Health Care Chiropractic Centre

CONFIDENTIAL CHIROPRACTIC NO-FAULT INTAKE FORM

Date: ___ /___ /_____

First Name_____ MI____ Last Name_____ Date of Birth_____

Address_____ City_____ State_____ ZIP_____

Social Security #_____ Martial Status (S) (M) (W) (D) Spouse_____

Contact: Home _____Cell _____Work _____Cell Carrier_____

Personal Email_____ Work Email_____

Contact Preference: Home ☐ Cell ☐ Work ☐ Emergency Contact_____ Phone_____

Occupation_____ Employer_____

Employer Address_____

Whom may we thank for referring you to our office? _____

Past History: Have you… If yes, please list the date and the name of the treating provider.

Been hospitalized in the last five years? Yes ☐ No ☐ _____

Do you smoke? Yes ☐ No ☐ How often? _____
Do you drink alcohol? Yes ☐ No ☐ How often? _____
Do you drink caffeine? Yes ☐ No ☐ How often? _____
Do you exercise? Yes ☐ No ☐ How often? _____

Medications:

List any medications you are currently taking, the dosage amount, and how frequently you take them.

Please include all non-prescription and over the counter vitamins, herbs, minerals, etc.

_____

_____

Allergies:

List any allergies and reactions you have if applicable:

_____

_____

Surgeries:

List any surgeries you've had, the date the surgery was performed, and the treating provider:

_____

Medical History:

List all your past medical history conditions:

_____

_____

List all your family's medical history conditions:

_____

_____

Please answer each question thoroughly about your accident:

Date of accident: ___ /___ /_____ What time did the accident occur? _____

Describe your accident in detail:

_____

_____

_____

Driving Role: ☐ Driver ☐ Passenger in the front ☐ Passenger behind the driver

☐ Passenger behind the front seat passenger

If you were the driver, were you gripping the steering wheel? ☐ Yes ☐ No

Were you aware the collision was to take place? ☐ Yes ☐ No

Were you unconscious? ☐ Yes ☐ No

Car Type: Yours _____ Theirs _____

How fast were you going? _____ MPH How fast was the other vehicle going? _____MPH

Road Conditions: ☐ Wet ☐ Dry ☐ Icy ☐ Snow

Visibility: ☐ Excellent ☐ Fair ☐ Good ☐ Poor

Were you wearing seatbelts? ☐ Yes ☐ No Were you looking straight ahead? ☐ Yes ☐ No

Headrest Position: ☐ Low ☐ Middle ☐ High

Did any part of your body make contact with the car? ☐ Yes ☐ No

If yes, where? _____

Were paramedics called? ☐ Yes ☐ No

Were you taken to the hospital? ☐ Yes ☐ No

If yes, which hospital? _____

How long were you admitted? _____

If no, did you seek medical attention elsewhere? [ ] Yes ☐ No

If yes, which doctor(s) did you see and when did you see them?

_____

_____

Have you seen any improvement under their care? ☐ Yes ☐ No

Have you been released from their care? ☐ Yes ☐ No

Since the accident have you missed any work and or school? ☐ Yes ☐ No

If yes, how many days have you missed? _____

Has the injury from your accident affected your ability to perform at your job? ☐ Yes ☐ No

Describe your normal routine at work: _____

Has the injury from your accident made it more difficulty to perform tasks at home or socially? ☐ Yes ☐ No

Have you had any automobile accidents in the past? ☐ Yes ☐ No

If yes, please state what date(s) and briefly describe:

_____

_____

Please answer the following in relation to the problem(s) you are currently experiencing:

Complaint I:

Where are you experiencing pain? _____

When did the pain occur? _____

What caused this pain? If you are unsure, please state so.

_____

Have you experienced similar pain in the past? ☐ Yes ☐ No

If so, please state how long ago you've experienced this pain before:

_____

What is the intensity of your pain?

☐ Mild ☐ Moderate ☐ Severe

☐ Mild to Moderate ☐ Moderate to Severe

Please rate the pain from 1-10 (1 = little pain | 10 = excruciating pain) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Describe the nature of your pain:

☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Tightness

☐ Stabbing ☐ Throbbing ☐ Radiating Pain. Where is the pain radiating into?

_____

☐ Other, please describe:

_____

How frequently do you experience this pain?

☐ 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 makes the pain worse? _____

What makes the pain better? _____

Complaint II:

Where are you experiencing pain? _____

When did the pain occur? _____

What caused this pain? If you are unsure, please state so.

_____

Have you experienced similar pain in the past? ☐ Yes ☐ No

If so, please state how long ago you've experienced this pain before:

_____

What is the intensity of your pain?

