Sports Chiropractic Service
Kenmore Square
654 Beacon St, 2nd Floor
Boston, MA 02215
617-536-1161

Confidential Patient Information

Name			Date
Street Address		City/State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Email Address	Date of Birth Male Female	Current Age	
Social Security # (required to process insurance)	Method of Payment for care or co-payment ☐ Cash ☐ Check ☐ Charge		

Who referred you to our office so we may thank them: _____

Health Insurance Information: PLEASE HAVE RECEPTIONIST COPY FRONT AND BACK OF INSURANCE CARD

Name of Health Company Phone #: ( )	Billing Address	Policy # and Subscriber
Name of Insured	Relationship to insured ☐ Self ☐ Spouse ☐ Child	Insured's Employer
Primary Care Physician Name Address		Phone # : ( )
Employer	Occupation	
Employer Address	City/State	Zip Code

Authorization and Assignment of Benefits

Dr. Peter A.Viteritti, is authorized by me to release any information concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me. I also request payment of government benefits either to me or to the party who accepts assignment on the HFCA-1500 form used to file my insurance.

I authorize payment of medical benefits to the physician or supplier listed on the HFCA-1500 form used by Dr. Viteritti for services described on the said HFCA-1500 form.

I authorize and assign the direct payment to Dr. Peter A. Viteritti of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I give assignment and lien against any claims against a third party whole negligence may have caused my injury, up to the amount of the bill for treatment.

In the event any insurance company obligated by contractual agreement to make payment to me or to you, for the charges made for your services, refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit.

If insurance payment is not received within 60 days from the time insurance is filed, I understand that I will be billed for the remaining balance.

I understand that interest in the amount of 1.5% per month may accrue for any balance over 60 days and that any balance over 120 days may be turned over to collections and I will be responsible for any and all collection and attorney fees. I waive the Statue of Limitations regarding the doctor's right to recover.

Signed _____ Date _____

Patient Name _____

Problem Focused History

Please list your major complaints in order of severity, with number one being most severe:

1.	4.
2.	5.
3.	6.

Complaint #1

What is the exact location of your symptoms?
When did you first notice this condition?
Did it begin ☐ immediately or ☐ gradually? Briefly describe:
Do your symptoms spread? ☐ Yes ☐ No Where?
How often do you experience these symptoms? ☐ Constant ☐ Frequent (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)
Is this condition progressively: ☐ Worsening ☐Improving ☐ Unchanged
Rate your symptoms on a scale of 1 to 10 (1 being minimal and 10 being severe) 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
Please indicate the quality of your symptoms ☐ Dull ☐Sharp ☐ Burning ☐ Aching ☐ Stiff ☐ Sore ☐ Pins/Needles ☐ Tingling ☐ Numb
Please indicate what activities provoke or aggravate your condition. ☐ Sitting____ min. ☐ Standing ☐Walking ☐Lying ☐ Lifting _____lbs. ☐ Driving ☐ Heat ☐ Cold ☐ Coughing ☐ Sneezing ☐ Bowel Movements ☐ Bright Lights ☐ Bending ☐Other_____ ☐ Other_____
Please indicate what helps to alleviate the symptoms. ☐ Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat ☐ Cold ☐ Medications Other_____ ☐ Other_____

Please list any doctors or therapists you have previously consulted with for this conation. Please indicate diagnoses, treatment received, length of treatment and any changes in your condition.

Please indicate any other relevant history in regards to this complaint.

