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

Health Care Chiropractic Centre

CONFIDENTIAL CHIROPRACTIC INTAKE FORM

_____
Today's Date

_____ _____ _____
First Name Middle Initial Last Name

_____ _____ ☐Male ☐Female
Social Security Number Date of Birth

_____ _____ ____ _____
Home Address City State Zip

_____ _____ _____
Home Number Cell Phone Work Phone

_____ ☐Single ☐Married ☐Divorced ☐Widowed
Email Address Martial Status

_____ _____
Spouse's Name Emergency Contact and Phone Number

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

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What is your main health concern: _____
Is it: Job Related ☐ Auto Accident ☐ Fall ☐ Home Injury ☐ Other: _____
When did this condition begin? _____ Is it recurring? Yes ☐ No ☐
Is the pain: Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐
Rate the level of severity (1 = minimal, 10 = extreme) _____
What makes your pain/condition worse? _____
What lessens your pain/condition? _____
What time of the day is the condition worse: Morning ☐ Afternoon ☐ Evening ☐ All Day ☐
Is your condition worsening? Yes ☐ No ☐
Is your condition interfering with: Work ☐ Sleep ☐ Social ☐ Other: _____
Have you seen other doctors for this concern? If so, what doctors did you see:

_____

Do you have any X-RAY or MRI reports? If so, what dates were the tests done and at what facility: _____

Have you seen a Chiropractor before? If yes, what was the doctor's name and when was your last treatment date: _____

Women Only: Are you pregnant? Yes☐No☐ Due Date: _____

Please list any medications or supplements you are taking and include dosage and frequency:

_____

_____

Have you had any surgeries? If yes, please list the surgery and the date it was performed:

_____

Have you had any accidents within the past year? If yes, please list the dates and describe:

_____

_____

Have you had any accidents that occurred over a year ago? If yes, please list the dates and describe:

_____

_____

Have you been hospitalized? If yes, please list the dates and the reason for hospitalization:

_____

_____

Do you have insurance coverage? If so, list below:
Primary _____ Secondary _____
Tertiary _____
Are you the policyholder?☐Yes ☐No
If no, who is the policyholder? _____
What is your relation to the policyholder? _____
Policyholder's date of birth? ___ /___ /_____

Please give your insurance card(s) to the front desk to make copies for our records.

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Please check in the boxes for any conditions
that you or your family have or had in the past:

	Yourself	Spouse	Children	Father	Mother
Acid Reflux					
ADHD					
Allergies					
Anxiety					
Arthritis					
Asthma					
Autoimmune problems					
Bed wetting					
Cancer					
Constipation					
Depression					
Diabetes					
Dizziness					
Ear Infections					
Eczema					
Fatigue					
Flu					
Headaches					
Heart problems					
Immune problems					
Indigestion					
Infertility					
Kidney problems					
Liver problems					
Menstrual problems					
Migraines					
Nausea					
Numbness					
Sciatica					
Scoliosis					
Seizures					
Sinus problems					
Stiffness					
Stomach trouble					
TMJ pain					
Ulcers					
Vertigo					
Other (Please explain)					

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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: _____