ISLE OF WELLNESS

New Patient Exam with Dr. Marina Mangano

Name _____ Date _____

Address_____ City _____ State _____ Zip Code _____

Primary Phone _____ Email_____

Emergency Contact Name _____ Emergency Contact Phone # _____

Date of Birth_____ Age_____ How did you find us?_____

Occupation_____ Employer_____

1. Primary reasons for seeking chiropractic care:

   _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for primary complaint:

   _____

3. Past Health History:
   a. Previous illnesses you've had in your life:

      _____

      _____

   b. Previous Injury or Trauma (including any broken bones or sprains):

      _____

      _____

   c. Surgeries (surgical or cosmetic) Date and Type of Surgery:

      _____

      _____

   d. Do you have any scars? (Surgical or Non-Surgical) If so, where?

      _____

   e. Allergies:

      _____

   f. Medications and Reasons for Taking:

      _____

      _____

   g. Pregnancies (date of delivery) and Outcomes:

      _____

4. Relevant health problems of relatives:

   _____

   _____

5. Social and Occupational History:

   Position/s that bother your body at work: _____

   Exercise/Recreational activities that increase your complaint: _____

   _____

DETAILED SUBJECTIVE:

Please answer ALL #s for your priority symptom. Draw scars or painful areas on diagram.

[SYMPTOM #1]

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0 ○—○—○—○—○—○—○—○—○—○ 10

Absent Uncomfortable Agonizing

5. Duration and Timing (what % of the time do you feel it?)

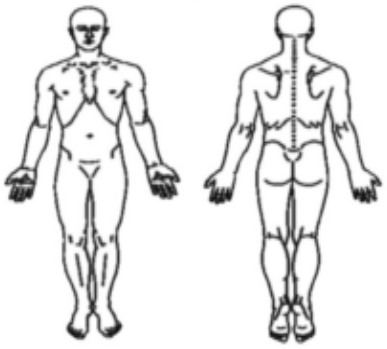
◯ Constant ◯ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- ◯ Prescription medication ◯ Surgery ◯ Ice
- ◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
- ◯ Homeopathic remedies ◯ Chiropractic Other _____
- ◯ Physical therapy ◯ Massage _____

Secondary issues to be addressed in new patient exam:

_____

_____

INFORMED CONSENT- CHIROPRACTIC

By signing below, you agree to the following:

Within the practice of chiropractic and other manual therapies there are some risks during examination and treatment procedures including, but not limited to, temporary soreness, bruising, fractures, disc injuries, dislocations, sprains and increased symptom or pain, or no improvement of symptoms or pain. *A rare but serious risk associated with neck manipulation is stroke.*

The Doctor of Chiropractic or office staff is not able to anticipate all the risks and complications of care but relies on clinical judgment based on all of the facts known at the time of the procedure to make decisions that are in the best interest of the patient. There are no guaranties or assurances concerning the intended results of the treatment.

As an involved patient, you have the right to be informed about your condition and the recommended chiropractic procedures to be used, so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. Together, we will create a comfortable and safe practice that matches your preferences.

I consent to providing Dr. Marina Mangano with an updated and honest medical history. I recognize that care will include close contact and that this consent covers the entire course of treatment.

Name:_____ Signature:_____ Date: _____

For a **minor or person represented by another party,** please sign on their behalf and state relationship.

Name:_____ Signature:_____ Date: _____

Relationship: _____

PAYMENT POLICY

Dr. Mangano Self-Pay Prices

Initial Office Examination (50 min)	$135.00
Follow-Up Treatments (20 min)	$85.00
Private Yoga Sessions (50 min)	$100.00
Raindrop Massage (20 min)	$60.00

SELF-PAY POLICY

As a self-pay patient, I understand Dr Mangano will NOT be filing/submitting/billing any treatments to my medical health insurance because she is not contracted with my health insurance company at this time. And further, I understand Dr. Mangano is NOT responsible for any claims I choose to file/submit/bill to health insurance on my own for out-of-network reimbursement. She will provide coded invoices on request for reimbursement.

INSURANCE POLICY

Dr. Mangano is only in-network with Horizon BCBCNJ and Amerihealth of NJ. She will call my insurance company to receive benefits and an EOB **ESTIMATE**. It is a summary of my benefits and **not a guarantee of payment from my insurance carrier.** Please ask for an explanation of insurance benefits if unclear. I understand that through utilizing my insurance carrier, I am responsible for my annual health insurance deductible, co-pays, and/or co-insurance. After maximum visits per year, my carrier may not cover maintenance care and self-pay/cash arrangement will be made.

CANCELLATION POLICY

The treatment plan prescribed by Dr. Mangano is vital to resolving your injury as quickly as possible, so patients are strongly encouraged to follow the doctor's guidelines regarding at-home exercises and future office appointments. In an effort to give best quality care, the doctor spends 50 minutes with the patient for the initial exam and 20 minutes with the patient for follow-up visits. Out of courtesy to the doctor, staff, and other patients, **please only make appointments that you are able to keep**. Dr. Mangano has a 24-hour cancellation policy.

Cancellation Policy: We require 24 hours to cancel or reschedule an appointment; otherwise a $50 cancelation fee or a $65 no-show fee will be applied to your account.

I understand that by signing below I accept the financial arrangements. Payment is due at time that services are rendered unless financial arrangements have been made with the doctor. If the patient is a minor, a parent must either be present at each appointment or provide the patient with funds to pay at the time services are rendered. Please sign that you understand and agree to the above policies.

_____ _____

Patient's Name (signature) Date

HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction of other business activities.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name