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: _____

Pediatric Pre-Exam Information

I. BIOGRAPHICAL DATA

Patient Name: _____ Today's Date: _____

Sex: F M Date of Birth: _____ Age: _____

Mother's Name: _____

Address: _____

Phone: _____ Occupation: _____

Father's Name: _____

Address: _____

Phone: _____ Occupation: _____

Sibling's Name 1: _____ Age: _____ Sex: F M

Sibling's Name 2: _____ Age: _____ Sex: F M

Sibling's Name 3: _____ Age: _____ Sex: F M

Sibling's Name 4: _____ Age: _____ Sex: F M

II. FAMILY PHYSICIAN

Name of pediatrician and date of last exam: _____

_____

III. FAMILY MEDICAL HISTORY

Check if any blood relatives of the patient had any of the following illnesses and mark accordingly by noting M(Mother); F (Father); S (Sibling); PGM (Paternal Grandmother); MGM (Maternal Grandmother); PGF (Paternal Grandfather); or MGF (Maternal Grandfather)

_____ Allergy	_____ Diabetes	_____ Scoliosis	_____ High Blood Pressure
_____ Asthma	_____ Heart Disease	_____ Mental Illness	_____ Mental Retardation
_____ Eczema	_____ Liver Disease	_____ Ulcers	_____ Food Sensitivities
_____ Cancer	_____ Thyroid Disease	_____ Stroke	_____ Other _____

IV. PRENATAL HISTORY - if known please indicate

Duration of the pregnancy _____ weeks Birth Weight and Length: _____

Apgar score at birth: _____ Apgar score at five minutes: _____

Check any problems the patient had at birth:

_____ Breathing	_____ Nursing	_____ Crying	_____ Jaundice
_____ Coloring	_____ Sleeping	_____ Choking	_____ Other

Explain: _____

Check if any items applied to the patient at birth:

_____ Medication	_____ Surgery	_____ Vitamin K
_____ Artificial Feeding	_____ Erythromyocin	_____ Circumcision

_____ Other: _____ (Explain)

Patient Name: _____ Date: _____

V. PREGNANCY

Check any areas that applied to the patient's mother during her pregnancy:

Complications	Vitamins	Allergic Reactions
Medications	Diagnosed Illnesses	Mental Trauma
Recreational Drugs	Hospitalization	Physical Injury
Smoking	Immunizations	Prenatal Classes
Alcohol	Bleeding	Chiropractic Care
Caffeine: Cola	Premature Contractions	Prenatal Care
Caffeine: Coffee	Back Pain	Carried to Full Term
Caffeine: Tea	Excessive Weight Loss	Attitude - Mostly Happy
Caffeine: Chocolate	Excessive Weight Gain	Attitude - Mostly Depressed
Caffeine: Other	Toxic Exposure	Other _____

Explain if applicable: _____

VI. LABOR AND DELIVERY

Greater than 12 hours	Medications	Cesarean
Complications	Forceps or Vacuum Extraction	Hospital
Fetal Monitor Used	Premature Delivery	Home Birth

Other _____

VII.MEDICATIONS AND IMMUNIZATIONS

List all prescription and over-the-counter medications and supplements the child is taking:

_____

_____

Has the child received immunizations and if so were any reactions observed? _____

_____

VIII. NUTRITION

Check if the child has received any of the following items:

Breast Milk	Goat's Milk	Juices
Commercial Formula	Solid Foods	Vitamins
Cow's Milk	Sweets	Medications

List the foods eaten in a typical day. If the patient gets most of their nutrition from breast milk, list the foods eaten by the patient's mother (if donor milk is given, indicate special diets followed by the donor if known). Diet below represents that of the (circle to indicate): PATIENT MOTHER DONOR

Breakfast _____ Snack _____

Lunch _____ Snack _____

Dinner _____ Snack _____

Beverages consumed throughout the day: _____

Does the child follow a special diet? If so, explain. _____

Patient Name: _____ Date: _____

IX. ILLNESSES

List any illnesses or surgeries the child has had with the date(s) and any treatments: _____

X. GENERAL SYSTEM REVIEW

Check if the child has experienced any of the following and explain in the space provided:

Been Unconscious	Stomach Pain	Trouble Breathing
Convulsions	Abnormal Stool	Allergies
Seizures	Frequent Urination	Eczema
Vision Problems	Painful Urination	Hay Fever
Chronic Ear Infections	Arm Pain	Hives
Diarrhea	Leg Pain	Asthma
Constipation	Back Pain	Drug Reactions
Vomiting	Walk with a Limp	Other _____

Explain: _____

XI. SOCIAL HISTORY

Who does the patient live with? _____

Does anyone in the home smoke cigarettes? _____ Yes _____ No

Is the patient generally active? What kinds of activities does the patient engage in? _____

How much sleep does the patient average per night? Explain the patient's general sleep patterns (i.e. bedtime, naps, etc.): _____

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 health information to me as an extension of my care in this office.**

Print the child's full name: _____

_____ _____

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

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Pediatric Health Questionnaire

Patient Name: _____ Date: _____

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

_____

_____

_____

How long has the child been experiencing their symptoms or had concerns regarding this matter?

_____

Are the child's symptoms a result of: _____ An accident or injury Date: _____

_____ A worsening long-term problem

_____ Other (explain) _____

How intense are the symptoms? (Please circle): MILD MODERATE SEVERE

How often does the child experience symptoms?

_____ Constant _____ Comes and goes. How often? _____

Where has the child felt and/or is currently feeling their symptoms (if applicable)? _____

_____

What makes the child's condition better or worse? (Such as time of day, movements, foods etc.)

What worsens the problem? _____

What lessens the problem? _____

What other treatments has the child received in the past or is currently receiving as a means to deal with these concerns? Please include medications prescribed or tests that have been performed.

_____

_____

_____

Are any of the child's activities restricted or avoided due to their symptoms or concerns? If so, please list the daily activities and specify how long they have been restricted.

_____

_____

Other comments you would like to share with the doctor that might assist in the care of the patient:

_____

_____

_____

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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: .....

Consent to Treat a Minor

I hereby authorize Dr. Jaclyn Borza Maher, D.C. to administer chiropractic care and/or services as deemed necessary to my child, _____.
Full Name

Parent/Guardian Name _____ Relationship to Child _____

Signed at _____
City State

X _____ Date: _____
Parent/ Guardian Signature

X _____
Witness

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