New Patient Information

Date______________________

Name____ Gender: ☐ Male ☐ Female D.O.B____/____/______

Address____ Marital Status: _______________

City____State_______Zipcode__________________

Email____Home Phone (_____)________________

Cell Ph#(_____)________________ Carrier ☐ Verizon, ☐ ATT, ☐ Sprint, ☐ Other:______________________

How may we contact you? (ie: appt reminders) ☐ Text Cell, ☐ Email, or Call my: ☐ Home ☐ Cell

Emergency contact____**Phone**(_____)____________________

Relationship to patient_________________________ How did you hear about us__________________________

Primary Physician ____ Phone# (_____)___________________

Referring Physician _______________________________________ Phone# (_____)___________________

Employment Status: (circle one) Full time/Part time/Retired/Self Employed/Not Employed

Employer____ Work Phone (_____)________________

Insurance Information

Primary Insurance_____________________________________Member ID #____________________________

Effective Date_____/_____/_____ Subscriber Name____

Relationship to Patient__________________________Subscriber D.O.B _____/_____/______

Secondary Insurance___________________________________Member ID #____________________________

Effective Date____/_____/_____ Subscriber Name____

Relationship to Patient__________________________Subscriber D.O.B. _____/_____/______

If your injury is from a car accident or work incident and you have No Fault Insurance or Workers Comp, additional paperwork is required. Please provide this information when making your appointment.

Financial Agreement

I authorize payment of my insurance benefits to Integrated Chiropractic or Integrated Physical Therapy. I agree to pay my financial responsibility. Deductibles, Copays and Co-Insurances are due at the time of service. **If not paid on the date of service, a $10 fee may be added to your account**, unless a prior financial arrangement is made. I acknowledge I am responsible to pay any fees charged by this office for my treatment that may not be covered by my insurance.

Signature: ____ Date: _____/______/______

Consent for Treatment

I hereby authorize the chiropractors and physical therapists employed by Integrated Chiropractic and Physical Therapy and whomever he/she may designate and his/her assistant(s) to administer treatment as he/she so deems necessary for my condition. I have the right to refuse any treatment I do not want.

Signature: ____Date: _________________

Witnessed: ____ Date: _________________

Please complete this section if Patient is a Minor (Under 18)

Mother's Name____DOB_____/______/______

Address____City_____________State_____Zip__________

Employer___________________________________Work Phone_______________Home Phone____________

Father's Name____DOB_____/_____/______

Address____City_____________State_____Zip__________

Employer__________________________________ Work Phone_______________ Home Phone____________

Authorization for Care of a Minor

I hereby authorize the chiropractors and physical therapists employed by Integrated Chiropractic and Physical Therapy to evaluate and treat my son/daughter as they deem necessary.

Signature: ____Date: _________________

Authorization for Medical Records

I hereby authorize Integrated Chiropractic and Physical Therapy to obtain any medical or surgical or diagnostic imaging reports relevant to my treatment. I authorize Integrated Chiropractic and Physical Therapy to release my medical records to my insurance company to facilitate payment and to other healthcare providers/DME vendors involved in my healthcare.

Signature: ____ Date: _____/______/______

In compliance with NYS Laws we offer the following to our patients

HIPAA Acknowledgment

As required by the HIPAA (Health Insurance Portability and Accountability Act) we adhere to the standards set forth in the NOTICE OF PRIVACY PRACTICES available on our website and at our front desk. This document states that we reserve the right to contact you by mail, email, or phone. We may leave messages regarding appointments, payments, and treatment issues. I was offered a copy of the Notice of Privacy Practices for Integrated Chiropractic/Integrated Physical Therapy and I give them permission to contact me.

Signature: ____Date: _________________

Optional Designation of a Personal Representative

I hereby designate ______________________________________ to act on my behalf in making decisions related to my health care and is authorized to receive, use and disclose my Protected Health Information (PHI).

Signature: ____Date: _________________

Integrated Physical Therapy Offers Direct Access

The Direct Access law, Chapter 298 of the Laws of 2006, allows physical therapists with three years of practical experience to treat patients for 30 days or 10 visits without a referral or prescription from a physician. It also requires physical therapists treating without a referral/prescription to provide certain information to the patient about the possibility that treatment without a referral/prescription may not be an expense covered by the patient's health care plan or insurer. **Medicare, Workers Comp and No Fault insurances still require a physician referral/prescription.**

Notice of Advice: I have been informed of the possibility that physical therapy treatment may not be covered by my health care insurer without the referral of a physician, dentist, podiatrist, or nurse practitioner, but may be a covered expense, if treatment was rendered with such referral.

I have read the Notice of Advice and agree to treatment without a referral and to pay my financial responsibility for treatment if my insurance does not.

Signature: ____Date: _________________

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Cancellation and No Show Policy

We are committed to providing you, our valued patients, with excellent quality and convenient services. We reserve time in our schedule specifically for you. We ask your cooperation by making every effort to keep your scheduled appointments.

