Registration Form

Please complete this form, print it out and bring to your appointment.

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP:

DATE OF BIRTH _____ HOME PHONE: _____ CELL PHONE: _____

AGE: ____ MARITAL STATUS: _____ SOCIAL SECURITY # _____

EMPLOYER: _____ ☐ FULL TIME ☐PART TIME

ADDRESS: _____

WORK PHONE: _____ E-MAIL: _____

OCCUPATION: _____ DRIVERS LIC. #: _____

How did your hear about our office? _____

SPOUSE/EMERGENCY CONTACT: _____

ADDRESS: _____ HOME PHONE: _____

RELATIONSHIP TO PATIENT: _____ WORK PHONE: _____

PRIMARY MD NAME: _____ PHONE #: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY COVERAGE (IF MOTOR VEHICLE ACCIDENT –LIST MOTOR VEHICLE INS. FIRST)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

SECONDARY COVERAGE (PLEASE WRITE "NONE" IF THERE IS NO SEC. INSURANCE)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

Check If Applicable: ☐Motor Vehicle Accident ☐Work Injury Date of Accident: _____

Health History Questionnaire
Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

Patient Name:_____ Date:_____

Age _____ Date of Birth _____ Marital Status: M S D W Other:_____

Guardian (if under 18): Name & Relationship_____

Gender: M / F Height _____ Weight _____lbs.

Major Complaint(s,) in order of significance to you:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Have you been treated with Acupuncture before this visit? Yes No If yes, when?_____

What diagnosis have you received from your physician?_____

Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays_____

Recent tests: (please indicate test results and date below)
Physical Cholesterol Prostate Blood (which?)_____
HIV/STD Pap Smear Mammography Colonoscopy Biopsy_____
Other:_____

Test Results and Date:_____

Please check the following that currently pertain to you. If you have symptoms in the following categories, it indicates that you have a problem with that organ's function:

Overall Temperature (Kidney function):

- Cold hands
- Cold fingers
- Cold feet
- Cold toes
- Sweaty hands
- Sweaty feet
- Hot body temperature (sensation)

Kidney Function (Continued):

- Cold body temperature (sensation)
- Afternoon flashes
- Heat in the hands, feet and chest
- Hot flashes any time of the day
- Thirsty
- Perspire easily
- Lack of perspiration
- Take water to bed

Overall Energy (Lung, Kidney function):

- Shortness of breath
- Difficulty keeping eyes open in the daytime
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise

Overall Blood (Liver, Spleen, Heart function):

- Dizziness
- See floating black spots

Heart Function:

- Anxiety
- Palpitations
- Sores on the tip of tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Drink coffee (# cups per week____)

Lung Function:

- Nasal Discharge (Color: _____)
- Cough
- Nose Bleeds
- Sinus Congestion
- Dry mouth
- Dry throat
- Dry nose
- Dry skin
- Allergies (To what? _____)
- Alternating fever & chills
- Sneezing
- Headache (Location: _____)
- Overall achy feeling in the body

Lung Function (Continued):

- Stiff neck
- Stiff shoulders
- Sore throat
- Difficulty breathing
- Smoke cigarettes (# of cig's per day_____ or _____packs/day)
- Sadness
- Melancholy

Spleen Function:

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in stomach
- Fatigue after eating
- Prolapsed organs (previously diagnosed. Which organ:_____)
- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry

Spleen, Stomach, Large Intestine, Small Intestine Function:

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools
- Undigested food in stools

Dampness trapped in the body:

- General sensation of heaviness in body
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

Stomach Function:

- Burning sensation after eating
- Large appetite
- Bad breath

Stomach Function (continued):

- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccoughs
- Stomach pain
- Vomiting

Liver, Gall Bladder Functions:

- Alternating diarrhea and constipation
- Chest pain
- Tight sensation in the chest
- Bitter taste in the mouth
- Anger easily
- Frustration
- Depression
- Irritability
- Frequently unable to adapt to stress (What causes stress?_____ _____
- Skin rashes
- Headache at the top of the head
- Tingling sensation
- Numbness
- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures
- Convulsions
- Lump in the throat
- Neck tension
- Limited Range-of-Motion, neck
- Shoulder tension
- Limited Range-of-Motion, Shoulder
- Drink alcohol
- Recreational drugs (Which? _____. How much per week?_____)
- High-pitched ringing in the ears
- Gall stones (history or current)
- Sexually transmitted disease (Which? _____)

Eyes (Liver Function):

- Itchy
- Bloodshot

Eyes/Liver Function (Continued):

- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

Libido:

- Normal
- High
- Low

Kidney, Urinary Bladder Function:

- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low-pitched ringing in ears
- Kidney stones
- Bladder infections
- Wake during the night twice or more to urinate
- Lack of bladder control
- Fear

Urination:

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Urgent
- Frequent

Women only:

Regular menstrual cycle? Yes No

Pregnant? Yes No

Number of children? _____

Number of pregnancies? _____

Age of first menstruation? _____

Age of menopause? _____

Average # days of flow?_____

Average # days of entire cycle? _____

Vaginal discharge _____

Bleeding between periods?_____

Do you experience any of the following pre-menstrual syndromes? (Circle all that apply)

Nausea Vomiting Water retention Breast swelling

Food cravings Headaches Migraines Breast tenderness

Depression Irritability Anxiety Other emotions_____

Dull pain: Where_____ Sharp pain: Where?_____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Clots (large, small, black, purple, red. other)							
Vomiting (check if yes)							
Nausea (check if yes)							

Men Only:

- Swollen testes
- Testicular pain
- Impotence
- Premature ejaculation
- Feeling of coldness or numbness in external genitalia
- Other:_____

Patient Signature _____

Acupuncturist Signature _____

Acupuncturist (Print Name) _____

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by Michael M. Credico, DC, Philip T. Casale, DC, and/or other licensed doctors of chiropractic, physical therapy, acupuncture or massage therapy who now or in the future work at Bloomfield Total Health Center.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinical personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks, but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, strokes dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

Patient Name (Print) _____

Patient/Parent/Guardian's Signature _____ Date _____

DO NOT WRITE IN THIS BOX

Accepted? YES NO

Doctor's Signature _____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Bloomfield Total Health Center, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Bloomfield Total Health Center, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Bloomfield Total Health Center, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Bloomfield Total Health Center, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date

BLOOMFIELD TOTAL HEALTH CENTER OFFICE POLICY

Office visits are scheduled according to the severity of your condition and the plan of care that our professional staff feels is best for you. Because your condition may require numerous appointments over the next few weeks or months, we have designed a Multiple Appointment Program for your convenience. This program minimizes your time in the office and facilitates your appointments into your daily routine.

The frequency of your treatment schedule is of paramount importance to your results so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results. If for any reason you are unable to keep an appointment we require that you telephone immediately to reschedule that visit. It is your obligation to make up a missed appointment within 7 days of cancellation. Also, this office reserves the right to charge for missed appointments and those appointments canceled without 24 hours notice.

FINANCIAL POLICY

Bloomfield Total Health Center has developed a Financial Agreement in an effort to help you, our patient, understand our fees and your financial obligations. We want you to know what to expect at the onset of care so that we may move comfortably forward and focus on what is most important – YOUR health. A member of our staff will explain your benefits and coverage as well as your financial obligation for continuing care. We will be happy to answer any questions you may have in an effort to ensure that you fully understand your policy. *Please note that Bloomfield Total Health Center does not assume ANY responsibility for the accuracy of information furnished by your insurance carrier or you.* This information is only used as a guide to estimate your out-of-pocket expense and may be subject to change pending notification from your insurance carrier.

