PERINTON HILLS
CHIROPRACTIC
your health is in reliable hands

Patient Registration Information

Please print & complete **ALL** sections:

Is your condition a result of a work injury? Yes or No

Is your condition a result of an auto accident? Yes or No

Marital status: Single Married Divorced Widowed Sex: Male or Female

Name:_____SS#:_____DOB:_____

Street address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work phone: _____

Cell phone: _____

E-mail: _____

Employer: _____ Occupation: _____

Insurance carrier: _____ Insurance ID #_____

Group # _____

Who referred you to our office? _____

Have you ever been to a chiropractor before? Yes or No

If YES, when and what for? _____

Reason for today's visit: _____

When did you first notice this problem? _____

Did this condition ever occur before? Yes or No If YES, when? _____

Other physicians treating you for this condition: _____

List all Medications: _____

Please list all previous surgeries, trauma or fractures: _____

_____

_____

Past medical history/family medical history: _____

_____

_____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of last visit: _____

Emergency Contact: _____

Home phone: _____ Work phone: _____

Cellular phone: _____ Relationship: _____

Patient's Signature:

I authorize the release of any medical or other information necessary to process claims regarding medical treatment rendered at Perinton Hills Chiropractic, PC. I also authorize payment of medical benefits to the rendering clinician at Perinton Hills Chiropractic, PC.

Name: _____ Date: _____

Insured's Signature (if different than patient):

Name: _____ Date: _____

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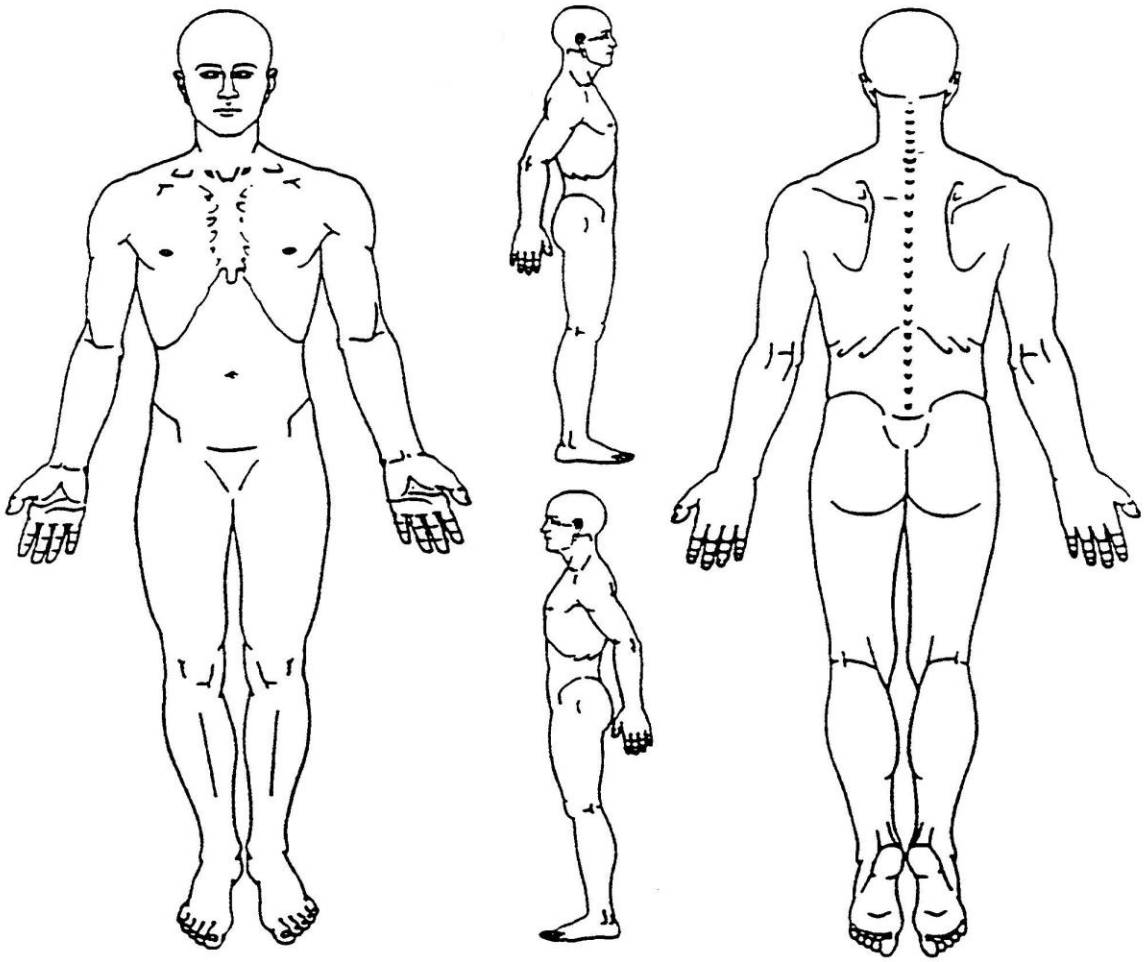
PAIN DRAWING

