



## New York Chiropractic Life Center – Tell Us Your Story



Welcome to our office. Thank you for taking a moment to fill out our ***Patient Intake Form***. Please fill this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete, please return it to our front desk **with the authorization checked, signature & date included.** We look forward to serving you.

### **PATIENT INFORMATION – Please Print Clearly**

\*First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ \*Last Name: \_\_\_\_\_

\*Gender: F M \*Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Height: \_\_\_\_\_ \*Weight: \_\_\_\_\_

Married: Yes No Spouse Name: \_\_\_\_\_ Number of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

\*Cell Phone: \_\_\_\_\_ \*Home Phone: \_\_\_\_\_ \*Email: \_\_\_\_\_

\*Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Preferred method of communication Email Phone Text Mail

Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Who Can We Thank for Referring You to Our Office?**

Referring Patient: \_\_\_\_\_ Referring Physician: \_\_\_\_\_ Advertisement: \_\_\_\_\_

Search Engine – Which one? \_\_\_\_\_ Website – Which one? \_\_\_\_\_ Other: \_\_\_\_\_

**Purpose of Your Visit:** Wellness Performance Complaint Injury Other: \_\_\_\_\_

**Is this visit for you alone, or for you and your family?** \_\_\_\_\_

You and your family deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences (subluxations) and keep them out of your life, so that you can heal quickly and live the quality lifestyle that you deserve!

### **Please Briefly Describe:** (If you are here for Chiropractic Wellness Services only, please skip this section)

What are your current symptoms? \_\_\_\_\_ Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

How often does this concern occur? Always Hourly Daily Occasionally

Does this concern interfere with? Work Sleep Daily Routine Other Activities

Are your symptoms worse at certain times of the day? Yes No. If yes, when? \_\_\_\_\_

List anything that aggravates this concern: \_\_\_\_\_

List anything that relieves or improves this concern: \_\_\_\_\_

Have you received professional treatment for this concern? Yes No. If yes, where/when? \_\_\_\_\_

Has this concern occurred before? Yes No. If yes, when? \_\_\_\_\_

Is this the result of an automobile or work-related accident? Yes No

**Personal Health History**

Family / Primary Physician: \_\_\_\_\_ Phone#: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

List any health conditions treated for in last year: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Duration of Care \_\_\_\_\_ Seen for? \_\_\_\_\_

Have you ever been hospitalized Yes No. If Yes, when/why? \_\_\_\_\_

**Women Only:**

Are you pregnant, or do you have any signs of pregnancy?  Yes  No. If yes, how many weeks? \_\_\_\_\_

Last day of menstruation: \_\_\_\_\_ Are you planning to get pregnant in the next 12 months?  Yes  No

**Family Health History:** (Please check all that apply)

Mother’s Side:  Heart attack  Arthritis  Cancer  Diabetes

Fathers Side:  Heart attack  Arthritis  Cancer  Diabetes

Please list any additional diagnosed health conditions and untimely deaths of your immediate family members: \_\_\_\_\_

