

ABOUT YOU

First Name _____

Middle Name _____

Last Name _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____

ZIP Code _____

Mobile Phone ____-____-____

Work Phone ____-____-____

Home Phone ____-____-____

Email _____

Date of Birth ____ / ____ / ____

Gender Male Female

Height ____' ____"

Weight _____ lbs

Marital Status Single Married Separated Divorced Widowed Other

Number of Children _____

Spouse's Name _____

EMERGENCY CONTACT INFORMATION.

Name _____

Phone ____-____-____

Relation To You _____

INSURANCE INFORMATION

Do you have Insurance? Yes No

Insurance Name _____ Phone ____-____-____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ ZIP Code _____

ID/Policy Number _____ Group Number _____

Insured's Name _____ Insured's Date of Birth ____ / ____ / ____

REFERRAL INFORMATION.

Referring Physician _____ Contact information. _____

Referring Patient _____

Are you working with an attorney? Yes No

How did you hear about us?

Word of mouth Advertisement Social media Direct marketing Internet

REASON FOR VISIT

What is the date of your scheduled appointment? _____ / _____ / _____

How long have you had this complaint?

- Less than 5 days (Acute)
- Between 5-30 days (Sub Acute)
- More than 30 days (Chronic)

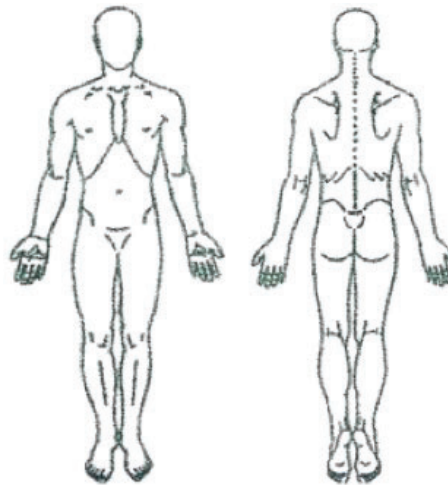
What caused this condition _____

What is the date this condition began? (Skip if due to accident) _____ / _____ / _____

What term(s) describes your discomfort best? _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

- P - pain
- N - numbness
- W - weakness
- S - shooting
- A - Aching



On a scale of 1 to 10, with 10 being the most severe, how do you rate your discomfort?

None 1 2 3 4 5 6 7 8 9 10 Unbearable

How often do you feel this discomfort? Constant Frequent Occasional Intermittent

How has this complaint changed since the onset? Worsened Remained the same Improved

What activity is most significantly affected by this discomfort? (Explain) _____

What treatment, if any, have you received since the injury? _____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

Have you ever had any previous episodes of this condition? _____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones or Joints No Yes **Explain:** _____

Nerves, Headaches, Dizziness, or Emotional No Yes **Explain:** _____

Head, Eyes, Ears, Nose or Throat No Yes **Explain:** _____

Heart, Blood Pressure, or Circulation No Yes **Explain:** _____

Shortness of Breath, Coughing, Asthma or Lung Condition No Yes **Explain:** _____

Stomach, Bowels or Digestive Conditions No Yes **Explain:** _____

Genital, Bladder, or Urinary Conditions No Yes **Explain:** _____

Diabetes, Thyroid or Glandular Conditions No Yes **Explain:** _____

Skin or Bleeding Conditions No Yes **Explain:** _____

Do you have any medication allergies? No Yes **Explain:** _____

WORK SOCIAL HABITS

Current work habits - Choose all that apply.

- Permanently fully disabled
- Permanently partially disabled
- Cannot work due to current condition
- Full-time (20-40+ hours/week)
- Part-time (1-19 hours/week)
- Retired Student Homemaker Unemployed

Personal social habits - Choose all that apply.

- Smoke or use tobacco products
- Drink alcohol
- Drink caffeine
- Use recreational drugs
- Other, to be discussed with doctor

Present exercise habits - Choose all that apply.

- No current exercises
- Exercises daily
- Exercises 3+ times per week
- Cannot return to exercise due to current condition

Diet and nutrition habits - Choose all that apply.

- Vegan or vegetarian
- Daily supplements
- Other

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm 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 become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ **Date:** ____ / ____ / ____

New Patient Acknowledgements

Patient Name: _____

Consent to Treatment

Initial

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment from Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC and I authorize this office and its staff to examine and treat my condition as the providers see fit. I consent to practice services, and I understand, acknowledge and affirm that such services (chiropractic, physical therapy, acupuncture, massage therapy, etc.), may involve bodily contact, and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

Authorization to Release/Obtain Information

Initial

I hereby authorize Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC to release all information, verbal and written, necessary to any insurance company, case manager, attorney, adjuster, employer, school, related health care provider, assignees and/or beneficiaries, and all other related persons as it relates to my treatment and/or payment for services provided. I authorize Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Patient Messaging Consent

Initial

By supplying my home phone number, mobile phone number, e-mail address and any other personal contact information, I hereby authorize Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or e-mail accounts) limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Financial Policy/Responsibility

Initial

I agree to pay Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC for the services provided to me or the party named above, if any law, such as Workers' Compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for all account balances. The intake Verification of Benefits form is only an explanation of coverage obtained from my insurance company, and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or if the insurance company changes its coverage, I will be responsible for payment of services. I understand that my good faith payment may not be inclusive of all payments for which I am

responsible, and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any current or initiated legal transaction during or after the course of my treatment unless agreed to in writing by myself and a representative of Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC.

The Emergency Medical Services and Surprise Bills Law requires physicians, ambulatory practices and hospitals to notify patients about the health plans in which they participate and share the names and contact information for all of the providers who will be involved in the patients' scheduled care, including those who are out-of-network. Out-of-network providers must provide patients with a cost estimate upon request, prior to delivering non-emergency care. In emergencies, regardless of whether the provider participates in the patient's health plan, patients will be required to pay only the amount due as if the services were in-network.

Assignment of Benefits

Initial

I hereby appoint Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the services provided from any third-party claim's payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, "my plan"). I authorize Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, "my Plan." I also authorize Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of "my Plan" through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by "my Plan" to Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to Long Island Integrated Chiropractic, Physical Therapy & Acupuncture, PLLC not later than ten (10) days after my receipt.

This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

Initial

I hereby acknowledge that I have been given the opportunity to receive and/or review the office Notice of Privacy Practices. I further acknowledge that a copy of the current policy is available at the front desk and that I may request a copy of any amended Notice of Privacy Practices at any time.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

I certify that I, as patient or Responsible Party, have read this form in its entirety and will abide by the above policies.

Patient or Parent/Guardian Name (Printed)

Patient or Parent/Guardian Signature

Date

HIPAA 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 carefully.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you (“Health Information”). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice’s privacy officer.

TREATMENT

We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

PAYMENT

We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

HEALTH CARE OPERATIONS

We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND HEALTH RELATED BENEFITS AND SERVICES

We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE

When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

RESEARCH

Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

SPECIAL SITUATIONS

As required by law, we will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

BUSINESS ASSOCIATES

We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

ORGAN AND TISSUE DONATION

If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

MILITARY AND VETERANS

If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

WORKERS' COMPENSATION

We may release Health Information for workers', compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS

We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

HEALTH OVERSIGHT ACTIVITIES

We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

LAWSUITS AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

LAW ENFORCEMENT

We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS

We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES

We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

PROTECTIVE SERVICES AND INTELLIGENCE ACTIVITIES

We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

INMATES OR INDIVIDUALS IN CUSTODY

If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

RIGHT TO INSPECT AND COPY

You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes.

To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

RIGHT TO AMEND

If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION

You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office. To file a complaint, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**