



Thank you for choosing and putting your trust in Advanced Chiropractic and Wellness, LLC.

We welcome you to our office. To insure that your visit is a pleasant one, here is an outline of the procedures you can expect on your first visit. Please feel free to ask questions at any time in your treatment here. You can expect your first visit to take approximately 45-60 minutes, as we want to know as much about you as we can, so that we have the best chance of guiding you to reach your health goals.

Please take the time to fill out the health questionnaire in its entirety; it will help us to create a better understanding of your current symptoms, concerns, health goals and an overall picture of your health.

Your first exam will include a physical, orthopedic, neurological, chiropractic, acupuncture, and kinesiologic exam. From the findings, we will together compile a treatment and wellness plan. During this time, we you will discuss the options for your care, the doctor will advise you as to the necessity of additional procedures, that in some cases may include laboratory work, such as X-rays. X-rays may be recommended to visualize the location of any spinal problems, reveal any pathology, and make your care more precise.

Dr. Yomtov will review his findings of your "initial examination", and together you will develop a treatment and wellness plan to meet your overall health goals. If you feel comfortable with the findings; treatment will begin and continue until all of your health goals have been met and sustained.

We will also discuss the possibility of optimizing your treatment via a home care treatment plan, as well as nutritional consultation, stress reduction techniques, exercise/rehab, and other follow up recommendations specific to you and your case.

You will also be advised concerning financial arrangements and insurance coverage as appropriate.

Guidelines:

- We ask that all patients avoid wearing any type of fragrance when coming to the office due to the large number of allergic and chemically sensitive patients that we treat.
- Please be courteous to other patients by turning off or place cell phones on silent.
- Whenever possible, wear loose, comfortable clothing and remove belts and shoes to allow for freedom of movement. We prefer women to avoid wearing one piece dresses and panty hose. Two piece slack or skirt outfits are a better option, and shorts are great for both men and women. If men are wearing a suit and tie, please remove them before seeing the doctor. Feel free to bring in a change of clothing for treatments.

I have (check all that apply): Swollen joints Arthritis/joint pain Tendonitis Bone pain
 Muscle cramping Muscle pain Repetitive Strain Injury
 Fractured Bone(s) Where? _____
 Other _____

Have you ever been to a chiropractor before? Yes No Explain: _____

Have you ever been to an acupuncturist? Yes No Explain: _____

Nature of problem you were treated for _____

Did you experience any relief? _____ Approximate date of last visit _____

Are you currently under care for your problem with another doctor? Yes No How long? _____

