Dr. Kerstin Medwin

www.medwinchiropractic.com

Name _____

How did you hear about our office?

_____ Internet Magazine _____

_____ Word of Mouth Doctor _____

_____ other, please explain: _____

Height _____

Weight _____

Blood pressure _____

Are you taking any medications? _____ No _____ Yes (list below)

_____ _____

_____ _____

_____ _____

Would you like to receive a complimentary monthly newsletter filled with tips and tricks for a happy and healthy life? If so, please leave us your email:

_____

If you would like to receive text message reminders about your upcoming appointments, please let us know your ***cell phone carrier*** (Verizon, Sprint, AT&T, etc) _____

130 Everett Road Albany, NY 12205 Ph: 518-435-1280 Fax: 518-435-1284

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NEW PATIENT DEMOGRAPHOC AND INSURANCE INFORMATION

Patient Information (as listed on your insurance card):

Last Name: _____ First Name: _____

Street address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home phone number: _____ Cell phone number: _____

Date of Birth: _____ Social security number: _____

Sex: ____M ____F

Marital Status: _____ Spouse's Name: _____ phone: _____

Contact person: _____ phone: _____

Referring physician: _____ phone: _____

Family physician (if different from referring): _____ Phone _____

Employment Information

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Information

Insurance company: _____ Policy/ID #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Subscriber: _____ Subscriber SS#: _____

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KERSTIN MEDWIN CHIROPRACTIC, PLLC

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN. LET US KNOW IF YOU HAVE ANY QUESTIONS.

We are required to keep your information private, release your information to others, only when we need to as followed by law or your written authorization, and follow legal requirements related to your information. We must follow specific rules to protect information relating to drug or alcohol, HIV/AIDS and mental health treatment. We are required to abide by the terms of this notice.

KERSTIN MEDWIN CHIROPRACTIC, PLLC may use and/or release your health information in connection with your health care treatment (for example, to help us provide you with the correct treatment), to determine if you are eligible for insurance benefits, or to process claims for benefits or payments, in connection with the practice's health care operations, or as required by law. These uses must be completed in compliance with applicable laws and rules for using this information. These uses, to the extent allowed by law, do not require your written authorization.

We must provide the information to you or your representative if you ask for it. We must also provide it to government agencies without your consent if the government agency requests it as allowed by law. Other uses or disclosures will be made only with your written authorization, and you may revoke your authorization, by notifying us in writing.

You have several rights related to your information:

- To get a copy of this notice
- To see or get a copy of your health care information
- To ask us to change your health information
- To ask us to limit our use of your information (which we may not have to agree to)
- To ask us to send you your information in a certain way (for example, by mailing it to a different address)
- To ask us to provide you with a form so you can tell us to send your information to someone else. You can always take back this permission, as long as the information hasn't been shared yet.
- To get a list of people who have received your health information. This will not include health information that you or your representative asked for or information we gave out for law enforcement purposes.

Please note that we have the right to change this notice and make the notice apply to any protected health information we maintain. We will give you a copy of any changes to the notice by mail or when you come into the office.

I confirm that I have reviewed a copy of this notice of privacy practices.

_____ _____

(Patient Signature) (Date)

If you have any questions, please let us know so we can address them. You may also file a complaint with the Secretary of Health and Human Services if you believe your privacy rights have been violated. You will not be, in any way, retaliated against for filing a complaint. Effective 4/18/2014

Medwin Chiropractic-Consent to Treat

Patient Name: _____ Date: _____

The primary treatment used by doctors of chiropractic is spinal manipulation or adjustments. We will use this procedure in your treatment program.

The nature of chiropractic manipulation:

We will use our hands to manipulate or loosen and reposition the joints of your spine. Often with this procedure you will hear a popping nose associated with the loosening and repositioning.

The material risks inherent to chiropractic manipulation:

As with any health care procedure, there are certain complications that may arise from chiropractic manipulation. These complications may include aggravation of degenerative or injured spinal discs, rib fractures, muscle strains, nerve injury or spinal cord compression. Manipulation of the neck has been associated with injury to arteries in the neck leading to or contributing to stroke. Local soreness and/or stiffness is typical in the early phases of treatment.

Probability of those risks occurring:

Fractures are rare occurrences and generally result from underlying bone weakness, which we check for during your examination and in your health history and X-rays. The exact incidence of stroke is uncertain, but is generally believed to occur in less than one per million treatments. We employ physical tests that are advocated to screen for this risk, but they are generally accepted as being insensitive. All other complications are also generally described as rare. The incidence of spinal fractures or other serious musculoskeletal injury is estimated at 1:4 million treatments.

The availability and nature of other treatment options for your condition may include:

*over the counter medications and rest *surgery

*medical care which may include anti-inflammatory drugs, muscle relaxants and pain medications.

Material risks inherent to your other treatment options:

The common analgesic and anti-inflammatory drugs have been shown to cause damage to the stomach, intestines and possible to the kidneys. Approximately 1 in 150 patients taking anti-inflammatory drugs for extended periods of time require hospitalization for stomach ulceration. There are about 16,500 deaths each year in the U.S. from these complications which is more common than deaths from either Hodgkin's Disease or cervical cancer. The risks are similar for both prescription anti-inflammatories as over-the-counter medications.

Spine surgery may be a consideration for some cases. However, it is reserved for those cases where extensive conservative treatment has been tried. Spine surgery is associated with a minor complication rate of between 9 per 100 and 15 per 100 cases depending on the area of the spine involved. More serious complications of the nervous system may occur in 1 per 400 cases and death has been reported in approximately 1 per 1500 cases.

While spinal manipulation is associated with complications in a small number of cases, it has a complication rate of several thousand times less than other typical treatment options.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND WHAT HAS BEEN STATED ABOVE!!

I have read (**initial**_____) or have had read to me (**initial**____) the above explanation of chiropractic manipulation or adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Printed name: _____ Witness: _____

Signature: _____ Witness: _____

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Statement of Acknowledgement of Financial Responsibility

*I understand that I may be financially responsible for any changes incurred at this office including copayments, deductibles, co-insurances and charges not covered by my insurance.

*I realize that my care may be subject to prior authorization from the insurance carrier and I accept any responsibility for charges which may not be approved. The insurance company will review all documentation submitted by Dr. Medwin and Dr. Whipple for review of medical necessity and base their decision upon this documentation.

*I understand this office agrees to notify me if a service is not covered and will notify me if my care is not approved by the insurance company as soon as possible. If a treatment plan is approved, this office will notify me of the number of visits allowed. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care while waiting for insurance approval. If the insurance company denies these charges, they then become the obligation of the patient. It is also the responsibility of the patient to notify Dr. Medwin, Dr. Whipple and their team of any changes to my insurance.

*The office will seek payment from you for any servicers your health plan determines to be not medically necessary.

*For those who receive multiple bills that are not paid in a timely manner, additional fees will be charged and will end up going to collections. The patient will be responsible for these fees and are at the office's discretion.

*If I suspend or terminate my care and treatment, any fees for professional services rendered to me will be automatically due and payable.

*I understand that cancellation of any scheduled appointments, less than 24 hours in advance, will result in **$30.00** billed directly to me. This also includes **missed appointments**.

I have read and understand what has been stated above.

Patient signature _____ Date _____

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