Cappiello Chiropractic, PLLC
562 Saratoga Road
Scotia, NY 12302
(P)518.399.2252 (F)518.399.4712
cappiellochiro@gmail.com

Our mission is to deliver exceptional comprehensive care to all of our patients. We believe in improving, educating, and maintaining optimal health for everyone in a professional and compassionate environment. We promise to devote ourselves to excellence and always remain open-minded to possibilities, keeping up with ever changing advances in health science. We are a family style practice, consisting of dads, pregnant moms, children, and grandparents, where everyone finds himself or herself comfortable, and where our chiropractic team is enthusiastic and caring to our patients and one another. Our goal is to build long lasting relationships where our patients feel right at home.

****Appointment Changes:**

We respect the importance of your time, and we work very hard to schedule appointments that can accommodate the busy scheduling needs of our patients. In return, we ask that you make every effort to keep the reserved appointments. Broken and missed appointments create problems for other patients, as well as for the practice. ***If you must change an appointment, we require a minimum of 24 hours notice so that we may accommodate another patient.*** **Effective October 1st, 2018, a *$30.00 fee will be assessed for patients who fail to cancel and/or reschedule the appointment within 24 hours of their appointment. If you are scheduled for a Monday appointment that you need to change, we must be notified no later than 12pm on the Friday prior.***

****Insurance:**

Unless arrangements have been approved in advance by our staff, ***Cappiello Chiropractic is a cash practice, and payment in the forms of cash, check, or credit card (Visa/MC only) is expected at the time services are rendered***. We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact our office promptly for assistance in the management of your account. We will provide you with the necessary documentation so that you may submit to your insurance company and collect on your claims. ***Please understand that your insurance benefit is between yourself and your chosen insurance company. It is your responsibility to know and understand your own insurance plan, including in network or out of network chiropractic benefits. No chiropractic insurance plan will cover all chiropractic needs, and not all services (such as exams, x-rays, surface EMGs, and orthotics) are a covered benefit. Any treatment is your financial obligation, regardless of chiropractic insurance.***

****Medicare Patients:**

Please understand that Medicare only pays for ***ACUTE DYSFUNCTIONAL CARE*** – they do ***NOT*** pay for maintenance/chronic care. ***If you are functional, there are no covered chiropractic benefits. Also, updated images are required on an annual basis, and surface EMGs (scan) are required every 6 months***. ***Cappiello Chiropractic is required to adhere to these specific Medicare guidelines, and it is of absolute necessity that any Medicare patients seen here in our office also adhere to these guidelines.***

We are very happy to welcome you as a new patient!

Signature:_____Date:_____

Printed name:_____

REGISTRATION INFORMATION

Date_____

Patient_____
Last Name First Name Initial

Street_____

City_____State_____Zip_____

Phone#_____ Email Address_____

Sex↑ M↑ / F↑ Age___ Birthdate_____↑Single ↑Married ↑Widowed ↑Separated ↑Divorced
↑Employed ↑Full-Time Student ↑Part-Time Student

Patient's School Name_____

Patient Employed By_____

Business Address_____

Occupation_____Business Phone_____

Who is responsible for this account?_____Relationship to Patient_____

Spouse (or responsible party) Name_____Birthdate_____

Social Security #_____ Spouse's Social Security #_____

Referred by: _____

Case History

Name_____Date_____
Address_____ State_____
Number of children/Ages_____ Have you ever received Chiropractic Care?_____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system and spine, which can result in poor health. Following your exam, Dr. Cappiello will outline a course of care, which will begin to connect these layers of damage and to help you recover your inborn/innate health potential.

Loss of Wellness

Let's begin at birth, when you may have first damaged your nervous system/spine, lost wellness, and began your journey to your present health.

Please circle Y or N for each of the following:			Patient Comment If Answer is Yes	Chiropractor's Comments
1. Regarding your birth process:				
Was the delivery long/difficult?	Y	N	_____	_____
Forceps or extraction used?	Y	N	_____	_____
Cesarean/ C –Section?	Y	N	_____	_____
Breach/ Cephalic?	Y	N	_____	_____
Home Birth?	Y	N	_____	_____
Hospital Birth?	Y	N	_____	_____
Mother given drugs during delivery?	Y	N	_____	_____
Was labor induced?	Y	N	_____	_____
2. Regarding your Growth and Development? Childhood:				
Were you breast fed?	Y	N	_____	_____
Were you taught how to care for your spine?	Y	N	_____	_____
Childhood Illnesses?	Y	N	_____	_____
Ear infections/ Colic/ Asthma?	Y	N	_____	_____
Attention Deficit?	Y	N	_____	_____
Accidents?	Y	N	_____	_____
Drugs, including prescription?	Y	N	_____	_____
Surgery?	Y	N	_____	_____
Did you fall down the stairs?	Y	N	_____	_____
Chair pulled out from you when you sat down?	Y	N	_____	_____
Were you ever yanked by your arm?	Y	N	_____	_____
Did you have other traumas?	Y	N	_____	_____
Did you ever break any bones?	Y	N	_____	_____
3. Current Health Habits:				
Did/ Do you smoke?	Y	N	_____	_____
Did/ Do you drink alcohol?	Y	N	_____	_____
Diet, do you eat healthy foods?	Y	N	_____	_____
Have you been in any accidents/ trauma?	Y	N	_____	_____
Have you had surgery and any organs removed/ replaced?	Y	N	_____	_____
Drugs, including prescription?	Y	N	_____	_____
Teeth problems?	Y	N	_____	_____
Eye problems?	Y	N	_____	_____
Hearing problems?	Y	N	_____	_____
Exercise regularly?	Y	N	_____	_____
Do you sleep well?	Y	N	_____	_____
Did/ Do you have occupational stress?	Y	N	_____	_____
Physical stress?	Y	N	_____	_____
Emotional/ Mental stress?	Y	N	_____	_____
Hobbies/ Sports injuries?	Y	N	_____	_____
Sleeping posture? Side Stomach Back			_____	_____