We understand that occasionally situations arise such as sickness, transportation problems, inclement weather, work, or family emergencies that make it impossible to keep your scheduled appointment. In consideration of other patients and our staff, **please call as soon as possible to reschedule your appointment.**

If you do not come in for your scheduled appointment & do not call to cancel or reschedule 24 hours prior to the time of your appointment, we reserve the right to charge a $20 fee. We will send a bill in the mail to you.

If we notice a repeating pattern of you calling to cancel your appointment on the day of your appointment, we reserve the right to apply a $20 fee for Broken appointments. We will send a bill in the mail to you.

Please Do Not Cancel if you are feeling worse and believe the treatment is not working. Keep your appointment and discuss any changes with your provider. Please understand that your pain will probably fluctuate as your course of treatment progresses.

Please Do Not Cancel if you are feeling better. Keep your appointment in order to take your care to the next level according to your treatment goals and to prepare for discharge.

I have read the Cancellation and No Show Policy and understand when the fees may be applied to me.

Signature: ____Date: _______________

Witnessed: ____ Date: _______________

Thank you for choosing us. We look forward to serving you. Please share us with your family and friends.

Health History

What is your primary reason for this visit? ____

Is this injury the result of a work incident or car accident? Yes / No

When did your symptoms start? ______________________How did they start? ___________________________

Have you had prior symptoms in this area?   Yes / No   Does the pain radiate anywhere? Yes / No

What makes your symptoms better? ____

What makes them worse? ____

When does it hurt? ____

How would you describe your pain? **Sharp, Dull, Burning, Aching, Numbness** (circle all that apply)

Would you say this condition is getting: **Worse, Better, Comes and goes, or Stays the same** (Circle one)

Have you seen your Doctor for this problem? Yes / No

Have you missed any work due to your problem? Yes / No   If yes how many days? _____________________

Have you been treated by a Chiropractor before? Yes / No   Chiropractor's Name ________________________

Have you been to Physical Therapy before? Yes / No   Name of PT Clinic __________________________________

Have you had any x-rays or MRI taken for this problem? Yes / No

If yes, Date___________________ Where were they taken? ____

Have you ever had any Surgery?   Yes / No   If yes, please list on the back of this sheet.

Have you ever experienced injuries from a fall, accident or playing sports? Yes / No

Are you currently taking any medications, supplements or vitamins?   Yes / No   If yes, please list below.

____

____

____

Have there been any significant changes in your health in the past year? Yes / No   If yes, describe below.

____

Please Circle all conditions you have had in the past or are currently experiencing.

Muscle/Joint	**Ears/Nose/Throat**	**Women Only**	**Diagnosed Conditions**
Arthritis	Asthma	Extreme cramps	Alcoholism
Bursitis	Deafness	Excessive bleeding	Anemia
Foot pain	Earaches	Painful periods	Appendicitis
Low back pain	Ringing in ears	Pregnant	Cancer
Hernia	Enlarged glands	Uterine fibroids	Cancer site:
Neck pain	Thyroid	Menopause	Congestive Heart Failure
Pain between shoulders	Eye pain	**Sleep Pattern**	COPD
Painful tailbone	Failing vision	Light	Dementia/Alzheimers
Poor posture	Nasal obstruction	Moderate	Diabetes
Sciatica	Nose bleeds	Heavy	Emphysema
Spinal curvature	TMJ pain	CPAP usage	Epilepsy
Stiff or Swollen joints	**Cardiovascular**	**Foot Support**	Fibromyalgia
Muscle Weakness	Hardening of arteries	Heel lifts	Gout
Pain/Numbness	High blood pressure	Sole lifts	Limb amputation
Shoulders	Low blood pressure	Inner soles	Lupus
Arms	Chest pain	Arch supports	Lyme Disease
Elbows	Poor circulation	Custom orthotics	MS
Hands	Heart attack		Paralysis
Hips	Rapid heart beat	**Regular Use of the following**:	Pleurisy
Knees	Slow heart beat	Alcohol	Polio
Feet	Swelling of ankles	Caffeine	Stroke
General Health	Pacemaker	Smoking/chewing tobacco	Tuberculosis
Allergies	**Respiratory**	Illegal drugs	Ulcers
Convulsions	Chronic cough		
Dizziness, Poor Balance, Frequent Falls	Difficulty breathing	**How often do you Exercise:**	
Fainting	Spitting up blood	Never	**Please list all surgeries and the dates**
Headaches	Spitting up phlegm	Occasionally	
Loss of sleep	Wheezing	Daily	
Weight loss	**Urological**	3 times a week	
Anxiety	Bed wetting		
Depression	Blood in urine	**Height:**	
Gastrointestinal	Frequent urination		
Constipation	Kidney infection	**Weight:**	
Diarrhea	Kidney stone		
Hemorrhoids	Painful urination		
Gall Bladder	Incontinence		
Liver	Prostrate trouble		
Nausea/Vomiting			