MAJOR MEDICAL

PATIENT INFORMATION

Date: _____

First Name: _____ Last Name: _____

Address: _____
City/State: _____ Zip Code: _____

Social Security #: _____ DOB: _____ AGE: _____

Sex (circle) MALE / FEMALE
# of Children _____ Marital Status: S M D W Spouses Name: _____

Contact Information:
Home # : _____ Cell # : _____
Work # : _____ Email Adress : _____

In Case of Emergency Contact : _____ Phone # : _____
Are you currently working? _____
Employer : _____ Occupation: _____
Work Address : _____ Phone #: _____

How were you referred to the office? _____
Is your injury work related? _____ Was the accident reported? _____
Is your injury related to an Automible Accident? _____

Main Complaint: _____
Secondary Complaint: _____

Have you ever seen another doctor for this complaint? _____
If YES what is the doctors name? _____

PRIMARY DOCTORS NAME: _____ Phone: _____

MEDICAL HISTORY

(Please Check if Applicable)

Do you have concerns about your current weight? _____ YES _____ NO

- ☐ Pregnant
- ☐ Diabetes
- ☐ TMJ
- ☐ Epilepsy/Seizures
- ☐ Cancer
- ☐ Lymphendema
- ☐ Stroke
- ☐ Arthritis
- ☐ Dizziness
- ☐ Broken/Fractures Bones
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ OTHER

Please Explain: _____

SURGICAL HISTORY

(Please Check if Applicable)

- ☐ Pacemaker
- ☐ Metal/Plastic Implants
- ☐ Joint Replacement

Any Surgical Procedures: _____

List any Drugs, Medications, or herbal Supplements you are currently taking:

_____

INSURANCE INFORMATION

Do you have health insurance? Yes or No (circle)

Name of Insurance Company: _____

Address: _____

Insured's Name: _____

Insured's Address: _____

Insured's Date of Birth: _____

Relationship to Insured: _____

Medical Records Request

I hereby authorize _____ to use and/or disclose copies of my medical

(Doctor/Hospital)

records to:

Dr._____

Albany Chiropractic and Physical Therapy

1694 Central Ave, Albany, NY 12205

Phone: 518-869-3884 Fax: 518-869-6030

I authorize the release of the following records (specifically describe information to be released, dates of service, type of services, etc.)

_____

_____

_____

This authorization will expire on: _____

_____ _____

Signature of Patient/Legal Guardian *Print Patient Name*

_____ _____

Date of Birth *Date*

Albany Chiropractic and Physical Therapy
1694 Central Ave
Albany, NY 12205
(518) 869-3884

Authorization for Use of Disclosure of Health Information

Patient Name: _____ DOB: _____

SS#:_____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Release of medical records to insurance companies for the purpose of obtaining payment for Services rendered and for Quality Assurance.

Release of medical records to physicians we refer you to for further medical treatment.

The above information will be called "Authorized Information" throughout the rest of this form.

People that will have access to your medical records will be: Office Staff including secretaries, Nurses, X-Ray technicians, and physicians.

People outside this office that will have access to your medical records will be: your insurance company, Physicians, Physicians we refer you to, and the Department of Health on an "as needed" basis.

Authorized information will be used and/or disclosed for the following purposes:

At the request of the individual (ex: sending records to a lawyer's office with your permission)

I understand that if the person or entity receiving Authorized information is not a health plan or Health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying:
Albany Chiropractic and Physical Therapy is writing. However if I chose to do so, I understand that my revocation will not affect any action taken by Albany Chiropractic and Physical Therapy before receiving my revocation.

Signature of Patient:_____ Date: _____

Albany Multi Medicine Group
1694 Central Ave
Albany, NY 12205
(518) 869-3884

Authorization for Use of Disclosure of Health Information

Patient Name: _____ DOB: _____

SS#:_____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Release of medical records to insurance companies for the purpose of obtaining payment for Services rendered and for Quality Assurance.

Release of medical records to physicians we refer you to for further medical treatment.

The above information will be called "Authorized Information" throughout the rest of this form.

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Albany Multi Medicine Group is writing. However if I chose to do so, I understand that my revocation will not affect any action taken by Albany Multi Medicine Group before receiving my revocation.

Signature of Patient: _____ Date: _____

PAYMENT INFORMATION :

I understand and agree that Health and accident insurance policies are an arrangement between an insurance carrier and me. I also understand that this office will prepare any forms and reports necessary to assist me in making collection from the insurance company and that an amount authorized to be paid directly to the office 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 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 or my dependent will be immediatley due and payable.

As a courtesy to our patient we verify your benefits and responsibilities with your insurance company. However, in the case of any miss-quotes, it is still your responsibility to know your insurance responsibilities and payment is expected.

