Welcome to Dr. Merckling's Office

About You

Todays Date:

Patient Name _____ (Last) _____ (First) _____ (M.I.)

Male ☐ Female ☐ I would prefer to be called: _____

Birthdate _____ Age _____ SS# ___ - ___ - ____

Street Address _____ Apartment _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile _____

Email Address _____ Reminders: Text or Email

Occupation _____ carrier Verizon, AT&T, Sprint

Employer _____ How Long? _____

Employer Address _____

City _____ State _____ Zip Code _____

Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse's Name _____ Number of children? _____

Who may we thank for your referral? _____ PCP _____

Have you been to a chiropractor in the past? ☐ Yes ☐ No Name

Your Health History

Date of last:

Physica☐ Exam _____ X-Ray _____

Spinal Exam _____ MRI, CT or Bone Scan _____

Are you taking any of the following medications? ☐ Nerve pills ☐Pain Killers (including aspirin) ☐Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other (s) _____

Place a mark on "Yes" or "No" to indicate if you've had any of the following:

Weight loss or gain	☐ Yes	☐ No	Swollen glands	☐ Yes	☐ No	Calf pain w/ walking	☐ Yes	☐ No
Fever or chills	☐ Yes	☐ No	Lump(s) in breast	☐ Yes	☐ No	Leg cramping	☐ Yes	☐ No
Rashes	☐ Yes	☐ No	Cough	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Itching	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Hair/nails changes	☐ Yes	☐ No	Wheezing	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Decreased hearing	☐ Yes	☐ No	chest pain or discomfort	☐ Yes	☐ No	Numbness	☐ Yes	☐ No
Earache	☐ Yes	☐ No	Palpitations	☐ Yes	☐ No	Tremor	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No	Ease of bruising	☐ Yes	☐ No
Pain in eyes	☐ Yes	☐ No	nausea/vomiting	☐ Yes	☐ No	Ease of bleeding	☐ Yes	☐ No
Blurry/dbl vision	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Heat or cold intolerance	☐ Yes	☐ No
Redness in eyes	☐ Yes	☐ No	Constipation	☐ Yes	☐ No	Nervousness/ Anxiety	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No	Burning/pain w/ urination	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Sinus pain	☐ Yes	☐ No	Blood in urine	☐ Yes	☐ No	Hallucinations	☐ Yes	☐ No
difficulty Swallowing	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No			

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please describe any injuries or surgeries you have had:

_____

_____

Your Concerns

What is your major complaint or concern? _____

_____

When did your symptoms appear? _____

Are your symptoms ☐ getting worse? ☐ getting better?

What treatment have you already received for your condition? ☐ Medications ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

Other doctor(s) that treated you for this condition:

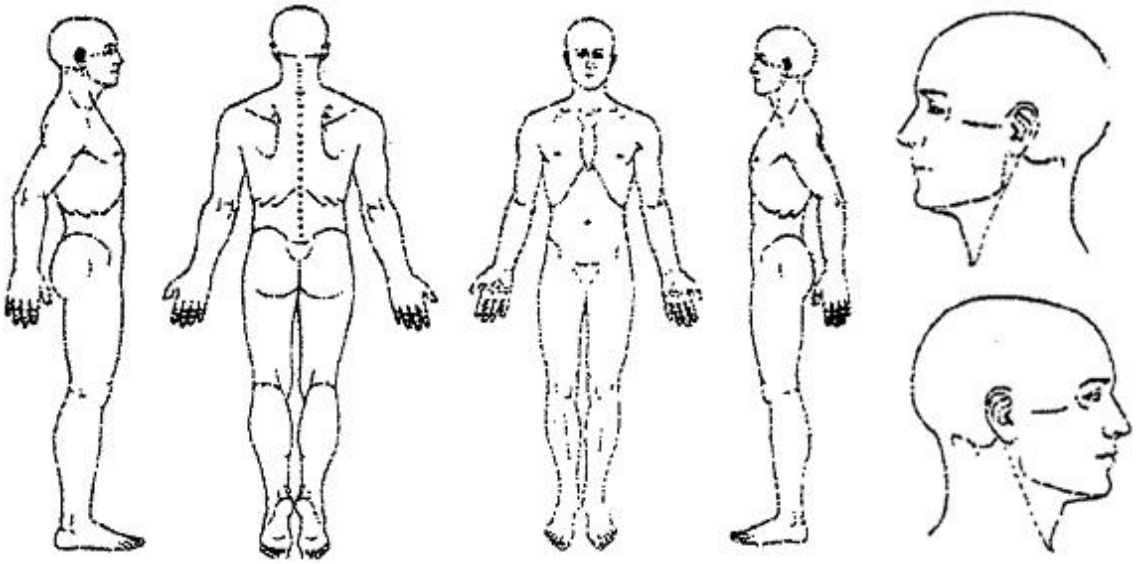
Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _____

Type of pain:

☐ **S**harp ☐ **D**ull ☐ **Th**robbing ☐ **A**ching ☐ **Sh**ooting

☐ **B**urning ☐ **N**umbness ☐ **T**ingling ☐ **St**iffness ☐ **O**ther

Place appropriate highlighted letters to mark the areas of discomfort



How often do you have this pain? ☐ +75% constant ☐ 50-75% Frequent ☐ 25-50% Occasional ☐ <25% Intermit

Does it interfere with Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful to perform:

Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

Who else have you seen for this problem? _____

Other comments or concerns regarding your condition:

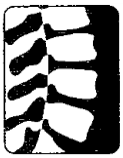
_____

Insurance Info: Primary Insurance carrier _____ ID _____

Secondary Insurance carrier _____ ID _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understating between provider and patient. Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the business manager. If account is not paid with in 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process/secure insurance claims/benefits, and I assign all applicable insurance benefits directly to the provider Merckling Family Chiropractic, PC. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Guardian if under 18 _____ Date _____



Merckling Family Chiropractic, P.C.

