Staten Island Wellness Care Health Profile

Name: _____ Date: ___/___/___

Age ____ Male____ Female____ Date of Birth ___/___/___

Address: _____City: _____ State____ Zip_____

Email: _____ Phone: Home _____ Cell _____

May we include you in our weekly text4health text messages: Yes No (you can stop anytime)

Occupation: _____ Employer: _____

Single / Married / Divorced / Widowed Spouse's name: _____

Number of Children: ___ Names, Ages & Gender _____

_____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Severity on scale of 1-10	When did episode begin?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR? ____ MEDICAL DOCTOR? ____ OTHER? _____

WHO AND WHEN? _____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

DIZZINESS	MIGRAINES	MENSTRUAL DISORDERS	NUMBNESS IN LEGS	LUPUS
HEADACHES	ANXIETY	HEART DISORDERS	NUMBNESS IN FEET	FIBROMYALGIA
VERTIGO	THROAT ISSUES	STOMACH DISORDERS	LOW BACK PAIN	CHEST PAIN
EAR INFECTIONS	THYROID PROBLEMS	KIDNEY PROBLEMS	HIP PAIN LEG PAIN	ARM PAIN
NAUSEA	ASTHMA	BLADDER PROBLEMS	SHOULDER PAIN	ADD/ADHD
TMJ	ULCERS	IRRITABLE BOWEL	LIVER DISEASE	KNEE PAIN
NECK PAIN	NUMBNESS IN HANDS	DISC PROBLEMS	CHRONIC FATIGUE	NERVOUSNESS
EPILEPSY	DISC PROBLEM	INFERTILITY	GASTRIC REFLUX	MID BACK PAIN
CHRONIC SINUS	OTHER: _____			

CIRCLE ANY CONDITION YOU HAVE NOW/HAVE HAD:

STROKE CANCER HEART DISEASE SEIZURES SPINAL BONE FRACURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS: _____

_____

LIST ALL OER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON:

_____ _____ _____

_____ _____ _____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YOU HAVE, WHO DID YOU SEE AND WHEN? _____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO

FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE _____

OTHER TRAUMA: _____

DO YOU VIEW YOUR HEALTH AS AN INVESTMENT OR EXPENSE?_____

HOW COMMITTED ARE YOU TO LIVING A HEALTHIER LIFE ON A SCALE OS 1-10, WITH 10 BEING THE HEALTHIEST LIFE POSSIBLE?_____

WRITTEN CONSENT

I AUTHORIZE DR. STEVEN GUAGLIARDO TO PERFORM DIAGNOSTIC PROCEDURES, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY LEADING EDGE CHIROPRACTIC.

DATE_____. SIGNATURE _____

Patient Information

Patient Name:_____

Date of Initial Visit:_____ Date of Initial Injury (if applicable):_____

Date of Birth:_____ Phone Number:_____

Insurance Information

Primary Insurance Company Name:_____

Insured ID No:_____ Policy Group No:_____

***If different from Patient**

Insured's Name:_____ Date of Birth:_____

Address:_____

Relationship to Patient:_____ Insured's Employer:_____

Secondary Insurance Company Name:_____

Insured ID No:_____ Policy Group No:_____

***If different from Patient**

Insured's Name:_____ Date of Birth:_____

Address:_____

Relationship to Patient:_____ Insured's Employer:_____

Patient Authorization

I request authorized insurance payment be made on my behalf to Staten Island Wellness Care. I also authorize any holder of medical data about me to release it to the Health Care Finance Administration (HCFA), or any other agent(s), any information needed to determine the benefits payable for related services. I also understand that I am responsible for medical services rendered to myself and dependents and for any amount not covered by insurance.

Patient or Guardian Signature:_____ **Date:**_____

Dr. Steven Guagliardo
Richmond Family Chiropractic & Wellness * Staten Island NY, 10306

Privacy Notice

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient of Dr. Steve, We may only give out your personal and health related information (PHI) about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. *Your PHI may be disclosed to others who may assist in your care, such as children, parents, etc. to the extend necessary to help with your healthcare or payment of your healthcare.
- Your health care records as well as your billing records may be disclosed to another party such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of services provided to you. *Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency,
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected hearth Information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We

are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice wilt apply for all of your health information in our files, You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. Copies are provided at a cost of $1.00 per page.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:
Dr. Steven Guagliardo 86 New Dorp Plaza. Staten Island, NY 10306

If you would like further information about our privacy policies and practices please contact:
Dr. Steven Guagliardo Call 718-980-4840 or
Fax 718-980-4841

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantage by this office or our staff in any manner whatsoever.

This notice is effective as of January 1, 2017. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party:

Name (Printed please) Signature Date

Description of the authority to act on behalf of the patient:_____

Permission to Text

I hereby consent to have my physician, Dr. Steven Guagliardo, and other staff at Staten Island Wellness Care, communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

Please Initial X_____