Chiro First Wellness Center

PATIENT INFORMATION

Date: _____

Name: _____
Last **First** **MI** **What do you prefer to be called?**

Email address: _____

Mailing Address: _____

_____
CITY **STATE** **ZIP**

Phone # **(H)**_____ **(W)**_____ **(Cell)** _____

Can we call you at work? ❑ Yes ❑ No Can we send you text message reminders? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____

_____
CITY **STATE** **ZIP**

Employer Phone #: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

FINANCIAL INFORMATION

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

ID Number: _____

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

Date of Birth: _____

ASSIGNMENT AND RELEASE (INSURED PATIENTS)

I certify that I (or my dependent) have insurance coverage with, _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

HEALTH HISTORY

Who is your primary care physician? (Doctor and/or practice) _____
Phone: _____

Have you been to a chiropractor in the past? If so, what was your experience? _____

What have you heard about chiropractic, positive or negative? _____

Will you use chiropractic as (please check one): ❑ A temporary form of symptom relief **OR** ❑ to maximize your health & avoid the problem from returning?

Are you interested in nutritional/supplemental counseling (please check one): ❑ yes **OR** ❑ no?

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Shoulder Pain	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	❑ Bowel/Bladder Changes
❑ Headaches	❑ Blurred Vision	❑ Night Pain	❑ Asthma	❑ Abdominal Pain

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc(s)	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ kidney disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fracture(s)	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	❑ Heart Disease
❑ Mumps	❑ Other _____			

Are you currently under medical care? ❑ Yes ❑ No If yes, for what? _____

Please list any medications and/or birth control you are currently taking:_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals/protein powder): _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

Have you had COVID-19 in the past? Have you been vaccinated? How many boosters have you received? _____

_____

Please list any allergies: _____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

How often do you exercise:	❑ Frequently	❑ Moderately	❑ Occasionally	❑ None
How often do you utilize alcohol:	❑ Frequently	❑ Moderately	❑ Occasionally	❑ None
How often do you smoke cigarettes:	❑ Frequently	❑ Moderately	❑ Occasionally	❑ None

By signing, I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

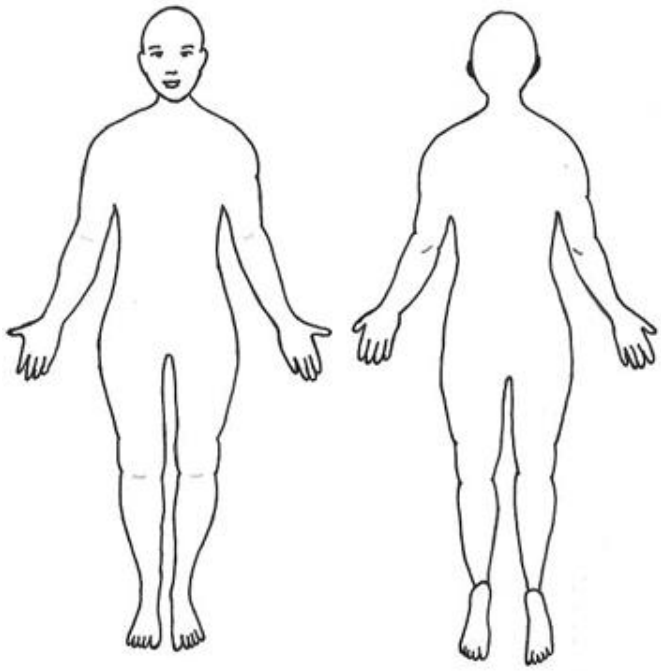
Doctor Initials/Date: _____

PATIENT PAIN DIAGRAM

Name:_____ Date:_____

Using the symbols given below, **mark the areas on your body where you feel the described sensations**. Include all affected areas.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
++++++	========	••••••	XXXXX	ΔΔΔΔΔ	ooooo



Is your pain aggravated by any of the following?

__ Coughing or sneezing
__ Walking a distance
__ When you wake up
__ Lying flat on your back
__ Sitting in a chair
__ Bending forward
__ Lying flat on your stomach
__ In the middle of the night
__ Standing too long

Height: _____ **Weight:** _____ **Right or Left-Handed:** _____

Rate your symptoms on a scale of zero to ten, ten being the worst:

No Pain 1 2 3 4 5 6 7 8 9 10 SEVERE

How often do you feel your symptoms:

❑ Constantly (76-100%) ❑ Frequently (51-75%) ❑ Intermittently (26-50%) ❑ Occasionally (0-25%)

If you didn't have these symptoms, what is the first thing you would do? _____

Have you had any recent imaging? (X-ray, MRI, etc.) Type: _____ Body Part: _____

Facility who performed imaging: _____

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the doctor.

