



Patient Information

Date: ___/___/___

(please circle one): Mr. Mrs. Ms. Dr. Rev. Father Sister Pastor

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: ___-___-___ Gender: _____ Martial Status: _____

Date of Birth: ___/___/___ Age: _____ Emergency Contact: _____

Home Phone: _____ Cell Phone: _____ Cell Company: _____

E-mail: _____

Best Source of Communication: _____

How did you hear about us? _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Smoking Status: (Circle One) Current Former Never

Employers Name: _____ Occupation: _____

Work Phone: _____ Ext: _____

Primary Insurance: _____ Secondary Insurance: _____

Relationship to Insured: (Circle One) Self Spouse Child Other: _____

If self; skip to bottom of form. If spouse, child or other be sure to fill out all of the holders information.

Name of Insurance Holder: _____ Date of Birth: ___/___/___

Address: _____

SSN: ___-___-___ Employer: _____ Phone: _____

Authorizations: I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me 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 products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Relationship: _____

Patient Case History

Name: _____

Date: _____

Please mark any allergies below:

- | | | |
|---|---|--|
| <input type="radio"/> Amoxicillin | <input type="radio"/> Erythromycin | <input type="radio"/> Ragweed/Pollen |
| <input type="radio"/> Anesthesia | <input type="radio"/> Fish | <input type="radio"/> Seasonal Allergies |
| <input type="radio"/> Animals | <input type="radio"/> Gluten | <input type="radio"/> Shellfish |
| <input type="radio"/> Aspirin/Pain Medicine | <input type="radio"/> Iodine | <input type="radio"/> Soaps |
| <input type="radio"/> Bug Bites | <input type="radio"/> Lactose Intolerance | <input type="radio"/> Sulfa |
| <input type="radio"/> Chlorine | <input type="radio"/> Latex | <input type="radio"/> Tylenol |
| <input type="radio"/> Chocolates/Sweets | <input type="radio"/> Morphine | <input type="radio"/> Vicodin |
| <input type="radio"/> Codeine | <input type="radio"/> Nuts | <input type="radio"/> Other: _____ |
| <input type="radio"/> Dairy Products (milk, cheese) | <input type="radio"/> Oxycodone | |
| <input type="radio"/> Dust | <input type="radio"/> Peanuts | |
| <input type="radio"/> Eggs | <input type="radio"/> Penicillin | |
| | <input type="radio"/> Percocet | |

Please mark any surgeries below:

- | | | |
|---------------------------------------|--------------------------------------|--|
| <input type="radio"/> Abdomen | <input type="radio"/> Ear | <input type="radio"/> Oral |
| <input type="radio"/> ACL | <input type="radio"/> Eyes | <input type="radio"/> Shoulder |
| <input type="radio"/> Adnoids removed | <input type="radio"/> Foot | <input type="radio"/> Sinus |
| <input type="radio"/> Ankle | <input type="radio"/> Gall Bladder | <input type="radio"/> Spleen |
| <input type="radio"/> Appendix | <input type="radio"/> Gastric Bypass | <input type="radio"/> Tonsils removed |
| <input type="radio"/> Back | <input type="radio"/> Heart | <input type="radio"/> Tubligation |
| <input type="radio"/> Bladder | <input type="radio"/> Hernia | <input type="radio"/> Vasectomy |
| <input type="radio"/> Brain/Tumor | <input type="radio"/> Hip | <input type="radio"/> Wisdom teeth removed |
| <input type="radio"/> Breast | <input type="radio"/> Hysterectomy | <input type="radio"/> Wrist/Hand |
| <input type="radio"/> Carpal Tunnel | <input type="radio"/> Knee | <input type="radio"/> Other: _____ |
| <input type="radio"/> Circumcision | <input type="radio"/> Neck | |
| <input type="radio"/> C-Section | <input type="radio"/> Nose | |

Please mark any past medical history conditions below:

