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34th St. CHIROPRACTIC AND WELLNESS

469 Seventh Avenue
Suite 1302

(212) 268-7366
(212) 643-0430 Fax
34thstreetwellness@gmail.com
www.healthcarechiropractic.com

Last Name:_____ First Name:_____ Sex: M F

Address:_____

City:_____ State:_____ Zip Code:_____

SS#:_____ DOB: _____ Age:_____

Phone:(Home) _____(Work) _____(Cell)_____

Emergency Contact Name:_____ Phone:_____

E-Mail Address: _____

Employment Status: □ Employed □ Unemployed □ Retired □ Student □ Disabled
Marital Status: □ M □ S □D □W Number of Children:_____

Spouse's Name (Parent if minor):_____
How were you referred to our office? Dr._____ Advertisement_____
Friend/Co-Worker:_____ Other:_____

Chief Complaint of Visit:_____
Primary Physician:_____ Chiropractor:_____

Insurance Information: (Please bring card & Identification up to front Desk)

Primary Insurance Carrier:_____ **ID#:**_____
Primary Cardholder Name:_____ **DOB:**_____
Subscriber's Employer Name:_____
Subscribers Address:_____
Secondary Insurance Co. Name: _____ **ID#:** _____

MVA/Worker's Comp:_____
Insurance Company:_____
Claim #:_____ **Date of Loss:**_____
Adjusters Name:_____ **Phone:**_____
Attorney:_____ **Phone:**_____

By signing this form, I certify that the consultations I am having are not related to an automobile or work related accident.

Patient Signature:_____ Date:_____

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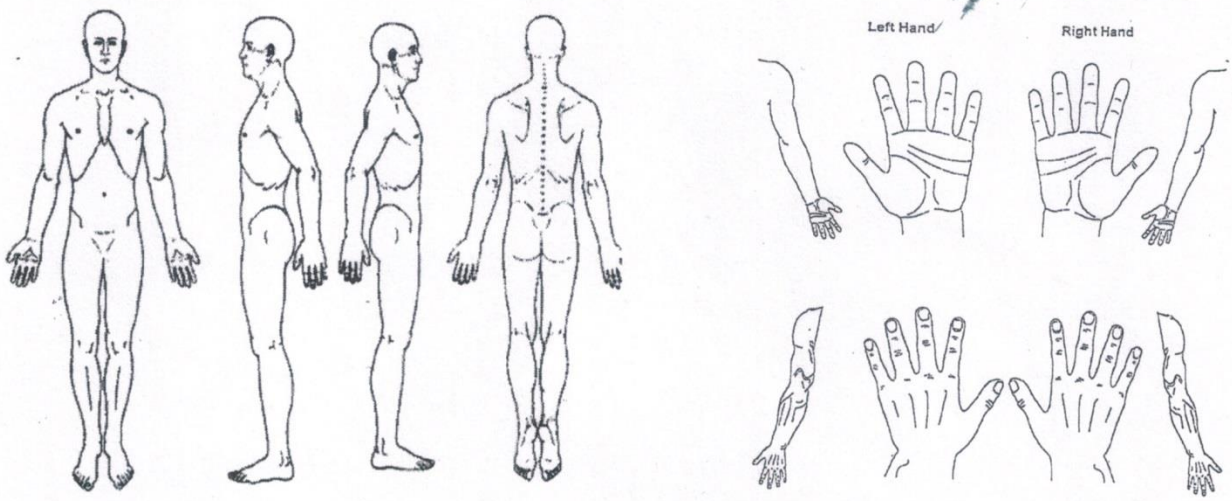
What brought you to our office today?

Please Draw the Location of Your Pain/Problem Using the Symbols Shown Below



D = Dull, B = Burning, N = Numb, S = Stabbing, T = Tingling, C = Cramping, A = Ache

Pain Scale (Please circle the number that best describes the question being asked)												
What is your pain RIGHT NOW?												
no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain possible
What is your TYPICAL or AVERAGE pain?												
no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain possible
What is your pain level AT ITS BEST?												
no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain possible
What is your pain level AT ITS WORST?												
no pain	0	1	2	3	4	5	6	7	8	9	10	worst pain possible

Patient Name: _____ Exam Date: _____

Pain Information (Please mark all that apply)
What caused your pain?
When did your pain start?
Is your pain a result of a motor vehicle or workplace accident or injury? ☐ Yes, ☐ No **If yes, please describe:**
How often does the pain occur? ☐ Constantly (76-100% of the day) ☐ Frequent (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)
What makes your pain better? ☐ Sitting ☐ Standing ☐ Lying ☐ Sleeping ☐ Ice ☐ Heat ☐ Stretching ☐ Medication ☐ Activity
What makes your pain worse? ☐ Sitting ☐ Standing ☐ Lying ☐ Sleeping ☐ Ice ☐ Heat ☐ Stretching ☐ Medication ☐ Activity

Previous Care (Please indicate all care you have received for your current complaint)			
Treatment	**Date(s)**	**Percent Improvement and Care Received**	
Medical/Primary Care			Date of Last Physical
OB/GYN			Date of Last Visit
Orthopedist			
Physical Therapy			
Pain Management			
Chiropractic			
Acupuncture			
Neurologist			
Other			

Patient Name: _____ Exam Date: _____

Previous Imaging (Please indicate all imaging studies for your current complaint and previous conditions)			
Study	**Date**	**Body Part**	**Facility**
X-Ray			
MRI			
CT			
Nerve Testing			

Medication (Please indicate all medication currently taking & any medication previously taken for your condition)	
Medication	**Dosage**

Allergies
(Please mark all that apply)

Do you suffer from any of the following allergies?

