# FOSTER
## Family & Sports
# CHIROPRACTIC


**Dr. Renee T. Foster**
*Chiropractic Physician*

**127 Union Avenue, Middlesex NJ 08846**
*PH:732-537-0009 * FAX:732-537-9966*

**Dr. Alan K. Foster**
*Chiropractic Physician*


## PATIENT INTAKE FORM

First Name: _____ Last Name: _____ Middle Initial: ___ Gender: ♟Female ♟Male

Date of Birth: _____ Age: ____ Marital Status: ♟Married ♟Single ♟Divorced ♟Widow ♟Separated

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Phone Carrier: _____

Social Security # _____ E-mail: _____

Employer Name: _____ Occupation: _____

Employer address: _____ Phone: _____

**How did you hear about us**? ♟ Our website ♟ Insurance Company: Which? _____ Other? _____

♟ Patient referral: Who? _____ ♟ Physician Referral: Who? _____

### Emergency Contact and/or Guardian information

Name: _____ Relationship: ♟ Spouse ♟ Parent/ Guardian ♟ Other _____

Cell Phone: _____ Work Phone: _____DOB: _____

Same address as above? ♟ Y ♟ N If no, please provide address: _____

Can we discuss your medical information with him/her? ♟ Yes ♟ No

### Primary Care Physician Information

Doctor's Name: _____ Phone number: _____ Fax: _____

Address: _____City: _____State: _____ Zip: _____

**Female Section Only**

I hereby expressly acknowledge that I am not pregnant at the present time and that the Drs. Alan & Renee Foster and Foster family & Sports Chiropractic is hereby expressly authorized and directed to complete a radiographic examination (X-rays) in connection with my chiropractic treatment. **Initial:** _____

**Minor Section Only**

I hereby authorize Drs. Alan & Renee Foster at Foster Family & Sports Chiropractic, together with whomever my treating doctor may designate as an appropriate individual(s) to administer chiropractic care, including X-rays, and appropriate adjunctive services as my treating chiropractor deems is necessary to my child. I acknowledge that I have legal authority to provide such written consent on behalf of such child/ward. **Initial:** _____

## Informed Consent for Chiropractic care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis. **Initial**: _____

## Patient Authorization for open Adjusting Environment

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patients being seen in the same adjusting area. Patients are within sight of one another, and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care, and this is NOT the environment used for taking patient histories or providing examinations. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. **Initial:** _____

*By signing below, I certify that all the above information is true to the best of my knowledge. I clearly understand and agree that all services are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Finally, I authorize the release of my medical information relevant to my condition and treatment at this office to any insurance company or doctor as may be needed in the normal course of my care and treatment.*

Signature: _____ Date: _____

# FOSTER Family & Sports CHIROPRACTIC, L.L.C.

**Alan K. Foster, D.C.**
*Chiropractic Physician*
**Renee T. Foster, B.S., D.C.**
*Chiropractic Physician*

127 Union Avenue
Middlesex, New Jersey 08846
Telephone: (732)-537-0009
Facsimile: (732)-537-9966

## ASSIGNMENT OF BENEFITS AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR

**Primary Insurance**

What Type? ♟ Commercial ♟ Self Pay ♟ Worker's Compensation ♟ Auto Insurance

Insurance Name: _____Subscriber ID#: _____ Group#: _____

Who is the primary insured? _____ Date of Birth: _____

If auto or work-related injury; Date of Accident/Incident? _____ Was it REPORTED? ♟ Yes ♟ No

**Secondary Insurance**

Insurance Name: _____ Insurance Phone #: _____Claim#_____

Name: _____Subscriber ID#: _____ Group#: _____

Claim's Address (back of card) _____Phone: _____

Who is the primary insured? _____ Date of Birth: _____

I irrevocably assign to FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. all my rights and benefits under any insurance contracts for payment for services rendered to me by FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. I irrevocably direct that all payments directly go to the above-named insurance company to pay by check issued, and mailed, directly to:

**FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C.**

**127 Union Avenue , Middlesex, NJ 08846**

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. to be released to FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. I irrevocably authorize FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. to file insurance claims on behalf of services rendered to me. I irrevocably authorize FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. to act in my behalf and report any suspected violations of proper claim practices to the proper claim practices to the proper regulatory authorities.