Turn over and complete other side, please!

Symptoms and Present State of Health:

Previous years of unnoticed and or unattended damage to the nervous system and spine may show up as acute or chronic symptoms.

Present complaint/ reason for seeking care in this office? _____

Pain or Problem started on: _____

Pains are: Sharp Dull with ache Constant Intermittent Other

Does this pain radiate, or travel in your body? Where? _____

Are you experiencing numbness or tingling in any area of your body? Where? _____

What activities aggravate your condition/ pain? _____

What activities lessen your condition/ pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routines? _____

Is this condition progressively getting worse? _____

Please circle where your pain level is: 0 being no complaint/ no pain, 10 being worst possible complaint/pain

0 1 2 3 4 5 6 7 8 9 10

Have you seen other Doctors for this condition? _____

Any home remedies? _____

Please mark any of the following that you now or have experienced?

_____ Headaches	_____ Pain in Hands or Arms	_____Chest Pains
_____ Neck Pains	_____ Numbness in hands or arms	_____ Heart Attack
_____ Sleeping Problems	_____ Pain in legs or feet	_____ High Blood Pressure
_____ Low back pain	_____ Numbness in legs or feet	_____ Stroke
_____ Nervousness	_____ Fatigue	_____ Cancer
_____ Tension	_____ Depression	_____ Painful Urination
_____ Irritability	_____ Lights bother eyes	_____ Diabetes
_____ Dizziness	_____ Loss of memory	_____ Constipation
_____ Pain between shoulders	_____ Shoulder Pain	_____ Stomach upset
_____ Neck Stiff	_____ Sinus	_____ Diarrhea
_____ Joint swelling	_____ Shortness of breath	_____ Menstrual Changes
_____ Fever	_____ Asthma	_____ Weight Loss
_____ Loss of balance	_____ Allergies	_____ Loss of smell or taste

Have you been under drug and medical care?_____

What medications are you taking?_____

How long?_____ Have you had surgery?_____ When?_____

What side effects have you experienced from the drugs and from surgery?_____

Females only- Date last menstrual period began on: _____, Are you possibly pregnant?_____

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's side	_____	_____	_____	_____	_____
Mother's side	_____	_____	_____	_____	_____

About Your Care

There are three phases of care that Chiropractic patients often go through. The first is Initial Intensive Care which corrects the most recent layer of Spinal and Neurological damage. This care often reduces or eliminates the symptoms. Then begins Reconstructive Care, which corrects the years of damage that occurred when there were few symptoms. Finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your Report of Findings. Then you'll be able to begin a course of care that fits your goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's guidelines, to provide me with chiropractic care.