Your oldest grandparent on record lived to the age of: \_\_\_\_\_

**Health Habits and Life Choices:** (Please check one in each section)

**Alcohol:** daily weekly occasionally never

**Drugs:** daily weekly occasionally never

**Water:** daily weekly occasionally never

**Tobacco:** daily weekly occasionally never

**Soft drinks/Caffeine:** daily weekly occasionally never

**Exercise:** daily weekly occasionally never

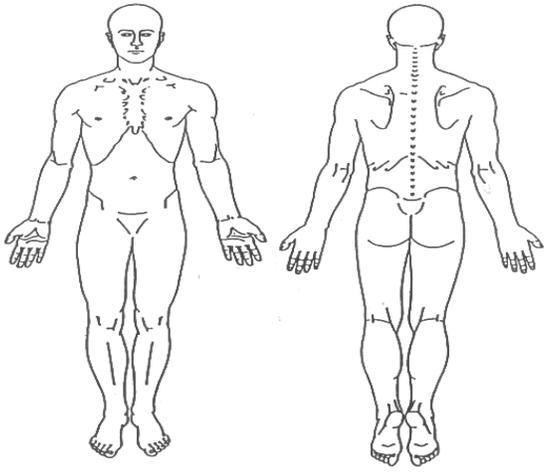
**Health Problems and Concerns:**

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Neck Pain          | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Loss of Balance      | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Back Pain          | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Loss of Memory       | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Numbness           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Sleeping Problems  | <input type="checkbox"/> Pins/Needles _____ | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Nosebleeds           | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Cold hands / feet  | <input type="checkbox"/> Swelling of Ankles  | <input type="checkbox"/> Ears Ringing/Buzzing | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Bedwetting         | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Bruise Easily       | <input type="checkbox"/> Sinus Infection      | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Poor Posture       | <input type="checkbox"/> Thyroid Condition   | <input type="checkbox"/> Headache             | <input type="checkbox"/> Swollen Joints    |
| <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Digestion Problems  | <input type="checkbox"/> Other: _____         |  |

**PATIENTS: Please fill in diagram below**

Using the letters below, please mark on these figures the area and type of altered sensation you are experiencing.

- P = Pain            T = Tingling        S = Stiffness
- B = Burning        N = Numbness       M = Muscle Spasm



**DOCTOR'S NOTES:**

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**Recommendations:**  X-rays  Ice/heat  MRI

**Patient Accepted:**  YES  NO  Referred

**Doctor's Signature:** \_\_\_\_\_

**Date** \_\_\_\_\_

I have reviewed the information contained on this form with the patient.

*Upon the completion of your first visit, you will receive a Chiropractic Report (On your second visit) to discuss your exam finding and the different types of Active Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family live as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.*

**As a result of my Chiropractic care, I would like to: (please check all that apply)**

- Feel better quickly
- Increase performance
- Have a healthier spine and nervous system
- Live a healthier lifestyle

**Authorization**

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 understand both the objective and the method that will be able to attain it. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 a health care provider who specializes in that area. 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 eliminate a major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations. I authorize this office and its staff to examine and care for my condition as the doctors see fit. I consent to the collection and use of the above information by New York Chiropractic Life Center and authorize the doctors to release all information necessary to any insurance company, attorney, or adjuster for purposes of claim reimbursement of charges incurred by me. I grant the use of my Signed Statement of Authorization for required insurance submissions. I understand and agree that all fees for professional services rendered to me are ultimately my financial responsibility, will be charged to me, and that I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will immediately become due upon suspension or termination of my care. I certify that I am the patient or legal guardian listed above. I have read/understand and completed the included information and certify it to be true and accurate to the best of my knowledge.

\* **I agree with the above statements**

Name of Insured / Financially Responsible: \_\_\_\_\_  
(Please Print)

Patient's / Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Finance:**

How do you plan to pay for care?  Personal Insurance  Third Party Insurance  No insurance-Self pay  Flex Spending Acc.

Name of party responsible for payment: \_\_\_\_\_ Responsible party Phone: \_\_\_\_\_

**\*If you intend to use your Insurance, Worker's Compensation or No Fault Insurance towards your care,**

**Please fill out the information on the back of this page\***

**Health Insurance Information & Verification:**

<b><u>Primary Insurance</u></b>	<b><u>Secondary Insurance</u></b>
Insurance Name:	Insurance Name:
Phone:	Phone:
Address:	Address:
City, State, Zip:	City, State, Zip:
ID/Policy#:	ID/Policy#:
Group:	Group:
Insured's Name:	Insured's Name:
Insured's Date of Birth:	Insured's Date of Birth:

**If auto accident, please provide:**

Claim: \_\_\_\_\_  
Insurance Contact Person: \_\_\_\_\_  
Insurance Phone: \_\_\_\_\_  
Attorney's Full Name: \_\_\_\_\_  
Attorney's Phone: \_\_\_\_\_

**If Worker's Compensation, Please Provide:**

WBC Case #: \_\_\_\_\_  
Carrier Case # \_\_\_\_\_  
Patient's Job title/Description: \_\_\_\_\_  
\_\_\_\_\_

New York Chiropractic Life Center  
91 Central Park West  
New York, NY 10023  
212-580-3350  
www.NewYorkChiropractic100.com

Handt Family Chiropractic  
3 Allisyn Court  
New City, NY 10956  
845-263-3033  
www.HandtChiropractic.com

# ABOUT MEDICARE COVERAGE

The government's Medicare program only pays Doctors of Chiropractic (DCs) for limited services. If your needed Chiropractic Adjustment (manipulation treatment) meets Medicare's rules, they will usually pay for it. There are three categories of Medicare services: 1) non-covered 2) always covered, and 3) perhaps covered.

