Chiropractic Health Questionnaire

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Cell Phone Number: _____

Cell Phone Carrier: _____ (we send appointment reminders via text)

Email Address: _____ Age: _____ Birth Date: _____

Marital Status: M S D W Number of Children: _____

Occupation: _____ Referred By: _____

Health Information

What are your complaints? _____

_____

How long have you had this condition? _____

Have you had this condition in the past? _____

What aggravates your condition? _____

Is the condition getting worse? Yes _____ No _____

Constant: Yes _____ No _____ Comes and goes: Yes _____ No _____

Have you had previous chiropractic care? _____

How long has it been since you felt well? _____

Name the Doctors who have treated this condition? _____

List surgical operations and year:

_____

Medications you are presently taking now: _____

Were you ever in an automobile accident? Yes _____ No _____

Please describe and give dates: _____

_____

Chiropractic Health Questionnaire

Were you ever injured at work? Yes _____ No _____

Please describe and give dates: _____

_____

Have you had any other personal injuries or accidents? Yes _____ No _____

Please describe all details and give dates: _____

Date of your last physical examination: _____

Family doctor: _____

HAVE YOU EVER SUFFERED FROM THE FOLLOWING

Dizziness _____ Backaches _____ Heart Trouble _____ Diabetes _____ Arthritis _____

Headaches _____ Asthma _____ Neuritis _____ Digestive Disorder _____

Nervousness _____ Sinus Trouble _____ Neck Pain _____

Are there any other ailments or conditions you have had in the past?

_____

Please list any treatments or Physicians you have had or seen for these conditions:

_____

_____

_____

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Dr. Frank J. Mandarino
Dr. Michael A. Carducci
Dr. Lonnie S. Gross
Dr. Judith Castro
Dr. Alexander Liberman
Chiropractors
2052 Richmond Road, Staten Island, New York 10306
Telephone: (718) 667-2190
Fax: (718) 667-7279

INSURANCE INFORMATION

Is your condition due to an auto or job related injury? YES: _____ NO: _____

Do you have health insurance? YES: _____ NO: _____

Name of Insurance Company: _____ Policy_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date: _____

Guardian's Signature _____ Date: _____

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PATIENT AGREEMENT FOR SERVICES RENDERED

I understand that the insurance payment for the fees incurred for my Chiropractic visits may be sent to me directly.

I agree to endorse and forward any payment or non-payment, along with the Explanation of Benefits and all other documents I receive from my insurance carrier. Copies will be made available to me by the provider. I am also aware that all payments made directly to me will be made known to the provider as well.

Patient Name: _____

Patient Signature: _____

Date: _____