CASE HISTORY UPDATE

In order for us to best serve to you, please provide the following Information and indicate if this is WORK or AUTO related before completing. If your insurance or demographics have not changed, you may skip that section. THANK YOU! **PLEASE PRINT**

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____ SSN: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____

Occupation: _____

Primary Care Physician: _____ Phone#: _____

Primary Physician's Address: _____

Since your last office visit here, have you consulted another doctor? ☐ Yes ☐ No

If yes, give doctor's name: Dr. _____

and condition for which you were treated: _____

List present complaints (describe fully): _____

_____

Duration of present complaint: _____

What do you believe caused this condition? _____

Describe any falls, surgery and/or accidents since last visit: _____

_____

Date of last exam: _____ Date of last adjustment: _____

Describe any condition(s) you were previously treated in this office and your response to the treatment(s):

_____

Doctor Preference: ☐ Dr. Santiago ☐ Dr. Saggal ☐ No Preference

_____

Patient Signature (Parent if minor)

PATIENT INSURANCE FORM

Please PRINT

FIRST (PRIMARY) INSURANCE INFORMATION

Carrier Name	Insured's Name (as printed on card)	Insured's Employer Name
Social Security #	Insured's DOB	Relationship to Patient
Policy #	Group #	Effective Date

SECOND (SECONDARY) INSURANCE INFORMATION

Carrier Name	Insured's Name (as printed on card)	Insured's Employer Name
Social Security #	Insured's DOB	Relationship to Patient
Policy #	Group #	Effective Date

OTHER INSURANCE INFORMATION

Injury due to an accident: [ ] At Work [ ] Automobile Accident [ ] Other

Accident City	Accident State	Date of Accident
Insurance Company	Policy #	Claim #

ASSIGNMENT OF BENEFITS AND AUTHORITY TO RELEASE INFORMATION

I hereby authorize the above named insurance company to directly pay Santiago Chiropractic Associates all benefits due to me for services rendered as provided for in my insurance policy. Further, I authorize release of information deemed appropriate concerning my physical condition to any insurance company, attorney, adjuster, or other physicians.

Signature of Patient or Responsible Party

Date

Santiago Chiropractic Associates

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.

Your Rights

Right of Access: You may inspect and request a copy of certain health information we have about you. We have forms for such requests. These requests must be made in writing and must be directed to our contact officer listed on the first page of this notice. We will provide a copy in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If you are the recipient of electronic notice, you may obtain a paper copy upon request.

We will charge a reasonable, cost-based fee when asked to provide copies of your health information. Charges will include costs for copying at .50 cents per page, postage, and staff time at the rate of $15.00 dollars per hour. If you request a summary of your health information, we will provide it, charging staff time at the hourly rate shown above. If you have any questions about our fees for these services, please contact us using the contact information provided above.

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. Such requests must be made in writing and must include a reason to support the request. Under some circumstances, we may deny such a request, but you are entitled to a written response within 60 days of our receipt of your written request.

Right to Request Restrictions: You may request that we restrict uses or disclosures of certain health information about you to carry our treatment, payment, or health care operations. We may not (and are not required to) agree to requested restrictions. We will not use or disclose any health information about you in violation or any restrictions that we agree to other than in providing emergency treatment.

Confidential Communications: Alternative Means, Alternative Locations: You may ask to receive communications of health information by alternative means or at an alternative location. We will accommodate all reasonable requests. You must provide this type of request to us in writing and provide an alternative method of contact or alternative address. We will provide an estimate of the fee for this service in advance and ask that you provide information as to how payment will be handled.

Accounting of Disclosures: You have a right to receive an accounting of disclosures we have made of health information about you for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations, and certain other disclosures. The first such accounting we provide within any 12 month period will be without charge to you. We will charge a reasonable, cost-based fee for each subsequent request for an accounting within a 12-month period. We will notify you in advance of this fee.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of the notice at any time. Even if you have agreed to receive the notice electronically, you may still obtain a paper copy. To obtain a paper copy, ask any Santiago Chiropractic Associates staff member.

Changes to This Notice: We reserve the right to change the terms of this notice and to make the changed notice provisions effective for all health information we have about you or create r receive in the future. We will promptly revise, post, and distribute a revised notice whenever there is a material change to the uses or disclosures, individual=s rights, our legal duties, or other privacy practices discussed in the notice. Our privacy notice will contain on he first page, in the top right-hand corner, the effective date.

Complaints: If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting:

Santiago Chiropractic Associates
75 North Beverwyck Road
Lake Hiawatha, NJ 07034
OFFICE: (973) 335-5666 **FAX:** (973) 335-6187

You may also file a written complaint with the U.S. Department of Health and Human Services by contacting:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Washington, D.C. 20201
Toll Free: 1-877-696-6775

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

Acknowledgment of Receipt of Privacy Practices

I, _____ have received a copy of Santiago Chiropractic Associates notice of privacy practices.

_____ _____

Patient/Guardians Signature Date

SANTIAGO CHIROPRACTIC ASSOCIATES
FINANCIAL POLICY

Thank you for choosing Santiago Chiropractic Associates as your chiropractic physicians. Our goal is to restore your health as quickly as possible and maintain an optimal level of health and performance. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of your Financial Policy, which we require you to read carefully and sign **prior** to any treatment.

TO ALL PATIENTS:

- Payment is expected on the day the treatment is rendered.
- We accept CASH, CHECKS, and/or VISA and MASTERCARD

TO PATIENTS USING INSURANCE:

- You must provide us with a copy of your current health insurance card(s) for proper billing. **Failure to provide complete insurance information may result in patient responsibility for the entire bill.**
- Whether participating or non-participating, we bill your insurance company as a courtesy to you.
- It is your responsibility to be fully aware of your insurance coverage.
- **All co-pays and deductibles are due at the time services are rendered**, as well as any prior balance you may owe.

TO PATIENTS NOT USING/WITHOUT INSURANCE:

- Full payment is due on the day services are rendered.

PAYMENTS:

- Unless we approve other payment arrangements in writing, the balance on your account is due upon receipt.
- If payment is not received and your account becomes past due, we will take the necessary action to collect this debt.
- If payment is not received, we reserve the right to refuse future appointments on delinquent accounts.

I have read, understand, and agree to the Financial Policy. I acknowledge full financial responsibility for services rendered by Santiago Chiropractic Associates. I understand I am responsible for prompt payment of any portion of charges not covered by insurance including: co-insurance, co-pays, and deductibles. I understand payment is due on the day of treatment, as well as any prior balances I may owe.

_____ _____

Patient Name **Signature of Patient or Responsible Party**

_____

Date