Name_____ **Date** _____

On the diagram below, please indicate where you are experiencing pain or other symptoms. Use the following to describe your symptoms.

A-Ache **B**-Burning **N**-Numbness **P**-Pins & Needles **S**- Stabbing **O**- Other-Describe: _____

R **L** **R** **L** **R**



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Please rate your current pain level on the following scale (circle one):

(**no pain**) 0 1 2 3 4 5 6 7 8 9 10 (**worst pain**)

Patient's Signature: _____ **Date:** _____

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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient's Name: _____

Address: _____

Phone #: _____ Date of Birth: _____

I _____ hereby authorize and request _____

_____ to furnish the following information about my condition and/or treatment including:

X-Ray: _____ MRI: _____ CT Scan: _____ Notes/Reports: _____

To: Perinton Hills Chiropractic, PC
Dr. Maria C. Zalone
Dr. Kevin M. Sommer

Blackwatch Office Park
6605 Pittsford-Palmyra Rd Suite E3
Fairport, NY 14450
Telephone: (585) 223-2610 / Fax: (585) 223-2646

I understand that this is a required consent and I must voluntarily and knowingly sign this authorization before any records may be released, and that I may refuse to sign, but in that event the records will not be released.

I further release my physician from any liability arising from the release of information to the individual(s)/agency designated herein.

Patient's Signature: _____ Date: _____

Witness: _____

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INFORMED CONSENT

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about potential risks relating to your care to allow you to be fully informed in consenting to treatment.

Specific Risk Possibilities Associated with Chiropractic Care Are:

Stroke: Stroke is the most serious complication of chiropractic treatment. It is extremely rare. Vertebral arteries, which supply the brain with blood, are located within the bones of the upper spine. Therefore, cervical adjustment poses a small risk of stroke, which is temporary or permanent brain dysfunction. Recent studies estimate the risk of stroke to be one in every three million upper cervical spinal adjustments. The risk of a fatal stroke following a cervical spinal adjustment is 0.00025%. As a comparison, the risk of death from NSAIDs (aspirin, ibuprofen, Naprosyn, etc.) is 0.04%. In other words, the risk of death or serious complication is 100-400 times greater for the use of NSAIDs than for the use of cervical manipulation.
Soreness: Chiropractic adjustments are sometimes accompanied with post-treatment soreness. This is normal, but please advise your doctor of chiropractic soreness.
Soft Tissue Injury: Occasionally, chiropractic treatment may aggravate a disc injury or cause a minor joint, ligament, tendon, or other soft tissue injury.
Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken in cases considered at risk. Treatment is performed carefully to minimize such risk.

Chiropractic is a system of health care delivery and, therefore, as with any health care delivery system, we cannot promise a cure for any systems, conditions, or disease. An attempt to provide the best chiropractic care is our goal, and if results are not successful, we will refer you to another health care provider. If you have any questions, please ask your doctor of chiropractic.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

_____ _____
Patient's Printed Name Today's Date

_____ _____
Patient's Signature Parent/Guardian Signature if Minor

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PATIENT FINANCIAL PAYMENT POLICY

The Patient Financial Payment Policy has been developed to help our patients understand their financial responsibilities related to their healthcare and to answer any questions regarding patient and insurance responsibility. If there are any questions regarding your health care benefits, contact your health care plan with their phone number located on your insurance card.

We will keep a copy of your current insurance identification card(s) on file; however, you are responsible to notify us of any changes to your health plan coverage as soon as possible.