- **Assign benefits to Bloomfield Total Health Center.** The privilege of insurance assignment begins when it is determined that your insurance covers Chiropractic and/or Physical Therapy. We will submit all necessary claim forms and documentation to your insurance company as a courtesy to you, with the understanding that you will forward to us, all Explanation Of Benefits (EOB) and payments made to you by your insurance carrier for the care received at our office. This reduces your out-of-pocket expense, enabling your entire family to receive care. If payment due to us is sent to you by your insurance company and you do not forward it to us immediately, the insurance assignment will be discontinued and the total amount billed to insurance will become due and payable.
- **Establish a payment plan with our office.** Together, we can calculate a fair weekly out-of-pocket payment amount that is within your budget. (*Out-of-pocket* is the portion of our services that is not paid by your insurance, such as Deductible and Co-insurance.) Again, if you have insurance, all necessary documentation will either be submitted to your insurance company or provided to you.
- **Pay by cash, check or credit card at the time of service.** An account balance may not exceed $150. A handling fee of $25.00 will be charged on any returned check.

MEDICARE PATIENTS

Bloomfield Total Health Center has selected to be a participating provider with Medicare. As such, our office charges the Medicare fee set by law and submits claims to Medicare for you. Medicare should reimburse us directly, however, in the event that Medicare sends *our* payment to you, kindly forward the check and the Explanation Of Benefits (EOB) to our office immediately. The EOB is the statement that Medicare sends to you to explain what portion of your claim was paid or denied. Please note that examinations, x-rays and structural supports are not covered. If not covered by a secondary insurance, your Copay and if applicable, Deductible payments are due at the time that services are rendered.

WORKERS' COMPENSATION

New Jersey State law requires that in Workers' Compensation cases, a written authorization from your employer must be obtained authorizing Bloomfield Total Health Center to provide treatment for injuries sustained while working.

MOTOR VEHICLE ACCIDENT PATIENTS

Prior to the commencement of your care (if possible,) please provide us with your attorney's contact information and/or the following items that are required for us to request pre-certification of your treatment (per New Jersey State law) and to bill your Automobile Insurance company.

- PIP Application
- PIP Claim Number
- PIP Claim Adjuster's name & telephone number
- PIP Policy Declaration Page
- Auto Insurance I.D. Card(s)
- Auto Accident Police Report
- Health Insurance I.D. Card(s)

If we do not receive this information you will be responsible for payment in full at the time that services are rendered at our facility.

PERSONAL INJURY / SLIP & FALL CASES

We must be notified immediately if you are pursuing a lawsuit due to injuries sustained in an accidental slip and fall caused by another party's negligence. Please complete the additional questionnaire regarding your accident and provide us with a letter of protection from your attorney. If we do not receive this information you will be responsible for payment in full at the time that services are rendered at our facility

ALL PATIENTS

It is the goal of this office to provide you with the finest quality health care as affordably as possible. We will make every attempt to offer you a feasible payment plan. We know you understand that in the event that Bloomfield Total Health Center is forced to turn your account over to a collection agency or attorney for non-payment, you will be responsible for any fees incurred for the collection of the outstanding balance.

If you have any questions with regard to your health care or any of our policies, please let us know. We will do our best to answer you as quickly and clearly as possible. We welcome your referrals and look forward to building a doctor-patient relationship that helps us to reach our mutual goal of restoring you to glowing health.

We ask that you sign this form as acknowledgement that you understand it and that you accept full financial responsibility.

Patient or Legal Guardian Signature:_____

Print Patient Name:_____

Date:_____

Acupuncture Consent Form

Patient Name: _____ Date: _____

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures on me (or on the patient named below, for whom I am legally responsible) by a licensed acupuncturist.

I understand the methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electro-stimulation, Tui Na (Chinese Massage,) and bleeding. I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, with possible dizziness or fainting. (Eating prior to acupuncture can avoid this.) Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax.) I understand that the risk of infection is negligible because all needles are sterile.

