**Island Chiropractic &**
**Next Step Physical Therapy**
of Hicksville

# Patient Information

Name:_____ Sex: M/F Date of birth:_____

Address:_____ City:_____ Zip Code:_____

Cell #:_____ Home #:_____Social Security #:_____

E-Mail:_____ Marital Status (circle one): M S D W Separated

Emergency Contact Person: _____

Relationship to you: _____ Phone #: _____

Physician who referred you to this office: _____

How did you hear about this office?: _____
(if anyone other than your physician)

## Primary Insurance Company

Health Insurance Carrier: _____ Policy Holder: _____

Insurance Card ID#: _____

I understand that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Island Chiropractic & Next Step Physical Therapy of Hicksville, PLLC will prepare any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to Island Chiropractic & Next Step Physical Therapy of Hicksville, PLLC will be credited to my account on 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 to me will be immediately due and payable. In the event of non-payment, I am legally responsible for any collection fees involved in satisfying my debt. I also authorize Island Chiropractic & Next Step Physical Therapy to evaluate and treat me as deemed appropriate by an Island Chiropractic & Next Step Physical Therapy provider.

Signature of Patient or Guardian:_____ Date:_____

Witness:_____ Date:_____

# PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

**Island Chiropractic & Next Step Physical Therapy of Hicksville**
**131 W Old Country Rd**
**Hicksville, NY 11801**
**(516) 681-8070**

**Notice of Patient:**
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections, and other important information.

**Patient Acknowledgement:**
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____
Patient Printed Name

_____
Patient Signature or legal representative

_____
If legal representative, state relationship

_____
Date

**FOR OFFICE USE ONLY:**
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:
___ the patient refused to sign
___we were not able to communicate with the patient
___due to an emergency situation it was not possible to obtain a signature
___other (please provide details):_____

_____
Name of the Patient

_____
Name of Staff Member

_____
Signature of Staff Member

_____
Date

# ISLAND CHIROPRACTIC P.C.

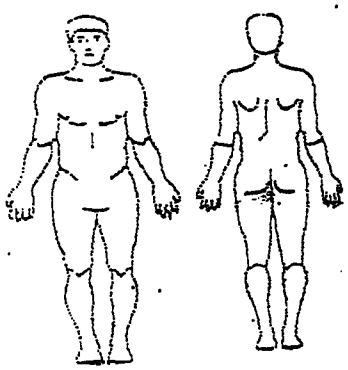
## CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:
Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept yc case.
THANK YOU.

Name_____ Age_____ Marital Status M S W D

## HEALTH INFORMATION

Please mark your areas of pain on the figures below:



Have you had previous chiropractic care? [ ] Yes [ ] No

What is your major complaint? _____

When did your problem begin? _____

Describe how your problem began_____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you been in an accident? [ ] Auto [ ] Work [ ] Other

If yes, when_____ Describe _____

Other doctors who recently treated this condition: _____

Have you had this or similar conditions in the past? [ ] Yes [ ] No [ ] Similar

Are you symptoms [ ] Always present [ ] Frequent [ ] Occasional [ ] On and off

How bad is your pain or ache? (0-no pain, 10- a lot of pain) 0 1 2 3 4 5 6 7 8 9 10

Describe your pain [ ] Sharp [ ] Shooting [ ] Dull/ache [ ] Stiff [ ] Tingling

[ ] Numbness [ ] Burning [ ] Throbbing [ ] Knife-like [ ] Other _____

- CONTINUED ON OTHER SIDE -

## HEALTH INFORMATION (CONTINUED)

| Have you ever suffered from: | Past | Present | | Past | Present |
|---|---|---|---|---|---|
| High blood pressure | [ ] | [ ] | Kidney Stones | [ ] | [ ] |
| Heart problems | [ ] | [ ] | Stroke | [ ] | [ ] |
| Diabetes | [ ] | [ ] | Asthma | [ ] | [ ] |
| Dizziness | [ ] | [ ] | Cancer | [ ] | [ ] |
| Convulsions | [ ] | [ ] | Prostate problems | [ ] | [ ] |
| Loss of bladder control | [ ] | [ ] | Blood disorder | [ ] | [ ] |
| Abdominal pain | [ ] | [ ] | HIV/AIDS | [ ] | [ ] |
| Aortic Aneurysm | [ ] | [ ] | Other | [ ] | [ ] |
| Difficulty in swallowing | [ ] | [ ] | | | |