- | | | |
|--|---|---|
| <input type="radio"/> Acid Reflux | <input type="radio"/> Eye/Vision Problems | <input type="radio"/> Mid Back Pain |
| <input type="radio"/> Allergies | <input type="radio"/> Fatigue | <input type="radio"/> Multiple Sclerosis |
| <input type="radio"/> Ankle Pain | <input type="radio"/> Fibromyalgia | <input type="radio"/> Neck Pain |
| <input type="radio"/> Anxiety | <input type="radio"/> Foot Pain | <input type="radio"/> Neurological Disorder |
| <input type="radio"/> Arm Pain | <input type="radio"/> Genetic Spinal Disorder | <input type="radio"/> Osteoarthritis |
| <input type="radio"/> Arthritis | <input type="radio"/> GERD | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Asthma | <input type="radio"/> Hand Pain | <input type="radio"/> Pacemaker |
| <input type="radio"/> Back Pain | <input type="radio"/> Headaches | <input type="radio"/> Parkinson's Disease |
| <input type="radio"/> Bi-Polar Disorder | <input type="radio"/> Hearing Problems | <input type="radio"/> Prostate Problems |
| <input type="radio"/> Broken Bones | <input type="radio"/> Heart Problems | <input type="radio"/> Psoriasis |
| <input type="radio"/> Cancer | <input type="radio"/> Heartburn/Indigestion | <input type="radio"/> Sciatica |
| <input type="radio"/> Carpal Tunnel Syndrome | <input type="radio"/> High Blood Pressure | <input type="radio"/> Scoliosis |
| <input type="radio"/> Constipation | <input type="radio"/> High Cholesterol | <input type="radio"/> Seizures |
| <input type="radio"/> Depression | <input type="radio"/> Hip Pain | <input type="radio"/> Shoulder Pain |
| <input type="radio"/> Diabetes | <input type="radio"/> Jaw Pain | <input type="radio"/> Significant Weight Change |
| <input type="radio"/> Difficulty Breathing | <input type="radio"/> Joint Stiffness | <input type="radio"/> Spinal Cord Injury |
| <input type="radio"/> Dizziness | <input type="radio"/> Kidney Stones | <input type="radio"/> Sprain/Strain |
| <input type="radio"/> Ear Infections | <input type="radio"/> Knee Pain | <input type="radio"/> Stroke/Heart Attack |
| <input type="radio"/> Eczema | <input type="radio"/> Leg Pain | <input type="radio"/> Thyroid Problems |
| <input type="radio"/> Elbow Pain | <input type="radio"/> Low Back Pain | <input type="radio"/> Whiplash |
| <input type="radio"/> Endometriosis | <input type="radio"/> Lyme Disease | <input type="radio"/> Wrist Pain |
| <input type="radio"/> Epilepsy | <input type="radio"/> Menstrual Problems | <input type="radio"/> Other: _____ |

Please list any medications or over the counter drugs (ie. Aspirin) you are currently taking and why:

Please list any vitamins or supplements you are currently taking:

Please list any Family History Medical Conditions and Who they Relate to: (Refer to Medical Conditions Above)

Example: Mom: High Blood Pressure

Have you had any falls, auto or other accidents? Yes No Describe: _____

Who is your **Primary Care Physician**? _____ **Date of Last Exam**? _____

Are you pregnant? Yes No How many weeks? _____ Due Date: _____

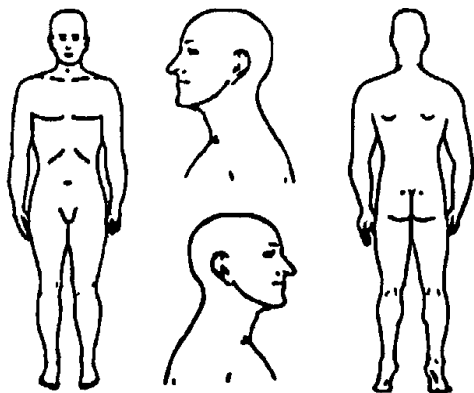
Who is your Midwife/Obgyn? _____

Do you smoke? Yes No Packs per day? _____ Do you use other drugs/substances? Yes No

Do you drink alcohol? Yes No How many per day? _____ Do you drink caffeine? Yes No How many per day? _____

Do you Exercise? Yes No (what forms and how often?) _____

Please mark your areas of pain on the diagram below:



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

Which side is the problem occurring? Right Left Both Center

Have you had this condition in the past? YES - NO

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1 2 3 4 5 6 7 8 9 10

Is the pain: Mild Moderate Severe Unbearable

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain

Tightness Stabbing Throbbing Other: _____

What makes your pain better (ice, heat, massage, etc)? _____

How often do you experience your symptoms?

