Incoordination	☐	☐	Abdominal Pain	☐	☐	HIV/AIDS
☐	☐	Visual Disturbance	☐	☐	Ulcer	☐	☐	Allergies (List)
☐	☐	Chronic Ear Infection	☐	☐	Hepatitis	☐	☐	_____
☐	☐	Dizziness	☐	☐	Liver Disorder	☐	☐	_____
☐	☐	High Blood Pressure	☐	☐	Gall Bladder Issue	Females only:		
☐	☐	Chest Pain	☐	☐	Cancer	☐	☐	Birth Control Use
☐	☐	Stroke	☐	☐	Tumor	☐	☐	Hormone Replacement
☐	☐	Angina	☐	☐	Asthma	☐	☐	Pregnancy
☐	☐	High Cholestrol	☐	☐	Chronic Sinusitis	_____		Date of Last Menstrual Period

Further explain any items from above if needed: _____

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Name: _____ Date: _____
Last MI First

Family History

Relative	Age	State of Health: Good	State of Health: Poor	Health Conditions
Mother		☐	☐	
Father		☐	☐	
Sister 1		☐	☐	
Sister 2		☐	☐	
Brother 1		☐	☐	
Brother 2		☐	☐	
		☐	☐	

Social History - health habits

	Daily	Weekly	How much?
Alcohol use	☐	☐	
Coffee use	☐	☐	
Tobacco use	☐	☐	
Exercising	☐	☐	
Pain relievers	☐	☐	
Soft drinks	☐	☐	
Water intake	☐	☐	

List any hereditary health issues that you know about? _____

Social History -diet, health habits and stress levels

Diet - list foods eaten in a typical day

Breakfast _____
Snack _____
Lunch _____
Snack _____
Dinner _____
Snack _____

How much sleep do you average per night? _____
Preferred sleeping position _____

Exercise Intensity: None Mild Moderate Strenuous
What type of exercise? _____

Do you follow a special diet? If so, explain. _____

Hobbies: _____

How much stress do you have in your life? None Mild Moderate Severe

How do you handle or relieve stress? _____

What would be the most significant thing you could do to improve your health? _____

Acknowledgements - please read each statement and initial your agreement

_____ Initials **I instruct the chiropractor to deliver the care that, in her professional judgement, can best help me in the restoration of my health. I understand that chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

_____ Initials **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

_____ Initials **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or heath information to me as an extension of my care in this office.**

If the patient is a minor child, print child's full name: _____

_____ _____
Parent or Guardian Signature **Date (MM/DD/YYYY)**

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NOTICE OF PRIVACY PRACTICES (MEDICAL)

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health care information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however; not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health& Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201
Toll Free: 1-877-696-6775

Acknowledgement of Receipt of Notice of Privacy Practices

Please sign and print your name and provide the date below to acknowledge that you have received, read and understand our Notice of Privacy Practices.

Patient Name: .....

Signature: ..... Date: .....