I affirm that the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____
Insured Signature: _____ Date: _____
Parent, Spouse, or Guardian Signature: _____ Date: _____

1694 Central Avenue
Albany, NY 12205
Phone: (518)869-3884

Notice of Privacy Practices

Effective Date: April 24, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOWYOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
If you have any questions about tjis notice, please contact Sheryl Drake, D.C., Privacy Officer 1694 Central Ave, Albany, NY 12205, or call (518) 869-3884.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information

authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights law.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care, 2) to protect your health and safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our privacy officer.

Right to Amend. If you feel that Health Information we have 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 by or for our office. To request an amendment, you must make your request, in writing, to our privacy officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request accounting of disclosures, you must make your request, in writing, to our privacy officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our privacy officer. *We are not required to agree to your request.* If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to our privacy officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, please notify our office staff.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with The U.S. Department Of Health and Human Services Office of Civil Rights, 200 Independence Avenue, S.W., Washington, DC 202201, (202) 619-0257. To file a complaint with our office, contact Sheryl Drake, DC, PrivacyOfficer 1694 Central Ave, Albany, NY12205 (518)869-3884. All complaints must be made in writing. You will not be penalized for filing a complaint.

I acknowledge I have read this notice:

Sign:_____ Date:_____

Print name of patient:_____

If you are signing as the patient's representative:

Print your name:_____ Date:_____

Relationship to patient:_____

Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Shoe Size:** _____

Shoe Width (Circle One): Narrow Medium (*average*) Wide

Types of Shoes (Circle all that apply): Athletic (*laces*) Loafer (*no laces*) Heel 1 - 2 "

Activity Level (Circle One): Intense Moderate Light

Stand more than 4 hours per day ←——————→ *Sedentary*

Have you worn orthotics before? Yes No

Areas of Pain, Please check all that apply:

	Left	Right
Ball of Foot, Toes	☐	☐
Arch Pain	☐	☐
Heel Pain	☐	☐
Ankle Pain	☐	☐
Knee Pain	☐	☐
Hip Pain	☐	☐
Low Back Pain	☐	☐
Neck Pain	☐	☐

For Office Use:

Scan Date: _____ Order Date: _____

Foot Flare: ☐ L ☐ R Low Medial Arch: ☐ L ☐ R

Bowed Achilles Tendon ☐ L ☐ R Excessive Shoe Wear: ☐ L ☐ R

Internal Knee Rotation: ☐ L ☐ R

Albany Chiropractic & Physical Therapy
Cancellation / No-Show Policy

The Chiropractors, Therapists and Staff of Albany Chiropractic and Physical Therapy are glad you are here. *You* are the reason this practice exists, and we promise to never forget that! Your successful rehabilitation is our top priority. To achieve the best possible outcome your provider has recommended a particular treatment schedule. To attain these results, it is very important that you attend your chiropractic/therapy sessions as scheduled.
We promise that 100% of our effort will go into your rehabilitation, but we need 100% dedication from you as well. We reserve time in our schedule specifically for you. With this in mind, we ask your cooperation by making every effort to keep scheduled appointments. Please take a moment to review the guidelines we have put in place to ensure that you get the most out of your experience at Albany Chiropractic and Physical Therapy.

☐ **Please give at least 12 hour notice in the event of a cancellation. If you are unable to give 12 hour notice, please contact us as soon as possible.**

☐ **If you are more than 15 minutes late, your appointment will more than likely need to be rescheduled due to conflicting appointments and a no show will be recorded for that day. If you are aware that you are going to be late, please call the office and let us know.**

☐ **If you do not call, you are considered a NO SHOW. You will receive one courtesy call after your first No Show, any additional No Shows will result in removal from any future scheduled appointments. You will need to call to resume and reschedule your appointments for treatment. The accumulation of 3 No Show appointments will result in discharge from your treatment program. You will be required to obtain a new order from the referring physician before any further appointments can be scheduled.**

☐ **Three (3) late cancellations (within less than 24 hours of your scheduled time) within a 30 day period will also result in discharge from the therapy program**

☐ **You may be subject to a $20.00 charge for a cancellation without proper notice (notice given within less than 12 hours of your scheduled time). This charge will not be covered by insurance, but will have to be paid out of pocket.**

Worker's Compensation and Personal Injury/ No Fault patient's documents of **any** missed or cancelled appointments are forwarded to your case manager and primary care doctor. This could jeopardize your claim and prolong or stop any benefits you may be entitled to.
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 progress your plan and prepare for discharge.
When you don't show as scheduled, three people are hurt. You, because you don't get the treatment you need; the provider, who now has a space in his/her schedule since the time was

reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

We appreciate the opportunity to provide you "Uncompromising Care". Thank you for your consideration of our staff and other patients.

_____ _____

Name (Signature) Date

_____

Name (Print)