## NON-COVERED

According to existing Medicare law, most of the available services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then:

### Examples of Non-Covered Charges

#### *All Services Other than Chiropractic Adjustments*

- \* Office visits – to evaluate and manage, re-evaluate, advise or counsel.
- \* Physiotherapy – i.e. massage, traction, electrical stimulation, neuromuscular re-education, etc.
- \* X-Rays, Laboratory, Supplies, Vitamins, etc.

#### *Various Chiropractic Adjustments*

- \* Adjustment on an area other than the spine (to the shoulder, arm, leg, etc.)
- \* Maintenance care – you are stable and not making any more improvement
- \* Wellness care – to promote better health.

NON-Covered items will appear on your insurance claim form. They will show as a Medicare NON-Covered service like this: "72010-GY". The "72010" code is for an x-ray. The "-GY" code means that it is not covered, allowing your service to go through the Medicare system. After denial by Medicare, it can then go on to your other insurance. If you have Medigap insurance (also known as Medicare Secondary or Supplemental insurance), they will pay according to the terms of your contract.

## ALWAYS COVERED

A typical example of a Medicare COVERED service (or clinically needed) is when you are in much pain due to a bad spinal condition. You should also expect Medicare to cover and pay for your rehabilitation as long as you are improving. When you have a COVERED chiropractic spinal adjustment (manipulation treatment), it will be shown on your Medicare claim form and payment reports as either "98940," "98941," or "98942."

## PERHAPS COVERED

Your Chiropractic Adjustment must be clinically needed according to Medicare. If Medicare thinks that your condition is not "Medically Necessary" they won't pay. If we know or believe that Medicare will not pay for your Chiropractic Adjustment due to any rules that they might have, we will let you know. We will give you a specific Medicare form known as the Advance Beneficiary Notice (ABN).

## STATEMENT OF UNDERSTANDING

I understand that I am personally financially responsible for all Medicare NON-covered services. I also understand that there could be times when my chiropractic adjustments might not be covered. If so, my doctor will let me know. I am also responsible for any annual deductibles or applicable co-payments as required by Medicare.

\_\_\_\_\_  
Signature of patient or person acting on patient's behalf

\_\_\_\_\_  
Date

## LONG-TERM AUTHORIZATION

You won't have to sign again during this time period. This authorization can be revoked upon your written request.

Patient Name: \_\_\_\_\_ Medicare # (HICN) \_\_\_\_\_

Provider Name:  
\_\_\_\_\_

Provider Address:  
\_\_\_\_\_

Authorization Period: From: \_\_\_\_\_, 20\_\_ To: \_\_\_\_\_, 20\_\_ (must be completed to be valid)

I request that payment under the Medicare insurance program be made either to me or to the provider named above on any bills for services furnished to me during the effective period of this authorization, and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers, or to any other payer any information needed to process claims. I further permit a copy of this authorization to be used in place of the original.

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

A. Notifier:

B. Patient Name:

C. Identification Number:

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
X-rays Therapy Nutrition Supports Theriputic Pillows Massage Maintenance care	Medicare only pays for correction of vertebral subluxation by adustments to the spine	\$35 - \$210 depending on procedure and/or product

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### G. OPTIONS: Check only one box. We cannot choose a box for you.

**OPTION 1.** I want the D. \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the D. \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the D. \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

### H. Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

## Chiropractic Office

### INFORMED CONSENT TO RECEIVE CHIROPRACTIC CARE

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to correct vertebral and extremity subluxations. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked,” and you may feel movement of the joint. Various professionally accepted ancillary procedures, such as hot or cold packs, therapeutic exercise, neuro-muscular re-education, manual therapy, therapeutic massage or traction may also be used.