As a courtesy to our patients, we participate with most major medical insurance companies. We verify insurance coverage for chiropractic benefits and bill the insurance company accordingly. In the event the insurance company does not pay for services rendered, for any reason, the payment due then becomes the responsibility of the patient.

We accept cash, check or credit card for any payments required below. If there is any financial hardship and you are unable to make payments at the time of service, please discuss payment options directly with the front desk staff.

Co-payments: All copayments must be paid at the time of service. There will be an additional **$25** charge for copayments not received at the time of service.

Deductible Plans: All deductibles must be paid at the time of service. We will electronically verify current deductible amount with your insurance. If this information is not available, you will be asked to make a **$75** payment toward the deductible; you will be billed for the balance after the insurance is processed.

Elective Therapies/ Products/ Supplements: Full payment due at the time of service.

Self-Pay Accounts/ Un-insured: Full payment due at the time of service.

Collection Process: All past due accounts of 120 days or more will be turned over to a collection agency, unless payment arrangements have been previously made. The additional fees associated with the collection agency will be the responsibility of the patient.

Missed Appointments: We require 24-hour notice of appointment cancellation, or a **$35** fee will be incurred on your account. This fee cannot be billed to your insurance carrier. Voicemail cancellations are accepted if adequate notice is given.

Returned Check Charges: There will be a **$45** charge for any check returned to us.

I, _____ have read, understand and agree to the above policy.
Print Name

_____ _____
Signature Date

Perinton Hills Chiropractic, PC

NOTICE OF PRIVACY POLICIES AND PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.
This notice describes how the personal information we collect will be used to disclose. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003 and applies to all protected information as defined by Federal Regulation.

UNDERSTANDING YOUR MEDICAL RECORD/ HEALTH INFORMATION
Each time you visit our office a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal documents outlining and describing the care you received
- Tools that you or another payer (your insurance company) will use to verify that services billed were actually provided
- Basis for public health officials who might use this information to assess and/ or improve state as well as national healthcare standards
- A tool that we can reference to ensure the highest quality of care and patient satisfaction.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS
You have certain rights under the federal privacy standards. These include:

- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected information (.75) per page
- The right to amend or submit correction to your protected information
- The right to receive an account of how and to whom your protected health information has been disclosed

OUR RESPONSIBLITES

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and locations

As permitted by the law we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we can provide you with a revised notice if requested. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or will discontinue using or disclosing your information after we have received a written revocation of the authorizing according to procedures included in the authorization.

Patient initial _____

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment. Your Health Plan, No Fault carrier or Worker's Compensation carrier may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for services rendered to you.

Business Associates. Occasionally, we contract separate entities to provide services for us. These "Associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples would be a billing service, collection agency, answering services, computer software provider or note services.

Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member or any other person that is involved in your care that you have authorized to receive this information. Please inform the practice when you DO NOT wish a family member or other individual to have authorization to receive information.

Health Care Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority, attorney, or other federal/state appointee if there are any circumstances that require us to do so.

Your Legal Representatives. If you are being represented by an attorney relative to a personal injury, work injury or No-Fault injury, information requested from an attorney will be provided.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.

Law Enforcement. Your health information may be disclosed to law enforcement agencies without your permission to support government audits and inspections, to facilitate law enforcement investigation and to comply with government mandated reporting.

Appointment Reminders. Typically, appointment reminders are a brief non-specific message left on your answering machine. If you DO NOT approve of this method or prefer alternative methods, please inform the practice.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information, you must submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undue any use or disclosure of information that occurred before you notified us of your decision.

If you believe that your privacy rights have been violated, you may contact The Practice Privacy Official or you may file a complaint with the Office of Civil Rights, United States Department of Health and Human Services. There will be no retaliation for filing a complaint with this office.

"THIS RELEASE IS FOR THE PURPOSE OF PROVIDING PERSONAL HEALTH INFORMATION TO THE REQUESTING PARTIES. I HEREBY AUTHORIZE **PERINTON HILLS CHIROPRACTIC, PC** TO FURNISH ANY RECORDES PERTAINING TO MY MEDICAL HISTORY, SERVICES RENDERED, INVESTIGATION OR EVALUATION OF THE CLAIM."

Signature_____Date_____Witness_____