***This is direct and irrevocable assignment of my rights and benefits under this policy. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.***

_____ _____ _____

Print Name Signature Date

# FOSTER Family & Sports CHIROPRACTIC, L.L.C.

**Alan K. Foster, D.C.**
*Chiropractic Physician*
**Renee T. Foster, B.S., D.C.**
*Chiropractic Physician*

127 Union Avenue
Middlesex, New Jersey 08846
Telephone: (732)-537-0009
Facsimile: (732)-537-9966

## Health Information Privacy Act Notice

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS: I consent to the usage or disclosure of my protected health information by FOSTER Family & Sports CHIROPRACTIC for the purpose of diagnosing or providing treatment to me, obtaining the payment for my health care bills or to conduct health care operations of FOSTER Family & Sports CHIROPRACTIC. I understand that diagnosis or treatment of me by FOSTER Family & Sports CHIROPRACTIC may be conditional upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to whom my protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. FOSTER Family & Sports CHIROPRACTIC is not required to agree to the restrictions that I may request. However, if FOSTER Family & Sports CHIROPRACTIC agrees to a restriction that I request the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that FOSTER Family & Sports CHIROPRACTIC has acted in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review FOSTER Family & Sports CHIROPRACTIC's *Notice of Privacy Practices* prior to signing this document FOSTER Family & Sports CHIROPRACTIC's *Notice of Privacy Practices* has been provided to me. *The Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of FOSTER Family & Sports CHIROPRACTIC. The *Notice of Privacy Practices* so provided at the front office. *The Notice of Privacy Practices* also describes my rights and FOSTER Family & Sports CHIROPRACTIC's duties with respect to my protected health information.

FOSTER Family & Sports CHIROPRACTIC reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. I may obtain a revised *Notice of Privacy Practices* by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____ _____

Print Name Signature Date

***A photocopy shall be considered as effective and valid as the original.***

# Authorization for Use and Disclosure of Protected Health Information

**Foster Family & Sports Chiropractic Authorization**

By my signature below, I affirm, as a patient of Foster Family & Sports Chiropractic OR as the parent or legal guardian of a minor child that is a patient of Foster Family & Sports Chiropractic (the "**Patient**"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "**Images**"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's first name; (iii) to publicize the fact that Chiropractic services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the "**Information**"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites. **Purpose:**

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided for the use of the Information.

**Expiration and Revocability:**

If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all redisclosure of information.

**No Effect on Treatment:**

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

**Name of Patient (printed):** _____

**Date of Birth of Patient:** _____

**Signature of Patient OR**
**Parent/Legal Guardian (if signing for minor):** _____

**Printed Name of Parent or Guardian:**
**(if signing on behalf of minor child)** _____

**Date of Signature:** _____

**Foster Family & Sports Chiropractic, LLC** **New Patient Case History**

Print Name: _____ Date of Birth: _____ Insurance Name: _____

What is your major complaint that you are being seen for **TODAY**?

_____

What are any other complaints you have had in the **PAST**?

_____

How would you describe your pain? (circle) Dull **Ache** **Sharp** **Shooting** **Throbbing** **Numbness** **Burning**

Does your pain travel or shoot anywhere? (circle) **Yes** **No** If yes, where? _____

How long have you been feeling like this? _____

How did it start? _____

Have you had this before? (circle) **Yes** **No** Is this condition progressively getting worse? (circle) Yes **No**

Is this condition interfering with circle) **Work** **Sleep** **Daily Routine** **Other**_____

What aggravates your condition? _____

What helps you to feel better? (Ice, heat, stretching etc.):_____

Have you missed any time at work? **Yes** **No** Are you currently working? **Yes** **No**

Are you taking any medications? (Prescription) Yes **No**

If so, which kinds? _____

Are you taking any medications? (OTC) Yes **No**

If so, which kinds? _____

Have you seen any other doctor for this condition? **Yes** **No**

Any diagnostic test done? Specify (i.e. X-rays, MRI, CT, Ultrasound) _____

Doctor's name: _____ MD DO DC DDS

What was prescribed/ what was the treatment: _____

Has it helped? **Yes** **No**

**Is this due to a motor vehicle, workers compensation or legal case? Yes No**

**Please provide the most RECENT XRAY and/or MRI?**

**MRI:(Body Area)** _____ **Facility Location** _____ **Report Y/N**

**XRAY:(Body Area)** _____ **Facility Location** _____ **Report Y/N**

*By signing below, I certify that the above information is true to the best of my knowledge. I clearly understand and agree that all services are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately dueand payable. Finally, I authorize the release of my medical information relevant to my condition and treatment at this office to any insurance company or doctor as may be needed in the normal course of my care and treatment.*