**Possible risks:** As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include muscle strain, ligament sprain, dislocation of joints, bone fracture, or injury to intervertebral discs, nerves or spinal cord. In extremely rare cases, cerebrovascular injury, or stroke, could occur upon severe injuries to the arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of care. The ancillary procedures could produce minor complications.

**Probability of risks occurring:** The risk of complications due to chiropractic treatment have been described as “rare,” about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million. The probability of adverse reaction due to ancillary procedures is also considered “rare.”

**Other treatment options** in lieu of Chiropractic Care that could be considered may include the following:

- **Over the counter analgesics.** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- **Medical care,** typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- **Hospitalization** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- **Surgery** in conjunction with medical care will complicate the condition and make future correction and rehabilitation more difficult.

I have read the explanation above of chiropractic care. I have fully evaluated the risks and benefits of undergoing chiropractic treatment. I have had the opportunity to have all my questions answered to my satisfaction. I have freely decided and choose to undergo the recommended chiropractic care, and hereby give my full consent to care and treatment.

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Printed Name

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Signature

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Date

Chiropractic Office

**TERMS OF ACCEPTANCE**

**At The New York Chiropractic Life Center**, 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, and that is to eliminate vertebral subluxations. On a daily basis, we experience physical, chemical and emotional stresses that often accumulate and result in these vertebral subluxations, which in turn can cause a serious loss of health and well-being. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential. Often times, the effects of these vertebral subluxations are gradual in nature and can remain undetected until they become severe. Symptoms are usually the last things to show up in the disease process and the first to disappear as the correction begins

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine, by hand or mechanical means.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of infirmity.

We do not offer to diagnose or treat any disease. We only offer to diagnose vertebral subluxations and associated conditions. However, if during the course of a chiropractic spinal 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 that specializes in that area.

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 eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

**CARE CHOICES:** Patients come to our office for a variety of reasons.

**Crisis/Relief Care:** symptomatic pain relief (patch-up care). It corrects the most recent layer of spinal or neurological damage.

**Reconstructive/Corrective Care:** cause of problem corrected as well as symptomatic relief (fix-up care). Concerned with corrected years of damage that occurred when there were few symptoms

**Wellness/Maintenance Care:** for relief and spinal correction in addition to looking forward to maintaining heightened state of wellness and vitality.

**Please choose type of care that best fits your health and life style goals.**

Relief care    Corrective Care    Wellness care    I would like the doctor to select the appropriate care \_\_\_\_\_ (initial)

I understand that no guarantee of assurance will be made or has been made to the results that may be obtained. I further understand that if my care requires x-rays to be taken, the fee paid for this service is for analysis only. The actual films are the property of The New York Chiropractic Life Center. Once films are used for the purposes of care, they cannot be released. Copies may be made if necessary, at a nominal fee.

I clearly understand and agree that all fees for services rendered to me are ultimately my responsibility.

I, \_\_\_\_\_, have read and fully understand the above statements.  
(please print your name) **Initial and Date** \_\_\_\_\_ / \_\_\_\_\_

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

**Pregnancy Release:**

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: \_\_\_\_\_ **Initial and Date** \_\_\_\_\_ / \_\_\_\_\_

**Consent to evaluate and adjust a minor / child**

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ have fully read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

# INSURANCE POLICIES & GUIDELINES

**The purpose of this letter is** to let you know how our office works in the handling of your insurance claims. We do this to help eliminate any questions while informing you of all our procedures and policies in advance. This better enable us to serve your health care needs effectively and efficiently. In this way, policies can be followed as intended.

**We itemize all our procedures.** The reason for this is to let the insurance company personnel know exactly what was done on each visit and why. In reporting to insurance companies, we are responsible to them on your behalf to accurately inform them as to your condition, status, any complications, exacerbations, unusual circumstances, etc., that would affect your recovery. We are also responsible for letting them know how long we anticipate your care will be, and at what frequency. All this involves a tremendous amount of staff and professional time and expense. However, we do this as a service to you. It lessens your burden of having to communicate with the insurance company, it lessens the responsibility and threat regarding when insurance no longer will cover care, and it makes care easier and more enjoyable for you. All we ask is your cooperation. Our usual procedures and their cost are the recommended fees set forth by the NYS insurance guidelines and are listed separately, a copy will be provided upon request.