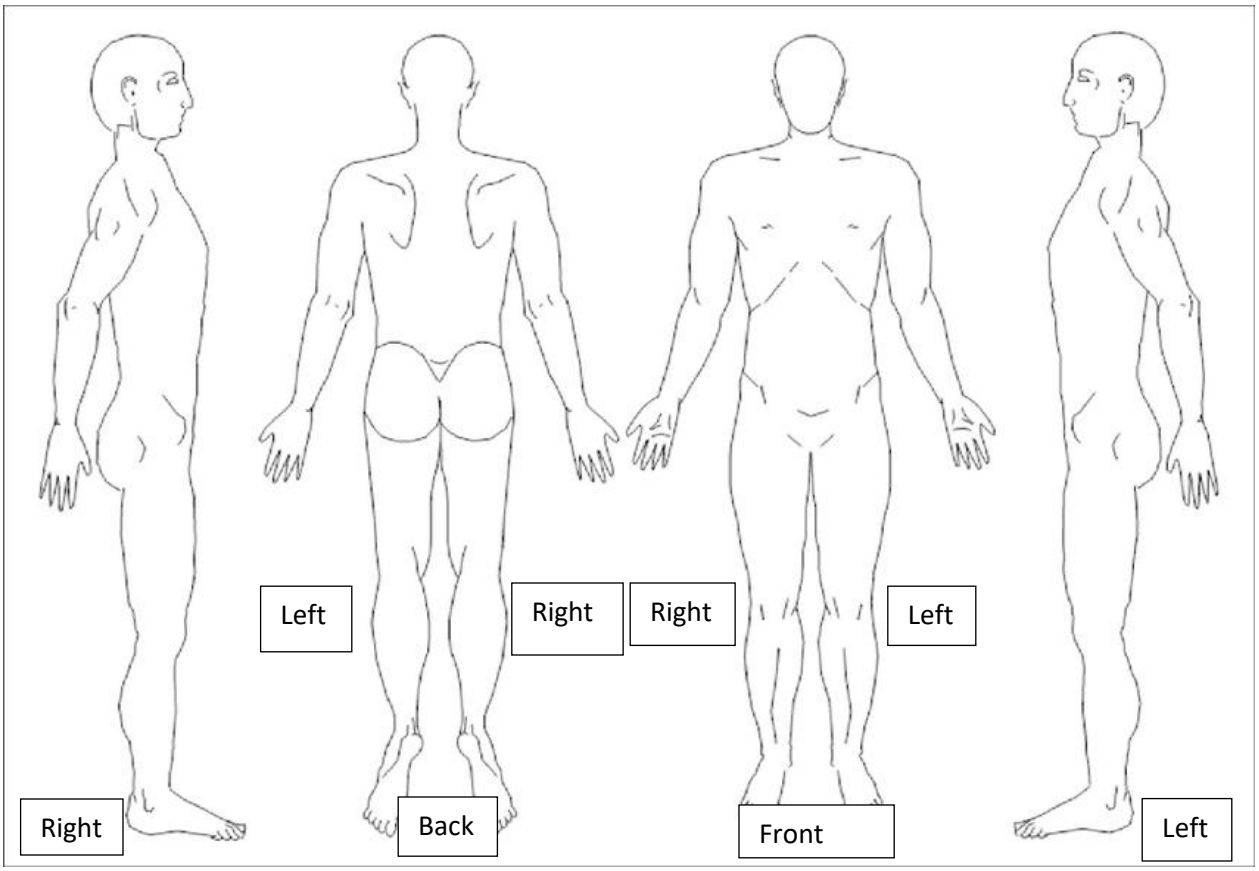
Patient Signature_____Date_____

PAIN CHART

Name: _____ Weight: _____ Height: _____

Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - -	ooooo	^^^^^	xxxxx	*******



Notes:

_____
_____
_____
_____
_____
_____

CAPPIELLO CHIROPRACTIC
PATIENT PAYMENT AGREEMENT

This Chiropractic office expects payment for services performed. To help you in your desire to come under chiropractic care, we offer several payment plans. Please indicate how you intend to pay for these services.

_____ Cash, check credit card (Visa or MasterCard)
_____ Payment plan**

In the event of non payment, I/We understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that Cappiello Chiropractic may add 1.5% per month to any balance owed, and in event of default to pay reasonable collection charges and/or attorney fees.
I authorize this office to charge my credit card, indicated below, for the total amount due to date.

_____ Visa _____ Master Card

Cardholder Name_____

Credit Card #_____

Expiration Date_____ CVC _____

Cardholder Signature_____

Date_____

I understand the information listed above and that this office may report my account to a collection agency to receive payment.

Patient's Signature_____ Date_____

Witness _____ Date_____

*** This office accepts/participates with an extremely limited number of insurance carriers. Please inquire with your insurance carrier and with the office staff to understand your insurance benefits as they relate to this office.**
**** Various payment plans are available depending on need and ability to pay. A minimum dollar amount and payment schedule is required and must be approved by the office staff to receive this plan.**

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Informed Consent to Chiropractic Care

Chiropractic care like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition and, rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instances per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care at Cappiello Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations deemed necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed) Relationship to Patient

Patient or legal Guardian Signature Date

Witness Signature Date

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Due to "new" privacy regulations enacted from former President Clinton (1996) that are in effect as of 2003, the Cappiello Chiropractic Office must have permission from their practice members for certain office procedures that take place within the office and through everyday mailings.

I, _____, give the Cappiello Chiropractic office permission to the following office procedures:

_____display name on the Referral Board
_____ send Birthday and Re-call cards
_____ display Kid-Profile on the wall
_____ Testimonial book
_____ Monthly statements
_____ Name in appointment book in view of counter
_____ Sign in sheet
_____Christmas cards on display
_____patient file on counter/clipboard
_____open door adjusting

This office uses and discloses your protected health care information for the following reasons:

***To share with other treating health care providers regarding your health care.**
***To submit to insurance companies or Workers Compensation Claim to verify that treatment has been rendered.**
***To determine patient's benefits in a health care plan.**
***Releasing information required by State or Federal Public Health law.**
***To assist in overcoming a language barrier when caring for a patient.**
***Business associates providing written assurances for your privacy have been attained.**
***Emergency situations.**
***Abuse, neglect or domestic violence.**
***Appointment reminders to household members or answering machines.**
***Sign-in logs may be disclosed to verify office visits.**

Any other uses or disclosures will only be made with your specific written authorization.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking staff.

I acknowledge that I have received and reviewed this notice with full understanding.

_____ Date_____
Name of Patient (Print) Signature of Patient/Legal Representative