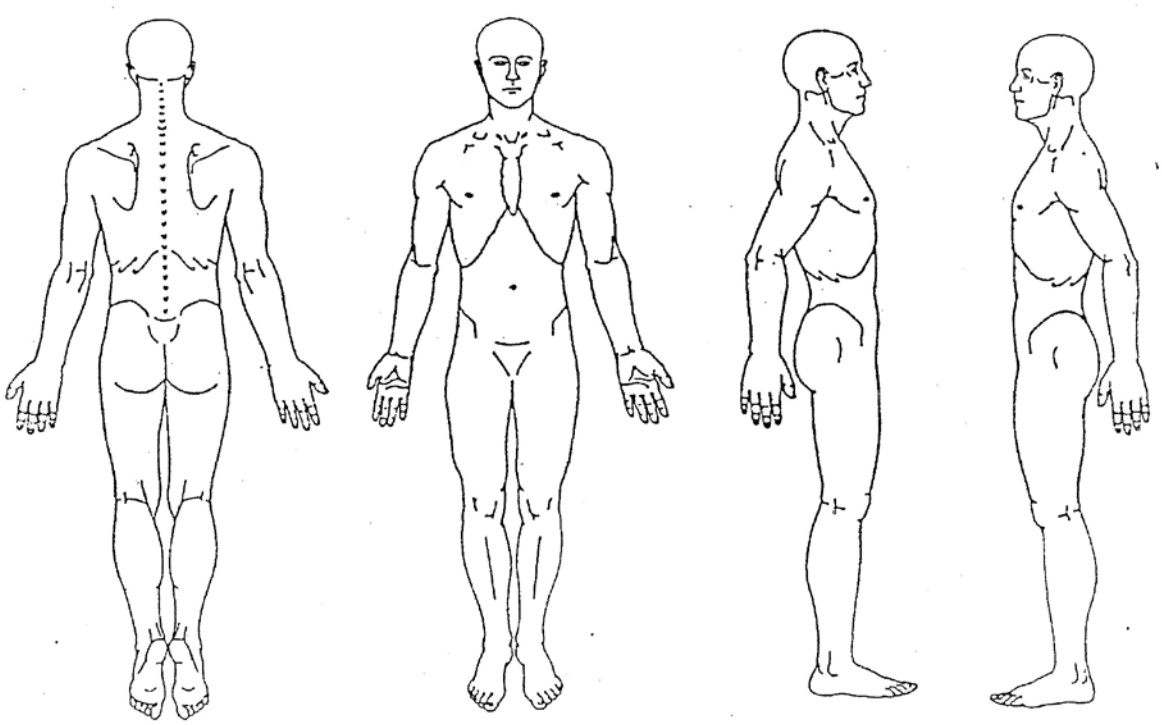
SYMPTOM DRAWING

Patient's Name: _____ Today's Date: _____

Please read carefully:

Mark the areas of your body where you feel your symptoms. Use the appropriate symbol(s) listed below.

Aching	>>>>>>>>	Tingling	########	Soreness	********
Burning	XXXXXXXX	Numbness	========	Stiffness	^^^^^^^^
Stabbing	////////	Throbbing	++++++++	Tightness	√√√√√√√√
Pins and Needles	oooooooo	Dullness	<<<<<<<<	Sharpness	□□□□□□□□



Severity Scale

0 being normal and 10 being severe. Indicate your degree of severity.

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Appointments: 617-536-1161
Billing or financial inquiries: 617-332-3905

Financial Policy: Dr. Peter Viteritti

Please note Dr. Viteritti is not affiliated with Joint Ventures Physical Therapy and Fitness. Any questions regarding billing or financial matters should be directed to the numbers listed above. Thank you.

THIS FORM MUST BE READ AND SIGNED PRIOR TO RECEIVING ANY SERVICES FROM THIS OFFICE.

Payment is expected at the time of service unless other financial arrangements are made.

For patients who self-pay we offer a significant "Time of Service" discount. It is not a cash discount as checks or credit cards are also accepted. Additional discounts are available for self- pay packages of 6 or more visits and only apply if paid in advance of service.

Many insurance policies do cover chiropractic services. Below are the carriers which Dr. Viteritti has agreed to participate with. NOT ALL OF THESE PLANS COVER CHIROPRACTIC BENEFITS. Please be sure to contact your carrier for update coverage information.

AETNA
Blue Cross Blue Shield
Cigna
Harvard Pilgrim Healthcare

There are numerous plans within each of these insurance carriers and it is impossible for us to know what your particular benefit coverage may be. Since your plan is a contract between you and your insurance carrier, it is your responsibility to verify if Dr. Viteritti is a provider on your particular plan. You will be asked to provide a unique Tax Identification Number for Dr. Viteritti which is 20-1417404. When possible, we will also call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We will not be held responsible for any benefits misquoted by your insurance carrier. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.

By your signature below, you acknowledge that you have read and understand the financial policy while receiving treatment at this office and that you have or will contact your insurance company regarding any chiropractic coverage.

Name: _____ Date: _____

HIPPA Notice of Privacy Practices

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with this reminder/information and understand that:

I may be contacted by: telephone, at home or work, cell phone, or by postcard. **Messages may be left: ( )** on answering machine, voicemail at work, on my cell phone; or with individuals answering my telephone at home or at work.

(Please place a line through any method that you refuse to be contacted by and initial.)

Information that we use or disclose based on this authorization may be subjected to re-disclosure by anyone that has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organization to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become affected once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (164.524).

I authorize the disclosure of my health information as described above and I acknowledge that I have received a copy of Dr. Peter Viteritti's Privacy Practices and Protected Health Information.

_____	_____	_____
Patient Name (printed)	Patient Signature	Today's Date