REGISTRATION

Patient: _____ Date: _____
Last Name First Name Initial

Street Address:_____

City/State/Zip: _____

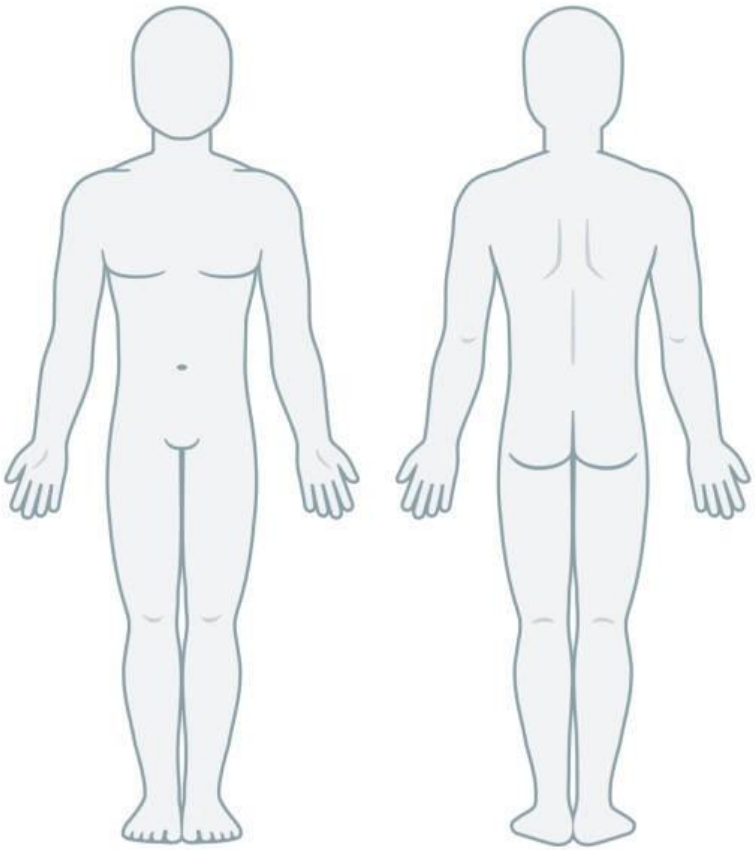
Sex: □ M □ F Age: ____ Birthdate: _____ Phone: _____

Social Security #: _____ Email:_____

I, the undersigned, give John Carlucci, D.C. permission to examine and treat me today.

_____
Signature

Please draw on the diagram where you are suffering from pain or other symptoms:



Medications / Supplements: *(please list all that you currently take)*

_____

Allergies: *(include all **medications** that cause allergic reaction)*

_____

Smoking: ___ Yes ___ No If yes, _____ Packs per day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

_____

Medical History:

Please circle any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ Asthma
□ COPD
□ Emphysema
□ Pulmonary embolism
□ Pneumonia
□ Tuberculosis
□ Respiratory arrest
□ Sleep apnea
□ Other: _____

Cardiac / Heart and peripheral vascular disease

□ Chest pain / angina
□ Heart attack
□ Congestive heart failure
□ Bleeding problems
□ High blood pressure
□ Heart murmur, valve disorder
□ Mitral valve prolapse
□ Other: _____
□ Irregular heartbeat
□ Peripheral vascular disease
□ Deep vein thrombosis

Neurologic Disorders

□ Stroke or TIA
□ Peripheral neuropathy
□ Parkinson's
□ MS
□ Cerebral palsy
□ Other: _____

Bone & Joint Disorders

□ Osteoarthritis
□ Rheumatoid arthritis
□ Other: _____
□ Gout
□ Lupus
□ Osteomyelitis
□ Ankylosing spondylitis

Gastrointestinal Disorders

□ Peptic ulcer or stomach ulcer □ Diverticulitis □ Hepatitis - Type _____
□ Acid reflux, GERD □ Irritable bowel □ Liver disease
□ GI bleed □ Inflammatory bowel disease
□ Other: _____

Genitourinary Disorders

□ Urinary tract infection □ Kidney problems □ Dialysis, kidney failure
□ Bladder problems □ Kidney stones □ Other: _____

Metabolic & Other Disorders

□ Diabetes _____ years □ Skin disorder _____ □ Depression
□ Thyroid problems □ Psoriasis □ Anxiety
□ Sickle cell disease □ Skin ulcer □ Alcohol or drug dependency
□ High cholesterol or lipids □ Tooth abscess, gingivitis

Cancer of any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

Family Medical History (of your parents and siblings):

Please circle any significant family medical history or problems.

□ Asthma □ Tuberculosis
□ COPD or emphysema □ Lung disease: _____
□ Heart attack □ Congestive heart failure
□ Irregular heartbeat □ Bleeding problems
□ MS or Parkinson's □ Neurological _____
□ Osteoarthritis □ Lupus
□ Gout □ Rheumatoid arthritis
□ Other bone or joint disease:_____
□ Acid reflux, GERD □ Inflammatory bowel disease
□ Liver disease □ Hepatitis
□ Kidney problems □ Diabetes
□ Thyroid problems □ High cholesterol or lipids
□ Cancer of any type, please specify: _____

Mother ___ alive ___ deceased Father ___ alive ___ deceased

Siblings: alive ___ deceased ____

Health Insurance: _____

Auto Insurance: _____

Date of Accident: _____

Adjuster: _____ Phone: _____

Claim #: _____ Policy #: _____

Primary Care Physician:

Name & Address: _____

_____

Phone #: _____

Attorney Information:

Name & Address:_____

_____

Phone #: _____

Emergency Contact:

Name & Phone #:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2. The practice reserves the right to change the privacy policy as allowed by law.
3. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
4. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
5. The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____

This consent was signed by:

_____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

Patient or legal Guardian: _____

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You, John F. Carlucci, D.C., my Chiropractic Provider, are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider the authority to affix my signature as noted below to obtain medical information from any hospital, medical provider, etc. as necessary as it relates to the care being provided by my chiropractic doctor.

3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any insurance company which may become obligated to pay me any sums.
I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.

4. ASSIGNMENT OF RIGHT TO SUE: In the event any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me. I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my Injury, including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you.

6. I waive the Statute of Limitations regarding my doctor's right to recover from me directly.

7. I hereby acknowledge that I am receiving (or about to receive) health care services from John Carlucci, D.C. (Doctor) and am advised that he is willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the Doctor or make other provisions for the protection of the interest of the Doctor; or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor or if I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor will be made on a current basis and my account paid in full immediately. I understand that the Doctor may or may not file PIP appeals and agree to pay any balance due regardless of the outcome of said appeals. I understand that the daily fee for my care with the Doctor is that specified by the State of New Jersey Department of Banking and Insurance Automobile Medical Fee Schedule and instruct my attorney to reimburse the Doctor for any amounts due to him from any aforementioned settlement in accordance with that Fee Schedule. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

8. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all Court costs, attorney's fees, service of process fees and any additional reasonable costs incurred in order to collect or that are associated with collecting monies due on the patient's account.

Dated: Day_____ Month _____ Year _____

_____ Signature _____ Witness