RUGANI FAMILY CHIROPRACTIC, P.C.
1515 ROUTE 9 HALFMOON, NY 12065
TEL: (518) 348-6366

YOUR CARE PLAN GUIDELINES & OFFICE POLICIES

Welcome to our office and thank you for choosing Rugani Family Chiropractic! The following is a summary of our office policies, fees, and guidelines for your care. I strive to help you achieve the best results in the shortest amount of time. It is my experience that patients who adhere to these care guidelines achieve the best results. As this is a cooperative process, I stress the importance of taking responsibility for your health and lifestyle choices. You have the right to terminate your care at any time, however I strongly encourage you to discuss this decision with me. It has been my experience that the termination of care in any therapeutic program is a very important step. I will discuss your status and progress with you on an on-going basis. I may on occasion call you at home to see how you are doing. I hope that you feel free to discuss your needs and concerns with me as they arise. - Dr. Silvio T. Rugani, D.C.

APPOINTMENTS

- The Doctor will prescribe a specific course of treatment for you. A designated number of treatments over a set period of time are required to get the best results. Therefore, please make up missed appointments as soon as possible to ensure your continuity of care. (Please read our policy below about cancellation.)
- For convenience, please bring your appointment book with you.
- Please wear comfortable clothing. We ask that you **avoid the use of perfumes, colognes and other strong fragrances** as these may trigger allergic reactions or migraines in others.

OFFICE HOURS

Monday: 8:00 a.m. – 1:00 p.m.; 3:00 – 6:00 p.m.
Tuesday: 12:00 – 6:00 p.m.
Wednesday: 8:30 a.m. – 1:00 p.m.; 3:00 – 6:00 p.m.
Thursday: Closed
Friday: 8:00 a.m. – 1:00 p.m.; 3:00 – 6:00 p.m.

FEES & PAYMENT OF BILLS

We expect you to honor the financial arrangements that you make with our office. If you find that you cannot fulfill your agreement, please advise us immediately so that new arrangements can be made. If the arrangement is terminated or suspended, a balance will be due reflecting the fee for services previously rendered.

- **Payments**: Payment is expected at time of service unless prior financial arrangements have been made. Payment in the form of cash, check, or credit card is accepted.
- **Usual and Customary office fees**: First visit for consultation, history and examination is $85. Subsequent visits thereafter $50.
- **Holidays, Weekends or House Calls:** There will be a $50 charge for all services rendered on holidays or house calls.
- **Co-payments and Deductibles:** Patients are financially responsible for insurance co-payments, co-insurances, deductibles and non-covered services. The amount of your patient responsibility is determined by your insurance plan.
- **Returned Checks:** Returned checks will have a $25 service charge.
- **Late Cancellation Fee:** We recognize that situations arise that require canceling appointments at the last minute. As a courtesy to our office and to other patients who may need your slot, we request that you provide at least 24 hours' notice if you need to change your appointment. Cancellation notification may be left on our answering

Patient Information

*Patient Name_____ Age _____ Patient SS #_____

*Address_____

_____
Street City State Zip

*Phone # (home)_____ (cell)_____ **Please circle the best number to reach you at.**

*Sex: □ M □ F *Date of Birth_____/_____/_____ Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced

Occupation_____
Employer_____

Employer Address_____Employer Phone_____

Do you wish to receive occasional news from our office by email? □ Yes □ No If Yes, please provide email address below.

Email Address:_____How did you hear about us?

_____

Would you like to receive appointment reminders via email? □ Yes □ No

Major Medical Insurance

Insured's Name **if other than yourself**_____
Date of Birth_____/_____/_____

Insured's Employer_____ SS #_____

WE WILL MAKE A COPY OF YOUR INSURANCE CARDS **Relationship to Patient**: □ Self □ Spouse □ Child □ Other

*Is Patient covered by additional insurance? □ Yes □ No If Yes:

Insured's Name if other than yourself_____
Date of Birth_____/_____/_____

Insured's Employer_____ SS #_____

Relationship to Patient: □ Self □ Spouse □ Child □ Other

Accident Information

*Is Condition due to an accident: □ Yes □ No Date_____ Type of accident: □ Auto □ Work □ Home □ Other

To whom did you report your accident? □ Auto Insurance Co. □ Employer □ Other Name of person contacted:_____

Attorney Name (if applicable)_____ Attorney Phone: _____

PLEASE COMPLETE THE APPROPRIATE BOX BELOW IF YOU WOULD LIKE US TO FILE AN ACCIDENT RELATED CLAIM

No Fault Insurance	Workers' Compensation Insurance
Insurance Co. _____ _ Address _____ _____ Phone #_____Ext_____ _____ Adjustor_____ _____ Claim#_____ Policy#_____ Insured's Name_____ _____ Relationship To Patient □ Self □ Spouse □ Child □ Other	Insurance Co. _____ _ Address _____ _____ Phone #_____Ext_____ _____ Adjustor_____ _____ Claim # _____ _____ Employer at time of Accident_____ Employer's Address_____ __ _____ _____ _____ _____