**Because we itemize and document** every procedure in accordance with insurance protocol rather than just describe what is being done as an "office visit," the charges per visit can vary depending on level of documentation & procedures per visit for the actual office visit, plus any additional charges for all special procedures performed. **For various reasons, we know that there are a lot of charges that will not be paid** by your insurance company, i.e.: maximum dollar amount limits per visit, procedures that the policy does not cover, etc. However, we still have to bill customary fees for all services we perform as required by you insurance Co. to adequately communicate with the insurance company in your best interest. It is the nature of insurance companies to question and adjust reimbursement fees.

**Our experience shows** that an insurance company that receives billings that describe your visit to an office as an "adjustment" or an office visit, does not understand what is being performed on that visit and why. Some have taken the position that billings sent in this generic way, without any diagnostic criteria to objectively determine what adjustment is needed on that visit, is incomplete. Insurance companies are not familiar with the principles of Chiropractic, and they look on this practice in reporting the same way they would if an MD. were to just

randomly give out shots or pills to every patient without first determining whether or not that patient actually needed anything done on that visit.

**Some companies** pay 100%, some pay 90%, some pay 80%, some pay 50%, some pay for x-rays but not examinations, some pay for examinations but not x-rays, some pay only for an adjustment, some pay everything BUT the adjustments. MEDICARE often pays only for 12—15 visits a year, demanding that x-rays be taken but not paying for them nor the examinations the patient must have, and the list goes on and on. We only state this so that you are aware of the practices that exist within the insurance industry.

**Family care:** For those patients who choose NOT to participate in our Family program, **you are responsible for your DEDUCTIBLE and all CO-PAYMENTS** do toward your patient portion that your policy demands you must pay. If you have a special financial situation that makes this difficult or impossible for you, you have only to speak to one of the staff and arrangements will be made so you can receive the care you need at a fee you can afford. We cannot, however, read minds . . . you must tell us. Then we can help you!

**When you choose to participate in our Family program,** any charges that your insurance company does not pay (*other than your deductible*) will NOT be billed to you. Your co pay is covered by your financial plan. We still have to report to your insurance company in a manner that informs them what is being performed, whether we are paid for it or not. **We accept only those patients we truly feel we can help regardless of condition or financial ability!!** This policy allows us to care for everybody based on THEIR NEEDS .

**ANY CORRESPONDENCE THAT YOU RECEIVE FROM YOUR INSURANCE COPANY MUST BE BROUGHT TO US SO THAT WE MAY HAVE A COPY OF IT FOR OUR RECORDS** (often the patient receives information that is vital to processing a claim that never finds its way to the doctor's office, such as the explanation of benefits . . . (the stub attached to a check), a scheduled independent examination, a scheduled hearing, etc. We ask that you please help us by bringing all documentation to us as soon as you receive them.

**Please understand** it is our purpose to obtain maximum coverage towards your care from your insurance company. In this way, we can help everybody achieve great health through chiropractic. By fully participating in the above policies, you help make this possible.

**Please sign your name below indicating that you have read the above and understand it. Thank you . . .**

Name (Please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

**Chiropractic Office**

# Chiropractic Office

## AUTHORIZATIONS AND RELEASES

**Patient name** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Relationship To Insured       Self       Spouse       Child       Other

<b>EMPLOYER</b>	Company Name _____ Occupation _____ Address _____ Phone _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time City _____ State _____ Zip _____
<b>SPOUSE (PARENT)</b>	Name _____ <small style="display: flex; justify-content: space-between; width: 100%;"> <span>Last Name</span> <span>First Name</span> <span>Initial</span> </small> Birth date _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____
<b>PATIENT INSURANCE INFORMATION</b>	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID #: _____
<b>SPOUSE COINSURANCE INFORMATION</b>	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured : _____ ID #: _____
<b>MEDICAL AND LEGAL INFORMATION</b>	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? <input type="checkbox"/> Yes <input type="checkbox"/> No      Your Initials: _____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No      Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No      Family Physician _____ Person to contact in emergency (Name and Phone #) _____  Attorney _____ Telephone: _____ Address _____

**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to New York Chiropractic Life PLLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

\_\_\_\_\_  
 Signature of Insured / Guardian      Date      \_\_\_\_\_      Witness      \_\_\_\_\_      Date

# The Primary Care Low Back Disability Questionnaire (PCLBDQ)

FAX (800) 599-8350

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ____/____/____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

**Instructions:** This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please **circle the choice which most closely describes your problem.**

## SECTION 1 – Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is very severe.
- F. The pain is severe and does not vary much.