Doctor's name: _____ Have you had X-rays in the last 6 months? Yes No

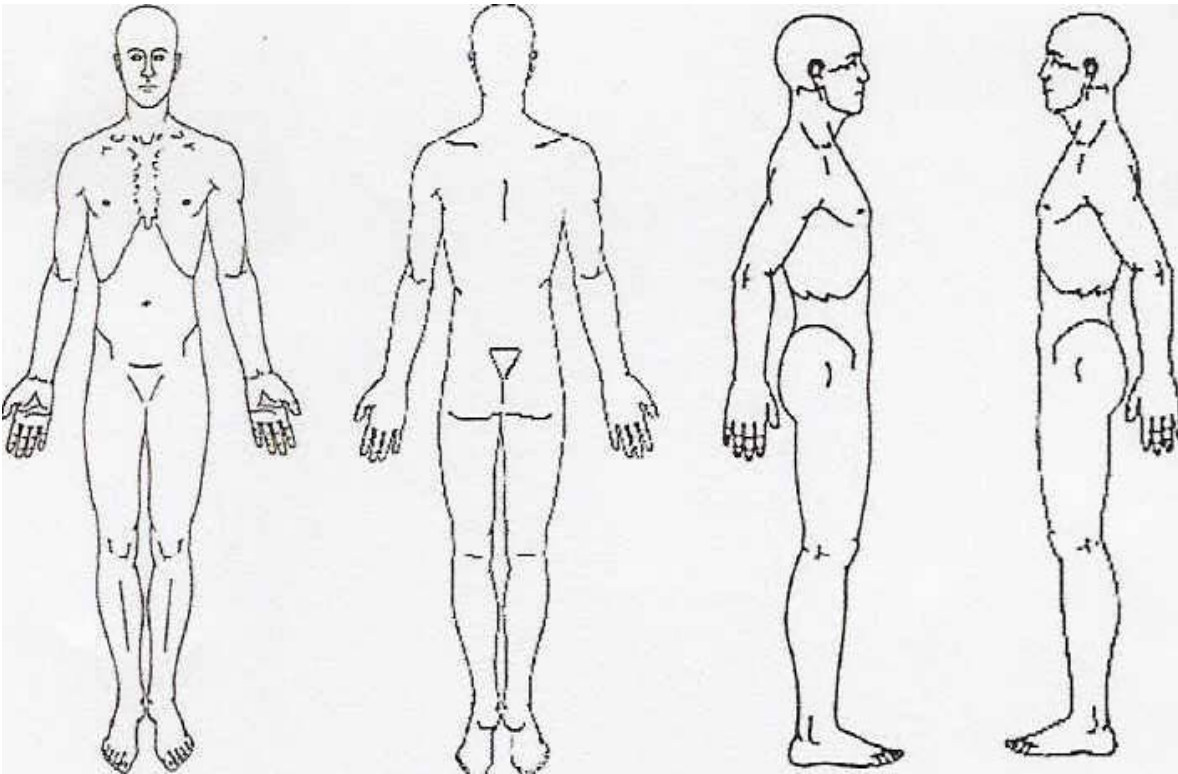
Type of X-ray and where were these X-rays taken? (Name of facility) _____

Are you taking medication for this problem? (If yes, type) _____

Are you, or might you be pregnant? Yes No Do you have a pacemaker or any other implants? Yes No

Please list (or provide a copy) of **ALL** other medications, vitamins or minerals you are presently taking:

Which of the following factors affect your problem? Pain Diagram (please mark all areas of pain on diagram below)
(A=aching B=burning N=numbness P=pins and needles S= stabbing pain O=other type of sensation)



Have you lost or gained any weight the past 5 years? (Yes No) Gained? _____ Lost _____ Weight

Have you had any of this condition(s)? Check all that apply:

AIDS/HIV Alcoholism Asthma Birth Trauma Cancer Diabetes
Emphysema Fibromyalgia Heart Disease Hepatitis A/B/C Herpes
Joint Replacements Lyme's Disease Lymph Nodes removed Multiple Sclerosis
Polio Rheumatic Fever Scarlet Fever Seizures
Sinus Infections Tuberculosis (Ever Exposed to? Yes No When? _____)
Operations _____

Other _____

Do you have a family history of: Diabetes Cancer Heart Disease Low Blood Pressure

High Blood Pressure Hypoglycemia Other _____

If disabled from work, please give information and dates _____

List your MAJOR car accidents, falls and injuries and approximate dates: _____

List your MAJOR surgeries and approximate dates _____

List any type of MAJOR dental work and approximate dates _____

Do you exercise on a regular basis? If so, what type? _____

How is your **Energy**? _____

What time of day is your energy: Highest? _____ Lowest? _____

Do you **Fatigue** easily? _____

How do you feel emotionally? _____

Do you have (check all that apply): Panic attacks Depression Anxiety Bad temper

Nervousness Fear attacks Poor memory Difficult concentration

Are you in a relationship? Yes No how do you feel about your relationship? _____

How do you hold **Stress**? _____

How do you **Relax**? _____

How do you feel about your work? _____

How long do you normally sleep? _____ hours per night

I have difficulties with (check all that apply): Falling asleep Staying asleep Dream-disturbed sleep

Waking up at about _____ am/pm and not being able to fall asleep again

Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:

List any **Allergies** (food, latex, etc.) _____

Do you smoke? Yes No _____ per day, for _____ years

Describe, if any recreational drug use: _____ Typical alcohol intake (# of drinks per week) _____