Constantly (76-100% of the day) Frequently (51-75% of the day)

Occasionally (26-50% of the day) Intermittently (0-25% of the day)

What activities aggravate your condition (working, exercise, etc)? _____

What is your SECOND complaint? _____ Date problem began? _____
How did this problem begin (falling, lifting, etc.)? _____
Which side is the problem occurring? Right Left Both Center
Have you had this condition in the past? YES - NO
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
 1 2 3 4 5 6 7 8 9 10
Is the pain: Mild Moderate Severe Unbearable
Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain
 Tightness Stabbing Throbbing Other: _____
What makes your pain better (ice, heat, massage, etc)? _____
How often do you experience your symptoms?
 Constantly (76-100% of the day) Frequently (51-75% of the day)
 Occasionally (26-50% of the day) Intermittently (0-25% of the day)
What activities aggravate your condition (working, exercise, etc)? _____

What is your next complaint? _____ Date problem began? _____
How did this problem begin (falling, lifting, etc.)? _____
Which side is the problem occurring? Right Left Both Center
Have you had this condition in the past? YES - NO
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
 1 2 3 4 5 6 7 8 9 10
Is the pain: Mild Moderate Severe Unbearable
Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling Radiating Pain
 Tightness Stabbing Throbbing Other: _____
What makes your pain better (ice, heat, massage, etc)? _____
How often do you experience your symptoms?
 Constantly (76-100% of the day) Frequently (51-75% of the day)
 Occasionally (26-50% of the day) Intermittently (0-25% of the day)
What activities aggravate your condition (working, exercise, etc)? _____

Have you ever had chiropractic care? No Yes

When? _____ Why? _____

Where? _____

Were X-rays taken? No Yes

When was your last adjustment? _____

Sasseville Chiropractic Wellness Center
Dr. Chandra Sasseville and Dr. Ted Stratman

416 Sabattus Street, Lewiston, ME 04240

Tel: 777-3333 Fax: 786-8921



Release Form for individuals involved in care of Patient

I, _____, give SCWC permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from SCWC. I also allow the following people to discuss information about my appointments.

This consent is valid until such time as I provide SCWC written revocation of it.

Patient Name: _____

DOB: _____

SCWC may speak with:

Name: _____

DOB: _____

Address: _____

Phone: _____

Relationship: _____

Name: _____

DOB: _____

Address: _____

Phone: _____

Relationship: _____

Name: _____

DOB: _____

Address: _____

Phone: _____

Relationship: _____

Patient/Guardian Signature: _____

Print Name: _____

Relationship to Patient: _____

Date: _____

HIPAA Omnibus Notice of Privacy Practices



**Sasseville
Chiropractic**
Wellness Center

Revised 2014
Sasseville Chiropractic Wellness Center
Dr. Chandra Sasseville & Dr. Ted Stratman
416 Sabattus St.
Lewiston, Me 04240

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Mainecare Benefits.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

(Continued on next page)

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information –This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications –You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

HIPAA COMPLIANCE OFFICER: Robyn Coleman, **Phone:** 207-777-3333, **Email:** sassevillechiropractic@yahoo.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.



**Sasseville
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**Dr. Chandra L. Sasseville
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Privacy Notice:

Along with the new HIPAA regulations, we have other policies which are mandated to protect your privacy. Please be assured that your records are strictly confidential. Your records are only sent to Insurance Companies, other than your own, with a signed release from you.

We are asking for permission, required by HIPAA, to send your initial and follow up evaluation notes to your Primary Care Physician. We would also like to send you Birthday Cards, Appointment Reminder Cards, Recall Cards, Sympathy Cards and Referral Thank You Card. Also, we are asking your permission to make phone calls to you as needed, at the phone numbers you have provided to us, and to leave a message when appropriate. In our office, we use sign in sheets on the front desk and would like your signature on them at every visit. We also use close treatment rooms where you may be in ear shoot of another patient. Please submit your e-mail address below for newsletters, information sheets, credit card receipts and other documents SCWC needs to e-mail to you.

We understand that at any time you have the right to revoke such authorization by issuing a written request to Sasseville Chiropractic Wellness Center.

We are required by HIPAA laws to have your signature on file annually, giving us permission to perform the above mentioned tasks.