## SECTION 2 – Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

## SECTION 3 – Lifting

- A. I can lift heavy weight without pain.
- B. I can lift heavy weight, but it gives me pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned- e.g., on a table.
- E. Pain prevents me from lifting heavy weights, but can manage light-medium weights if they are conveniently positioned.
- F. I can only lift very light weights at the most.

## SECTION 4 – Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk using a stick or crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

## SECTION 5 – Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than 1hour.
- D. Pain prevents me from sitting more than ½ hour.
- E. Pain prevents me from sitting more than 10 minutes.
- F. Pain prevents me from sitting at all.

## SECTION 6 – Standing

- A. I can stand as long as I want without pain.
- B. I have some pain on standing but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. Pain prevents me from standing at all.

## SECTION 7 – Sleeping

- A. I get no pain in bed.
- B. I get pain in bed but it doesn't prevent me from sleeping well.
- C. Because of my pain my normal night's sleep is reduced by <¼.
- D. Because of my pain my normal night's sleep is reduced by <½.
- E. Because of my pain my normal night's sleep is reduced by <¾.
- F. Pain prevents me from sleeping at all.

## SECTION 8 – Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted by social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

## SECTION 9 – Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain restricts all forms of travel except that done lying down.

## SECTION 10 – Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening

**Office Use Only PCLBDQ SCORE:** \_\_\_\_\_

I understand that the information I have provided above is current and correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

With permission: Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

**Mailing address:**  
Landmark Healthcare, Inc., 1750 Howe Avenue, Suite 300, Sacramento, CA 95825

KAM120307

# Neck Disability Index Questionnaire

FAX (800) 599-8350

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ____/____/____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

**Instructions:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem right now.**

## SECTION 1--Pain Intensity

- A. I have no pain at the moment
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

## SECTION 2--Personal Care (Washing, Dressing etc.)

- A. I can look after myself without causing pain.
- B. I can look after myself normally but it causes pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

## SECTION 3--Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

## SECTION 4 --Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

## SECTION 5--Headache

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

## SECTION 6 -- Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

## SECTION 7--Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

## SECTION 8--Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my car at all because of severe pain in my neck.
- F. I cannot drive my car at all.

## SECTION 9--Sleeping

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

## SECTION 10--Recreation

- A. I am able engage in all recreational activities with no pain in my neck at all.
- B. I am able engage in all recreational activities with some pain in my neck.
- C. I am able engage in most, but not all recreational activities because of pain in my neck.
- D. I am able engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all

**DISABILITY INDEX SCORE:** % \_\_\_\_\_

I understand that the information I have provided above is current and correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Chiropractic Office

## **THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at The New York Chiropractic Life Center, we may use or disclose personal and health related information about you in the following ways:

\*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, 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 they are or may be responsible for the payment of your services.) \*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, 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 to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

\*If we are providing health care services to you based on the orders of another health care provider. \*If we provide health care services to you in an emergency. \*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so. \*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care. \*If we are 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 chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences. You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an 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 state and federal law to maintain the privacy of your patient file 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 are 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. If changes are made to our privacy notice, we will notify you in writing as soon as change in our privacy notice will apply for all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: New York State Insurance Dept.

If you would like further information about our privacy policies and practices please contact: Dr. Handt, DC

### **Patient Authorization for appointment reminders, Sign in sheets and scheduling related matters**

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive.

If you choose not to authorize this information use your decision will have no adverse effect on your care from Dr. Handt or your relationship with our staff.

This notice is effective as of \_\_\_\_\_ . This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

\_\_\_\_\_  
Name (Printed please)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are a minor, or if you are being represented by another party

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of the authority to act on behalf of the patient.

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