☐ Mild ☐ Moderate ☐ Severe

☐ Mild to Moderate ☐ Moderate to Severe

Please rate the pain from 1-10 (1 = little pain | 10 = excruciating pain) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Describe the nature of your pain:

☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Tightness

☐ Stabbing ☐ Throbbing ☐ Radiating Pain. Where is the pain radiating into? _____
☐ Other, please describe:
_____
How frequently do you experience this pain?
☐ 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 makes the pain worse? _____
What makes the pain better? _____

Complaint III:
Where are you experiencing pain? _____
When did the pain occur? _____
What caused this pain? If you are unsure, please state so.
_____
Have you experienced similar pain in the past? ☐ Yes ☐ No
If so, please state how long ago you've experienced this pain before:
_____
What is the intensity of your pain?
☐ Mild ☐ Moderate ☐ Severe
☐ Mild to Moderate ☐ Moderate to Severe
Please rate the pain from 1-10 (1 = little pain | 10 = excruciating pain) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Describe the nature of your pain:
☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Tightness
☐ Stabbing ☐ Throbbing ☐ Radiating Pain. Where is the pain radiating into? _____
☐ Other, please describe:
_____
How frequently do you experience this pain?
☐ 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 makes the pain worse? _____
What makes the pain better? _____

Please answer the following regarding your medical coverage:

Who is your insurance carrier for this claim? _____

What is your policy number? _____

What is your claim number? _____

What is the medical billing address for this claim (if you have it)?

_____

_____

Have you retained an attorney? ☐ Yes ☐ No

If yes, what is your attorney's name? _____

What is their contact number? _____

What is their address? _____

_____

Please carefully read below and sign.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 professional services rendered me will be immediately due and payable.

_____ ___ /___ /_____

Patient Signature Date

_____

Parent/Guardian's Signature

If patient is under 18 years of age

Health Care Chiropractic Centre **Dr. Steven B. Goldstein** **215 Atlantic Avenue Suite A**
516-887-1001 **Lynbrook, New York 11563**

TERMS OF ACCEPTANCE/CONSENT TO TREATMENT

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- **Adjustment**: An adjustment is the specific application of forces to facilitate the body's correction of the vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.
- **Health**: A state of optimal physical, mental and social well-being; not merely the absence of disease or infirmity.
- **Subluxation**: A misalignment of one or more of the 26 vertebrae in the spinal column which is caused by an alteration of nervous system function and interference with the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a Chiropractic neurological examination, we encounter Non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to find and remove vertebral subluxations. Our only method is specific adjusting to correct neurological subluxations.

I hereby consent to and authorize the administration of all diagnostic and Chiropractic treatments that may be considered advisable or necessary in the judgment of Health Care Chiropractic Centre. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier me. Furthermore, I understand that while Health Care Chiropractic Centre may prepare necessary reports and forms to assist me in making collections from the insurance company, all services rendered to me are charged directly to me and I am personally responsible for payment. In addition, all co-pays and any other form of financial patient responsibilities are due at the time of service.

I have read, understand, and agree to Health Care Chiropractic Centre's Terms of Acceptance/Consent to Treatment.

Signature (parent/guardian, when applicable): _____

Date: _____

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HIPPA NOTICE OF PRIVACY PRACTICES

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 describes how Health Care Chiropractic Centre may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your doctor, 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 Health Care Chiropractic Centre, and other use required by law.

TREATMENT: Health Care Chiropractic Centre will use an disclose your PHI 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, Health Care Chiropractic Centre would disclose your PHI, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your PHI will be used, as needed, to obtain payment from your insurance company for your health care services.

HEALTHCARE OPERATIONS: Health Care Chiropractic Centre may use or disclose, as needed, your protected health information in order to support the business activities of Health Care Chiropractic Centre. The staff at the office may use a sign-in sheet at the registration desk where you will be asked to sign your name, may call you by name in the waiting room when the doctor is ready to see you, may use or disclose your PHI as necessary to contact you to remind you of your appointment by leaving a voicemail message on the contact numbers listed on your intake form.

- ✓ **I give Health Care Chiropractic Centre permission to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday-related cards, newsletters, information about treatment alternatives, or other health-related information.**
- ✓ **If Health Care Chiropractic Centre contacts me by phone, I give them permission to leave a message on my voicemail or answering machine.**
- ✓ **Health Care Chiropractic Centre may also contact me via text message or e-mail for appointment reminders or missed appointments. I may also request to opt-out of receiving text messages and e-mails.**

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your doctor has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request to receive confidential communications 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 In an alternative medium, such as electronically.

You may have the right to have your doctor amend your PHI. 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 such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

If you believe that Health Care Chiropractic Centre has violated your privacy rights, you may file a complaint with Dr. Steven B. Goldstein at Health Care Chiropractic Centre, 215 Atlantic Avenue Suite A, Lynbrook, NY 11563.

I have read, understand, and agree to Health Care Chiropractic Centre's Notice of Privacy Practice.

Signature (parent/guardian, when applicable): _____

Date: _____