Yours in Health,

Dr. Chandra L. Sasseville, Dr. Ted R. Stratman and staff

By my signature below, I give permission to Dr. Sasseville, Dr. Stratman and their staff to use my patient information in the manner described in this letter and the new HIPAA letter.

Print Name

Signature

Email Address

Date



**Sasseville
Chiropractic**
Wellness Center

**Dr. Chandra L. Sasseville
Dr. Ted Stratman
416 Sabattus St.
Lewiston, Me. 04240**

Our office is very grateful for the support and loyalty which our patients show our practice. In fairness to all of you, we would like to clarify our office policy regarding missed appointments, arriving 15 minutes late for an appointment, and last minute cancellations. We are aware of the wait many of you have to experience before you can have your treatment needs met, so in an effort to best meet these needs, we are implementing a guideline to address these troublesome occurrences. When a patient does not honor their appointment they are adversely affecting three parties: first and foremost they are putting their health at risk by not addressing their own chiropractic needs. Secondly, they are creating a void in the schedule that Dr. Sasseville and her staff could be utilizing to treat other patients in need of chiropractic care. Finally, they are showing a discourtesy to other patients in the practice who have had to wait for their appointments.

With these points in mind, we are implementing the following policy effective immediately. One missed appointment or cancellation without at least 24 hours notice **may** result in a charge of at least \$35.00 at the staff's discretion. If there are two or more broken or late cancellation of an appointment there **will** be a **minimum** \$50.00 charge per occurrence. If a patient shows up more than 15 minutes late for an appointment, this **may** be considered a no show and will need to be rescheduled. We apologize for any occasions where you may have to wait, but these are almost always a result of an emergency treatment of one of our patients or an unforeseen treatment need on a scheduled patient. It is **not** because we deliberately overbooked our schedule.

As a courtesy of our office, we have implemented a system via text and e-mail reminders for scheduled appointments. However, as there may be technology glitches, patients are still held responsible for their appointments and the missed appointment policy will be enforced.

Since most of our patients are considerate of both their chiropractic needs and respectful of our time, the aforementioned plan will not have any affect. However, for those who have continued to compromise appointment availability for other patients, these guidelines will be strictly enforced. Once again, we thank you for your trust and confidence and look forward to providing you with the highest quality of chiropractic care.

Dr. Chandra L. Sasseville, Dr. Ted Stratman and Staff

Sasseville Chiropractic Wellness Center

New Patient Signature

Date



**Sasseville
Chiropractic**
Wellness Center

**Dr. Chandra L. Sasseville
Dr. Ted Stratman
416 Sabattus St.
Lewiston, Me. 04240**

Billing Policy:

Please be sure to contact your insurance company for specific benefit information. Although the chiropractor may participate with your insurance company, they may not be covered. Some out-of-state policies do not reimburse for services provided by Doctors of Chiropractic (DC) since they do not credential them independently.

- We will submit your claim for you. Co-payments are due at the time of service.
- Please direct any coverage, benefit or participation questions directly to your insurance company.
- **Be sure to give your insurance company the name of the provider you will be seeing.**

Services denied as not covered by your insurance company are your responsibility.

We appreciate timely payment on patient statements. Payment in full is due on each statement. If payment in full can not be made, please contact our billing department at 777-3333 to discuss payment options. It is important to us that we work with you to ensure continuity of care.

Patient balances are payable within 30 days of original invoicing. If the patient account balance is still outstanding after 90 days, the account will be submitted to our collection agency.

- The patient will be responsible for any reasonable collection cost, including attorney fees if incurred.

Who is responsible for this account? This should be the holder of the insurance plan.

May we discuss your account with the Responsible Party listed below? (Please circle one): YES NO

_____	_____	_____
Name of Responsible Party	Social Security Number	Relationship

Address / City / State / Zip

It is your responsibility to keep us informed of any changes in your insurance coverage. Most plans have a filing limit, so any delay in the submission of claims may result in the denial of a claim. A delay caused by lack of information will be billable to you.

We accept cash, VISA, MasterCard, Discover, and personal checks. We do NOT accept American Express.

I acknowledge awareness of the billing policies of Sasseville Chiropractic Wellness Center and agree to their terms. I agree to be financially responsible for services provided to me today and in the future at Sasseville Chiropractic Wellness Center.

Signature of patient or responsible party

Date