I have read and understand the foregoing.

_____

Patients Signature

Doctor Initials/Date: _____

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I am may be pregnant at this time.

☐ Yes, I am definitely pregnant.

☐ No, I am definitely not pregnant at this time.

☐ I request that x-ray films not be taken because: _____
_____
_____

Date of last menstrual period: _____

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who will follow this notice?

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g., a billing service), sites and location of this practice may share medical information with each other for treatment, payment purposes or heath car operation as stated in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies or prior injuries or surgeries that could influence our treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records

- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment and other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medial information about your, you may revoke that authorization, in writing, at any time. IF you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING:

Disclosures and Changes to Your Medical Information

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or heath care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request you must tell us what information you want to limit.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Amend. If you feel that medical information, we have about you 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. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Your Access to Medical Information

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about your, you must submit your request in writing to the privacy officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed heath care professional chosen by this practice will review your request and the denial. The person conducting the review will not be that person who denied your request. We will comply with the outcome of the review.

Right to a Paper Copy of This Notice. You have the right to a paper 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. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Office at this practice.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communication sent. To request confidential communication, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complains must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

I have read and understand the Notice of Privacy Practices.

_____ _____

Patient's Signature Date

PLEASE READ THOROUGHLY, INITIAL AT EACH SECTION AND SIGN AT THE BOTTOM. THANK YOU.

Authorization to Release Information

_____ I authorize Chiro One Wellness P.C. to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

Information about Possible Risk of Chiropractic Treatment

_____You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure. Two different types of adjustment techniques are used in this office. Primarily, for a large majority of our patients, our office is currently utilizing state- of- the- art technology; therefore, safety is not a concern. In addition to spinal manipulation, treatment can also involve other forms of therapy including ultrasound, electrical stimulation, traction, hot and cold packs, hydrotherapy, infrared heat, low level laser, trigger point, massage, exercise, topical pain-relieving gel, nutritional supplement, and spinal decompression. As with any health procedure complication may arise during treatment. These complications include soreness, muscle or ligament strain, dislocation, fractures, stroke, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Spinal Decompression

_____ You have the right, as a patient, to be informed about the recommended additive therapy spinal decompression. If treatment of spinal decompression is recommended, you understand, as with any healthcare procedure, there may be certain complications that arise. This may include: strains, muscle spasm, disc injury, or worsening pain. This list is not all inclusive. The complications are considered RARE. The most common risk is dull, achy soreness similar to having just worked out for the first time in a long time. This is usually due to stretching of tight muscles that haven't been stretched in this way. This will typically go away within the first week or two of treatments. We will warm the tissues up before treatment and will decompress your spine more conservative at first to prevent as much soreness as we can. It is recommended that you ice for 20 minutes up to 3 times daily for the first week to decrease pain and soreness.

Assignment of Benefits

_____I assign all benefits payable to me for my care to Chiro One Wellness, PC. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care.

Consent for Treatment

_____I authorize the performance of diagnostic tests, procedure and treatment deemed necessary by personnel involved in my care.

Authorization to Treat a Minor

_____ I hereby request my doctor at this clinic to perform diagnostic test and render chiropractic adjustment and other treatment to my minor son/daughter. This authorization also extends to all other doctors in this clinic and is intended to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and condition of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Disc Doctor.

Signature of Patients or responsible party: _____ **Date:** _____

Relationship to Patient: _____

Doctor Signature: _____ Date: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____
Patient DOB: _____
Patient Phone Number: _____

TO: _____
Physician's Name/Office

_____
Street City State Zip

TO BE RELEASED TO:

Dr. Mohamed Munassar
Chiro First Wellness Center
4214 Clinton St.
West Seneca NY 14224

Phone: 716-675-2225
Fax: 716-675-2222
Email: info@chirofirstwellnesscenter.com

_____ _____
Patient's Name (Printed) *Date*

_____
Patient's Name (Signature)

Additional Comments: