42 West 38th st, suite 1204
New York, NY 10018

Tel: 212-320-3722

1) PATIENT INFORMATION

Date:___________________

Last, First Name: ____

Date of Birth:_____________________________ Sex: ☐M ☐ F

Address:____ APT:_____________

City:___________________ State:_______________ Zip Code: ________________________

E-mail:____

Marital Status: ☐Married ☐Single ☐Widowed ☐Separated ☐Divorced ☐Partner

Occupation:____

Patient Employer/School:____

Employer/School Phone: (____)______________________

Primary Care Provider (if applicable): ____

Address:____Tel: (____)____________________

Contact Information

Primary Contact: (____)_________________________Relation to contact:________________

What is the best time and place to reach you?:____

Emergency Contact

Name:_______________________________ Phone number:___________________________

Relationship to patient:_______________________________

2) Accident Information

Is this condition due to an accident? ☐YES ☐NO

If yes please answer the following questions on this section

What is the Date of Accident?_______________________________

What is the Type of Accident? ☐Auto ☐Work ☐Home ☐Other:_______________

If other, please specify:____

To whom have you made a report of your accident? ___________________________________

☐Auto Insurance ☐Workers Comp ☐Employer ☐Other:___________________________

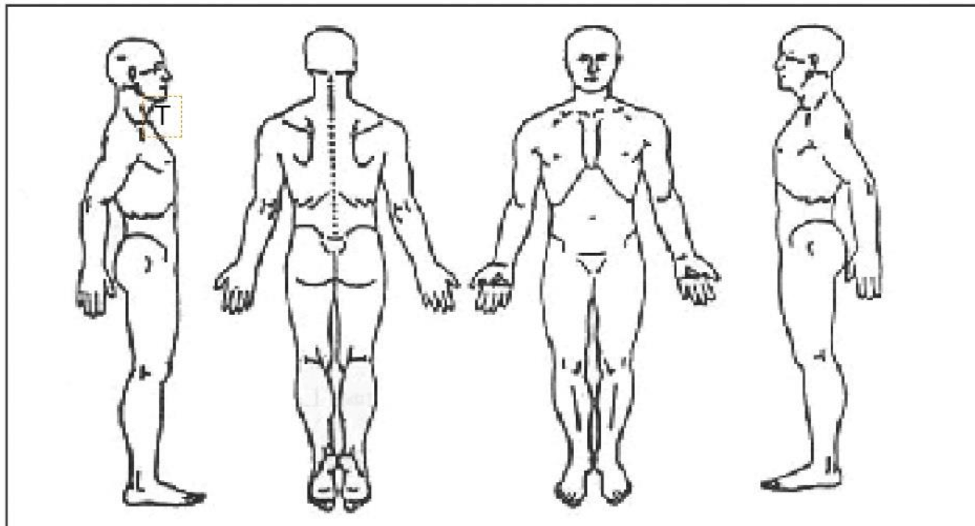
Attorney Name (if applicable): ____

3) <u>What Brings you into the Office Today?</u>

☐Neck ☐Shoulder ☐Low back ☐Hip ☐Headaches ☐Jaw Pain

Other (Please specify): ____

Indicate on the drawing below where you have pain/symptoms



How often do you experience your symptoms?

☐Constantly (76-100% of the time) ☐Occasionally (26-50% of the time)

☐Frequently (51-75% of the time) ☐Intermittently (1-25% of the time)

How would you describe the type of pain?

☐Sharp ☐Numb

☐Dull ☐Tingly

☐Diffuse ☐Sharp with motion

☐Achy ☐Shooting with motion

☐Burning ☐Stabbing with motion

☐Stiff ☐Electric like with motion

☐Other:____________________

How are your symptoms changing with time?

☐Getting Better ☐Staying the Same ☐Getting Worse

On a scale from 0-10 (10 being the worst), how would you rate your pain/problem?(circle)

0 1 2 3 4 5 6 7 8 9 10

How much has the problem interfered with your work?

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

How much has the problem interfered with your social activities?

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

How long have you had this problem for?

____

Although your current complaints have started recently, please note the first time in your life that you can remember having any complaints in the same or similar area:____

____

How do you think this problem began?____

Do you consider this problem to be severe?

☐YES ☐YES, AT TIMES ☐NO

What activities or positions make your pain worse?

____

____

What makes your pain better and what treatments have you tried?

____

____

What concerns you the most about your problem; what does it prevent you from doing?

____

____

HEALTH HISTORY

What would you rate your overall health?

☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

What type of exercises do you do?

☐Strenuous ☐Moderate ☐Light ☐None

Do you have a family history of any of the following?

☐Rheumatoid Arthritis ☐Diabetes ☐Lupus

☐Heart Problems ☐Cancer ☐ALS

Please list all current and past medical conditions you have or had:

Current:____

Past:____

List all prescription medications you are currently taking along with dosage if known (if any):

____

____

List all over-the-counter medications you are currently taking (if any):

____

List all surgical procedures you have had in the past if any and approximate date (if any):

____

What activities do you do at work?

Sit: ☐Most of the day ☐Half of the day ☐A little of the day

Stand: ☐Most of the day ☐Half of the day ☐A little of the day

Computer/desk work: ☐Most of the day ☐Half of the day ☐A little of the day

On the phone: ☐Most of the day ☐Half of the day ☐A little of the day

Have you ever been hospitalized? ☐NO ☐YES

If yes, why?____

Have you had significant past trauma? ☐NO ☐YES

If yes, what kind?____

Anything else pertinent to your visit today? ____

____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____________________ and assign directly to **Link Chiropractic** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-mentioned may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____

Signature of Patient, Parent, Guardian or Personal Representative

____

Please print name of Patient, Parent, Guardian or Personal Representative

_________________ __________________________

Date Relationship to Patient

HIPAA Notice of Privacy Practices

Link Chiropractic P.C.

42 West 38th st, suite 1204, New York, NY 10018

Tel: 212-320-3722

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 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 without entities that have a relationship with you (for example, your health plan) for their healthcare 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 family or a close friend. We also may notify your family about your location and 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 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 of 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 is specific in our contract.

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

Student Health Center. If you are under a student health plan, we may release Health Information as required by your clinician from your student health center.

Worker's Compensation. We may release Health Information for worker's 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 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 a 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 the Health Information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request 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 regarding 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 Restrictions. You have the right to request restriction or limitation on the health Information we use or disclose for treatment, payment, or health care operation. You also have the 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 do not share information about your 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 information needs 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 by mail or at work. To request confidential communications, you must make your request in writing without a privacy officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
Rights 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. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint without office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our privacy officer. All complaints must be made in writing. **YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.**
By subscribing to my name below, I acknowledge receipt of a copy of this notice and my understanding and my agreement to its terms.

______________________________ ______________________________________

Print Patient’s Name Signature of Patient or Guardian and Date

LinkChiropractic

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic examination, adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (for whom I am legally responsible) by the doctor of chiropractic, who now or in the future treat me while employed by, working or associated with or serving as back up for the treating doctor of chiropractic, including those working at the clinic or office listed below or any other offices or clinic.

I have the opportunity to discuss with the treating Doctor of Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to increased symptoms in the treated area, sprains and strains, dislocation, fracture, or stroke. The possibility of such injuries occurring in associations with chiropractic adjustments is extremely remote and minimal. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I also agree that if I refuse to get x-rays even though the doctor best recommends such a procedure to be done, I give the treating doctor permission to treat. I am aware of the risks mentioned above.

I have read or have read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____________________________ ________________________________

Print Patient's Name **Signature of Patient or Guardian and Date**