Signature: _____ Date: _____

**Please Circle All Present Symptoms**

**HEAD:**

☐ Headache (circle all that apply)
- ☐ Sinus (allergy)
- ☐ Entire Head
- ☐ Back of head
- ☐ Forehead
- ☐ Temples
- ☐ Migraine

☐ Head feels heavy
☐ Loss of memory
☐ Light Headedness
☐ Fainting
☐ Light sensitivity
☐ Blurred or Double vision
☐ Loss of vision
☐ Loss of taste
☐ Loss of balance
☐ Dizziness
☐ Loss of hearing
☐ Pain in ears
☐ Ringing/buzzing in ears

**NECK:**

☐ Neck pain
☐ Neck pain with movement
☐ Forward
☐ Backward
☐ Turning to: **Left Right**
☐ Bending to: **Left Right**
☐ Pinched nerve in neck
☐ Neck feels out of place
☐ Muscle spasms in neck
☐Popping/grinding
☐ Arthritis

**SHOULDERS:**

☐ Pain in shoulder joint: **Left Right**
☐ Pain across shoulders
☐ Bursitis: **Left Right**
☐ Arthritis: **Left Right**
☐Cant raise arm above: **Shoulder Head**
☐ Pinched nerve in shoulder **Left Right**
☐ Muscle spasm in shoulder **Left Right**

**ARMS AND HANDS:**

☐ Pain in upper arm: **Left Right**
☐ Pain in elbow **Left Right**
☐ Movement Aggravated
☐ Tennis Elbow **Left Right**
☐ Pain in fingers **Left Right**
☐ Pain in hands **Left Right**
☐ Pain in forearm: **Left Right**
☐ Pins and needles in arms: **Left Right**
☐ Pins/needles in fingers: **Left Right**

☐ Numbness in arms: **Left Right**
☐ Fingers go to sleep: **Left Right**
☐ Swollen/sore joints in fingers
☐ Arthritis in fingers: **Left Right**
☐ Loss of grip strength: **Left Right**

**MID BACK:**

☐ Mid-Back pain
☐ Sharp stabbing pain
☐ Dull ache
☐ Pain from front to back
☐ Pain from back to front
☐ Muscle spasms
☐ Pain in kidney

**CHEST:**

☐ Chest pain
☐ Shortness of breath
☐ Pain around ribs
☐ Breast pain
☐ Irregular heartbeat

**ABDOMEN:**

☐ Nervous stomach
☐ Gas
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids
☐ Food

**LOW BACK:**

☐ Low back pain
☐ Upper lumbar
☐ Lower lumbar
☐ Sacroiliac
☐ Slip disc
☐ Muscle spasms
☐ Arthritis

**PAIN IS WORSE WHEN:**

☐ Walking
☐ Lifting
☐ Standing
☐ Sitting
☐ Bending
☐ Coughing
☐ Lying Down

**HIPS, LEGS & FEET**:

☐ Pain in buttocks: **Left Right**
☐ Pain in hip joint: **Left Right**
☐ Pain down legs: **Left Right**
☐ Knee Pain: **Left Right**
☐ Leg cramps: **Left Right**
☐ Cramps in feet: **Left Right**
☐ Pins and needles in legs: **Left Right**

☐ Numbness in legs: **Left Right**
☐ Numbness in feet: **Left Right**
☐ Numbness in toes: **Left Right**
☐ Swollen ankles/feet: **Left Right**

**WOMEN ONLY:**

☐ Menstrual pain
☐ Irregularity
☐ Birth control, type: _____
☐ Hysterectomy
☐ Menopause
☐ Tumors
☐ Is there a chance you may be pregnant?

**MEN ONLY:**

☐ Urinary frequency
☐ Difficulty starting
☐ Night urination
☐ prostate pain

**GENERAL:**

☐ Surgeries: _____
☐ Nervousness
☐ Irritable
☐ Depressed
☐ Fatigue
☐ Loss of sleep_____ HRS/Night
☐ Abnormal weight gain/loss___lbs
☐ Cups of coffee/tea per day _____
☐ Cigarettes _____ packs a day
☐ Diabetes
☐ Hypo/hyperglycemia
☐ Other

_____
_____
_____
_____

**Coronavirus History:**
Negative OR Positive
**Vaccine** Y/N Type:

_____

Date: _____

☐ Opted Out

**Complications?** _____

_____

_____

_____