Caffeine intake per day / week? _____ day _____ week How much water do you drink? _____ oz

I have (check all that apply): Belching Nausea Vomiting vomiting of blood Ulcers
Bloating Acid regurgitation Heartburn Hernia Indigestion severe stomach pain
Bowel movements: How often? _____ time(s)/day _____ days/week

I have (check all that apply): Irregular Constipation Diarrhea Gas Burning sensation
Hemorrhoids Undigested food in stool loose stool Hard stool
Blood in stool Itchiness Painful bowel movements

Urination: How often? _____ times per day Color: Pale yellow Dark yellow/orange Clear

I have or had (check all that apply): Trouble starting stream Frequent urination Incontinence Pain
Burning Dribbling when sneezing Blood in urine Kidney stones Urinary tract infections
Other _____

I have (check all that apply): Frequent colds Chronic runny nose Frequent sore throat
Chronic cough Coughing blood Cough up mucous Pain inhaling
Shortness of breath on exertion/at rest Asthma Nose bleeds
Painful/red eyes Poor vision See spots/floaters Dizziness
Cold sores Bleeding gums Dry mouth Ear pain
Ringing in ears Clogged/popping in ears
Frequent headaches/migraines, describe: _____

I have (check all that apply): Chest pain Palpitation Varicose veins Phlebitis
Cold hands and feet Irregular heart beat Poor circulation

I have or often have (check all that apply): Dry skin Skin rashes Itching Acne Eczema
Hives Hair loss Premature graying Other: _____

Additional Information or concerns: _____

Patient Signature: _____ Date: _____

ADVANCED CHIROPRACTIC & WELLNESS, LLC.

Financial Policy

Patient Name: _____ **Soc. Sec. #:** _____
Last First M.I

Name of Insured: _____ **Relation:** _____ **D.O.B** _____
(if different from patient) Last First

Primary Insurance Company or Health Care Plan Name: _____ **Effective Date:** _____

ID #: _____ **Policy Group #:** _____

Secondary Insurance Company or Health Care Plan Name: _____ **Effective Date:** _____

ID #: _____ **Policy Group #:** _____

____ **Private Pay:** I will pay for all services, as they are rendered, and submit my own insurance claims. We will fill out any additional forms or give you an itemized bill to submit to your insurance company.

____ **Insurance:** I will pay Advanced Chiropractic & Wellness LLC a partial payment (co-pay) until such time that my insurance company acknowledges this claim and pays Advanced Chiropractic & Wellness LLC directly in full, all monies due for services rendered on my behalf.

Payment at the time of service is required. Cash and check are accepted as payment options.

AUTHORIZATION (to release information & settle insurance appeals or disputes) **& ASSIGNMENT** (of benefits to the doctor)

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Advanced Chiropractic & Wellness LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

Advanced Chiropractic & Wellness requires 24 hours advanced notice for cancellation, missed appointments and short notice cancellations(less than 24 hours) will be processed at a fee of \$25 per incident.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chosen in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above name doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate, with such doctor and clinic in any attempts by such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

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. I have read and fully understand this agreement.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

SIGNATURE OF INSURED/GUARDIAN: _____ **DATE:** _____



NOTICE OF PRIVACY PRACTICES

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

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed by us. It also tells how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communication.
5. The right to report of disclosures of your information; and
6. The right to a paper copy of this notice.

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Practices contains information about how we will insure that your information remains private.

If you have any questions about this Notice of Privacy Practices, the name and phone number of our contact persons are listed on this page.

Effective Date of This Notice: July 24, 2006
Contact Persons: Dr. Brian Yomtov & Sally Yomtov
Phone Number: (203) 316-8477

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of Advanced Chiropractic & Wellness' Notice of Privacy Practices. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the person state above. I further understand that Advanced Chiropractic & Wellness will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changed in any way.

Print Patient or Representative Name

Signature of Patient or Representative

Date

Patient refused to sign Patient was unable to sign because: _____