Sleeping position: Back [ ] Side [ ] Stomach [ ] Pillows: How many ____
Cervical [ ] Orthopedic [ ]

Work Description _____ ____Full time/____ Part time

Age of Mattress _____ Comfortable [ ] Uncomfortable [ ]

List surgical operations and year _____

Are you pregnant? Yes [ ] No [ ]

Present weight ___ lbs. Height ___ feet ___ inches Right handed [ ] Left handed [ ]

**Medication list**

Medication # 1
Date started _____
Drug name_____
Strength_____
Dosage_____
Prescribed by _____

Medication # 2
Date started _____
Drug name_____
Strength_____
Dosage_____
Prescribed by _____

Medication # 3
Date started _____
Drug name_____
Strength_____
Dosage_____
Prescribed by _____

Medication #4
Date started _____
Drug name_____
Strength_____
Dosage_____
Prescribed by _____

**Allergies?** _____

**Smoking Status** (Circle One)

Current Former Never

# CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. 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 the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hope to avoid more invasive procedures. However, like all health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have has 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____

## NO FAULT/AUTO ACCIDENT INFORMATION

**CLAIMANTS NAME** _____

**CLAIMANTS ADDRESS** _____

**PHONE NUMBER** _____

**DATE OF ACCIDENT** _____

**INSURANCE COMPANY** _____

**CLAIM #** _____

**POLICY #** _____

**POLICY HOLDER** _____

**ATTORNEY** _____

**HAS THE ACCIDENT BEEN REPORTED?** YES NO
**HAVE THE INJURIES BEEN REPORTED TO THE INSURANCE COMPANY?** YES NO

**ARE YOU UNDER CARE OF ANOTHER CHIROPRACTOR OR PHYSICIAN?** YES NO
IF YES: NAME _____ ADDRESS: _____

**DID YOU REQUIRE HOSPITALIZATION:** YES NO WHERE _____

**WERE X-RAYS TAKEN?** YES NO BY WHOM? _____

**HAVE YOU LOST TIME FROM WORK DUE TO THIS ACCIDENT?** YES NO DATES____

**ARE YOU PRESENTLY WORKING?** YES NO

**WERE YOU THE** DRIVER PASSENGER PEDESTRIAN
**HOW WERE YOU STRUCK? DESCRIBE YOUR ACCIDENT:**

_____

_____

_____

**LIST YOUR INJURIES AS YOU KNOW THEM:**

_____

_____

_____

PLEASE NOTE SOME NO-FAULT INSURANCE POLICIES HAVE A DEDUCTIBLE. THE DEDUCTIBLE, IF APPLICABLE, IS THE RESPONSIBILITY OF THE PATIENT. THE DEDUCTIBLE MAY NOT APPLY IF YOU WERE THE PASSENGER OF THE VEHICLE. ALL OTHER SERVICES ARE COVERED AT 100% BEYOND THE DEDUCTIBLE.

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to Island Chiropractic & Next Step Physical Therapy of Hicksville PLLC ("Assignee")
(Print patient's name) (Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)

to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Date of signature)

_____
(Address of Patient)

Dr. Jamie Wentz _____
(Print name of Provider) (Signature of Provider)

Island Chiro & Next Step PT
131 Old Country Road
Hicksville, NY 11801

_____
(Date of signature)

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE**
**PAGE 3**

**PATIENT:** Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

**ASSIGNMENT OF NO-FAULT BENEFITS:**

**I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR**

PRINT NAME _____ SIGNED _____ DATE
PATIENT (Assignor) PATIENT

PRINT NAME Brett Pastuch SIGNED _____ DATE
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? [X] YES [ ] NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? [X] YES [ ] NO

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.**

| DATE | PROVIDER'S SIGNATURE | IRS/TIN IDENTIFICATION NO. | WCB RATING CODE IF NONE, SPECIALTY |
|---|---|---|---|
| | | 932108250 | DC |

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.