DR. JOSEPH R. MERCKLING
16-2 Station Road
Bellport, NY 11713
Telephone: (631) 286-2300
Fax: (631) 286-4615

FINANCIAL POLICY

Dear Patient,

Merckling Family Chiropractic P.C. requests that your payment for services be made at the time of your visit. This policy simplifies our billing and helps keep our fees down. For your convenience, we gladly accept DEBIT, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER.

As a benefit to you, our office will be happy to bill your insurance. However, you are responsible for the difference between what your insurance pays and the total charges for your care. Health insurance is designed to help you meet the cost of your health care, but ultimately the basis responsibility is yours. Your insurance contract is strictly between you and your insurance company. We are not a party to that contract. If you have a plan under which we are not contract providers you will likely have a co-payment, and deductible. Please be prepared to pay those charges at the time of your visit.

No one should be without their needed chiropractic care. In the case of financial difficulty, please let us know so that a manageable payment schedule can be worked out. At your request, Dr. Merckling will discuss the charges with you before care begins. Hardship agreements can be arranged.

Patient Signature_____ Date _____

REV. 9/14

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PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Name:_____
(Last) (First) (Middle)

I understand that Merckling Family Chiropractic, P.C. ("the Practice") may use my health information for treatment, payment and health care operations. I have been shown a copy of the Practice's Notice of Privacy Practices that describes how my information is used and disclosed. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Practice's Privacy Officer at (631) 286-2300.

_____ _____
Signature of Client/Parent/Legal Guardian or Personal Representative — **Date**

_____ August 1, 2013
If signed by Personal Representative, relationship to client — Privacy Notice Effective Date

DOCUMENTATION OF GOOD FAITH EFFORT (TO BE COMPLETED BY PRACTICE STAFF)

Notice of Privacy Practices and Written Acknowledgement provided to the client/parent/ legal guardian or other personal representative, by:

- ☐ Hand delivery,
- ☐ Sent to the client/parent/legal guardian at the address of record, or
- ☐ Sent to the client/parent/legal guardian at the Email address of record

Client/parent/legal guardian or other personal representative:

- ☐ Expressly states they decline to sign Written Acknowledgement of receipt of Notice because _____
- ☐ Has not expressly declined, but has failed to return the signed Written Acknowledgement, despite the following good faith efforts to obtain the return of the Acknowledgement:

_____ _____
Signature — Date

Please return the completed form for processing to Merckling Family Chiropractic's Privacy Officer at the address above.
Effective Date: August 1, 2013

Merckling Family Chiropractic PC

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: A **Chiropractic Adjustment** is the specific application of forces to facilitate the correction of a vertebral subluxation. Chiropractic adjustments is a "hands on" approach to patient wellness. A **Subluxation** is a misalignment of one or more of the vertebrae in the spinal column. This subluxation can cause alteration of the functioning of the nerves, leading to pain and dysfunction. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, traction, passive and active exercise may also be used.

Permission for Physical Contact. I understand that, in the course of various chiropractic examination procedures and treatment methods, the doctor of chiropractic or other clinical staff may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment, and is prohibited. Nevertheless, I also realized that some chiropractic procedures may require that the doctor or clinician contact me in some physically sensitive areas, such as underarm areas, and over buttock/hip or upper thigh muscles. I understand, however, that before any sensitive contact or procedure occurs the doctor or other clinical staff member will explain to me □ what is to be done, □ how it will be performed, □ why it will be performed, □ that I may refuse that particular test or procedure, or alternatively that I may request that another member of the staff be present.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications, if you are allergic to latex, rubber, or cloth used in the towels.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include gastrointestinal bleeding, kidney and liver disease as well as other undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of infection and adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the following risks of care and I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

Patient: _____ _____ _____

Printed Name **Signature** **Date**

Merckling Family Chiropractic P.C.
Dr. Joseph Merckling, D.C.
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Bellport, NY 11713
(631) 286-2300
FAX (631) 286-4615

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Date:
Patient's Name
D.O.B:
SSN:

The above named individual has recently become our patient. We would appreciate it very much if you would send us his/her medical history. We are aware of HIPAA compliance and have obtained the patient authorization to request the medical records. If you have any questions concerning this request, please contact our office at 631-286-2300. You may fax the documents to 631-286-4615.

I herewith authorize (name of Facility where tests were performed):

Name:

Address:

City:

State/Zip:

To release to Dr. Joseph Merckling, DC, my medical history, laboratory reports, x-rays, and any other material regarding medical consultations and treatment I received. My records should be under the following name:

First Middle Maiden Last

Patient's Signature