I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, based on the facts then known, is in my best interest.

I understand the clinical and administrative staff may review my medical records and labs reports, but all of my records will be kept confidential and will not be released without my written consent.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

The potential benefits are as follows: Acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of a presenting problem.

With this knowledge, I voluntarily consent to the above procedure realizing that no guarantees have been given to by said acupuncturist regarding cure or improvement of my conditions.

I have carefully read and I understand the foregoing and so am fully aware of what I am signing.

_____ or _____

Signature of Patient / Guardian Signature of person authorized to consent

Bloomfield Total Health Center

Acupuncture Initial Evaluation (99201-99205)

Patient Name_____ Date_____

DOB_____ M / F

Chief Complaint_____ Since_____

Other _____

Medical Diagnosis_____

Past Medical History:_____

_____

Family History_____

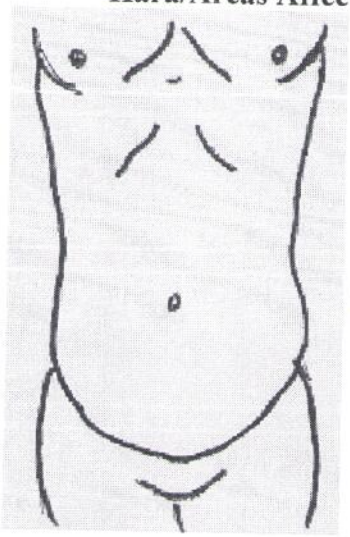
_____

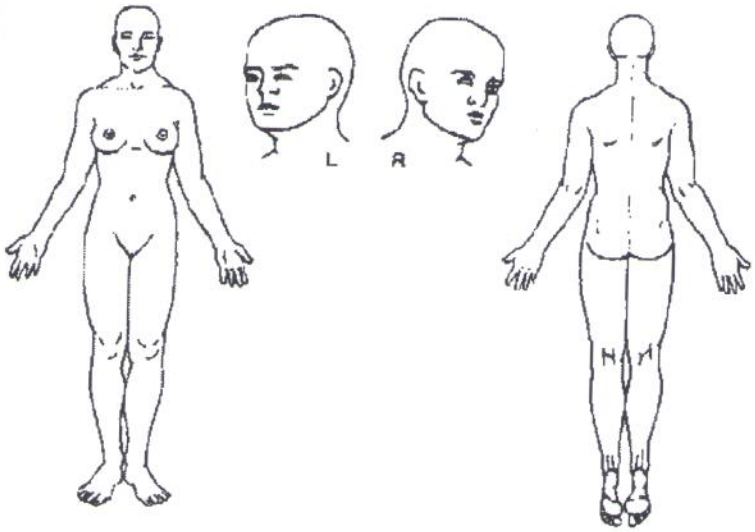
Surgeries_____

Scars_____

Could you be pregnant? Yes / No On HTN meds or blood thinners? Yes / No

Hara/Areas Affected





Patient Name:_____

Pulses:

Left	Right

Tongue:

Coating	Thick/Thin	White/Yellow	Glossy/Dry	Normal	Other_____
Color	Red	Pale	Purple	Normal/Pink	Other_____
Body	Thick/Thin	Scalloped	Deviated	Shaking	Other_____

Meridians Involved/Major Reflexes:

LU	**LI**	**ST**	**SP**	**HT**	**PC**
TW	**SI**	**BL**	**KI**	**GB**	**LV**

☐ **Oketsu**	☐ **Cardiac/BP**
☐ **Immune**	☐ **ST/SP**
☐ **Autoimmune**	☐ **Liver**
☐ **Kidney/Adrenal**	☐ **Hormone**

TCM Diagnosis: Repletion/Vacuity; Yin/Yang; Heat/Cold, Internal/External

_____

_____

Referrals/Recommendations:

_____

_____

Acupuncturist: Print Name Signature Date