☐ No known allergies ☐ Penicillin ☐ Iodine ☐Anesthesia ☐Latex ☐ Adhesive tape

☐ Other Medication: _____ ☐Food: _____ ☐ Seasonal _____

Surgical History/Hospitalization (Please indicate all surgical procedures/hospitalizations for current or previous conditions)	
Date	**Surgery/Hospitalization**

Medical History
(Please mark all that apply)

Venous Dz

Do you suffer from any of the following?

☐ ankle swelling ☐ leg cramps ☐ aching/throbbing ☐ leg burning ☐ heaviness

☐ open sores ☐ red warm areas ☐ restless legs ☐ spider veins ☐ varicose veins

OB/GYN

Do you suffer from any of the following?

☐ Severe cramps ☐ hot flashes ☐ pelvic pain ☐ fibroids ☐ urinary problems

☐ night sweats ☐ inability to lose weight ☐ irregular or heavy bleeding

☐ bleeding between periods

Medical History
(Please mark all that apply)

Do you suffer from any of the following?

☐ Lightheadedness ☐ dizziness ☐ nausea ☐ pain prevents sleep

Patient Name: _____ Exam Date: _____

ACTIVITES DISCOMFORT SCALE

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't hurt at all	Hurts a little	Hurts very much	Almost unbearable	Unbearable pain prevents activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing stairs					
9. Carrying					
10.Pushing and pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					
TOTAL					

DATE: _____ SCORE: _____ (72)

HIPPA NOTICE

PATIENT AUTHORIZATION FOR CONTACT REGARDING HEALTH RELATED SERVICES
THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO OBTAIN THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

In the course of your case as a patient at 34th Street Chiropractic & Wellness, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you to further testing, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine or one may be sent to your email address. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office regarding those matters. Should you decide to not provide us such authorization, your care will not be affected in this office. Under federal law, we are also permitted or require using or disclosing your health information without consent or authorization under the following circumstances:

- Should we provide health care services to you based on the orders of another health care provider
- Should we provide health care services to you as an emergency
- Should we be required by law to provide care to you and are unable to obtain your consent after attempting to do so
- Should there be substantial communication barriers between you and our office and our office's professional judgment believes you intend for our office to provide care
- Should we be ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as described in the examples outlined above will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive care.
You have the right to inspect and/or copy your health information for seven years from the date the record was amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.
We are required by the state and federal law to maintain the privacy of your patient files and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.
We further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. Should changes be made to our privacy notice, we will notify you in writing as soon as possible. Should you have any concern regarding the information we use or disclose based on this privacy notice, our privacy practices, or any aspect of our privacy practices, please contact Faye Taylor at the office.

Patient Name Patient Signature Date

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Assignment of Benefits Form

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies
- I permit a copy of this authorization to be used in place of the original.
- I authorize and assign the health insurance benefits to which I am entitled (including any checks I may receive directly from insurance) to my Care Provider for their services.
- I authorize my Care Provider to release all information necessary to secure the payment of benefits.
- I understand that my Care Provider may submit insurance claims as a courtesy to me; however, in some cases exact insurance benefits cannot be determined until the insurance company receives my claim. In the event that the service is not covered, **I am aware that I am financially responsible for any and all services provided to me.** This will also include any pillows, cushions, nutritional supplements, or any other durable medical equipment supplied to me, or my minor.
- Upon a 30-day default this account may be placed with our collections agency.
- I have signed this authorization in my Care Provider's office on the date below.

Name _____

Signature _____ Date _____

PATIENT FINANCIAL STATEMENT

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any unpaid balance by my insurance company.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the Office Manager. If an account in not paid within 90 Days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process my insurance claims.
- I fully understand that 34th Street Chiropractic & Wellness has the right to charge a fee of $25 if I fail to reschedule or cancel my appointment without 24 hours notice for any appointments made for a Massage
- I fully understand the above information and guarantee this form was completed correctly to the best of my knowledge. I know it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

34th Street Chiropractic &Wellness

469 7th Ave Suite 1302

New York, NY 10018

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Consultation and Missed Appointment Agreement

As your massage appointment is reserved specifically for you, 34th Street Chiropractic & Wellness has a cancellation/missed appointment policy. Out of consideration for your massage therapists' time, we ask that you notify us 24 hours in advance if you need to cancel or reschedule your appointment. 34th Street Chiropractic & Wellness will charge a $25 cancellation fee for missed appointments and cancellations without 24-hour notification.

As a courtesy, 34th Street Chiropractic & Wellness will email and/or call you to confirm your appointment 24-48 hours prior to your massage appointment; however it does remain the patient's ultimate responsibility to keep track of his/her appointment(s).

I have read and understand 34th Street Chiropractic & Wellness cancellation/missed appointment policy. I consent to these terms.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____