Patient Condition

Reason for your visit?_____Where is the pain located?
_____

When did your symptoms begin?_____ What do you think was the cause?
_____

How often do you have this pain?_____Is it constant or does it come and go?
_____

Does the pain interfere with your □ Work □ Sleep □ Daily Routine □ Hobby/Recreation

Have you ever received Chiropractic care? □ Yes □ No

Does anyone in your family have a history of spinal conditions or problems similar to your complaint today? Please list here:
_____
_____
_____
_____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will help to uncover the layers of damage, especially to your nervous system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Yes	No		Patient Comment if answer is Yes
		Chiropractor Comments	
□	□	Did you have a difficult birth?	_____
□	□	Did you ever fall out of bed?	_____
□	□	Childhood Sicknesses?	_____
□	□	Chair pulled out when sat down?	_____
□	□	Did you ever fall down stairs?	_____
□	□	Did you play sports?	_____
□	□	Did you ever have a car accident?	_____
□	□	Did you ever slip and fall?	_____
□	□	Surgeries?	_____
□	□	Physical Stress?	_____
□	□	Mental Stress?	_____
□	□	Occupational Stress?	_____
□	□	Did you have any other traumas?	_____
□	□	Sleeping posture	□ Side □ Stomach □ Back
□	□	Do you Smoke?	□ Yes □ No

Health History

Who is your Primary Care Physician? _____ Are you being seen by other specialists? _____

(Female Only) Who is your OB/GYN Physician?_____ What treatment have you already received for your condition?

□ Medications
(list)_____
_____

□ Surgery (date)_____ □ Physical Therapy □ Chiropractic Care (who)_____ □ Other_____ □ None

Date of Last : Physical Exam_____ Spinal X-ray_____ MRI, CT, Scan_____

PLEASE CIRCLE IF YOU HAVE HAD ANY HISTORY OF THESE CONDITIONS

AIDS/HIV	**Diabetes**	**Kidney Disease**
Psychiatric Care		
Alcoholism	**Emphysema**	**Liver Disease**
Pneumonia		
Allergies	**Epilepsy**	**Migraine**
Prostrate		
Anemia	**Fatigue**	**Multiple Sclerosis**
Rheumatoid Arthritis		
Arthritis	**Fractures**	**Numbness in Fingers**
Stroke	**Goiter**	
Gout	**Numbness in Toes**	**Thyroid Problems**
Asthma	**Headaches**	**Osteoporosis**
Tumor/Growth		
Bleeding Disorder	**Hepatitis**	**Pacemaker**
Ulcer's		
Breast Lump	**Hernia**	**Parkinson's**
Other_____		
Cancer	**Herniated Disc**	**Pins and Needles in arms**
_____		
Chemical Dependency	**High Cholesterol**	**Pins and Needles in legs**
_____		
Depression	**Neck Pain**	**Back pain**

INFORMED CONSENT TO CHIROPRACTIC CARE

DR. SILVIO T. RUGANI
Rugani Family Chiropractic
1515 Route 9
Clifton Park, NY 12065
Telephone: (518) 348-6366

Patient: Please discuss any questions or concerns with the Doctor before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or the other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE:_____**DATE:**_____

PARENT/GUARDIAN SIGNATURE:_____**DATE:**_____
(If patient is a minor)

DOCTOR'S SIGNATURE:_____**DATE:**_____

Rugani Family Chiropractic
NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS A SUMMARY OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

1. 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 who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- You have the right to inspect and copy your protected health information.
- You have the right to request a restriction of your protected health information.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You may have the right to have your physician amend your protected health information.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
- 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 electronically.

3. 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 Dr. Silvio Rugani of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Dr. Silvio Rugani at (518) 348-6366 or email him at DrRugani@RuganiChiropractic.com for further information about the complaint process.

3. Written Acknowledgment

I acknowledge that I have reviewed the NOTICE OF PRIVACY PRACTICES which provides me with a summary of my privacy rights.

_____ _____

Signature of Patient or Legal Representative | Signature of Witness

_____ _____

Date | Date

This notice was published and becomes effective on **1/01/2012**

RUGANI FAMILY CHIROPRACTIC, P.C.

1515 U.S. 9, Clifton Park, NY 12065

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

The Non-Medicare Patient

I hereby assign to Rugani Family Chiropractic, P.C. any and all benefits from any insurance plans or any other protection maintained by the Patient and/or for the Patient's behalf or benefit and authorize and direct such benefits to be paid directly to Rugani Family Chiropractic, P.C. for services provided to the Patient by Rugani Family Chiropractic, P.C.. I certify that the information given by me to Rugani Family Chiropractic, P.C. in applying for payment under Medicare, insurance plans, or other protection is correct and complete. I authorize release of all records required to act on this release and assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

The Medicare Patient

I request that payment of authorized Medicare benefits be made to me or on my behalf to Rugani Family Chiropractic, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to Rugani Family Chiropractic, P.C. in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

All Patients

I agree to be financially responsible for all charges. I have read this information and understand it.

Patient:_____

Signature:_____

Date: _____