NO FAULT INSURANCE

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 # : _____

Employer : _____ Occupation: _____
Work Address : _____ Phone #: _____
Are you currently working? _____ Are you a FT or PT employee? _____
How were you referred to the office? _____
Is your injury work related? _____ Was the accident reported? _____
Is your injury related to an Automible Accident?
If you are currently not working what was your first day out of work? _____

Main Complaint: _____
Secondary Complaint: _____

Have you ever seen another doctor for this complaint? _____
If YES what is the doctors name? _____
Have you experienced these symptoms prior to your accident? _____
Prior to your accident were you in good health? _____
PRIMARY DOCTORS NAME: _____ Phone: _____

It is common procedure that our providers will contact your treating providers to keep them updated on your progress, and for referral purposes.
Please initial below if you DO NOT want other providers contacted.

_____ .

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: _____

Adjuster's Name: _____ Phone # : _____ Ext: _____

WCB # : _____ Carrier Case # : _____

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

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: _____

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: _____

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 as required by military command

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:_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
(ASSIGNMENT OF BENEFITS FORM)
(For Accidents Occurring on and After 3/1/02)

Claim Number: _____

I, _____("Assignor") hereby assign to Albany Chiropractic and Physical Therapy, ("Assignee")

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 _____, notwithstanding any other agreement to the contrary. (Print accident date)

This agreement may be revoked by the assignee when the 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 ANYCOMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSIST, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRADULENT INSURANCE ACT, WHICH IS ACRIME. AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT EXCEEDING FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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

_____ _____
(Home Address) (Date of Signature)

_____
(City y/Town State Zip Code)

Albany Chiropractic and Physical Therapy
1694 Central Ave
Albany, NY 12205

_____ _____
(Signature of Provider) (Date of Signature)

NEW YORK MOTOR VEHICLE NO-FAUL T INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

ADJUSTER NAME: *TELEPHONE:*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATIONS.
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

YOUR NAME: *YOUR ADDRESS:*

1. YOUR NAME	1. PHONE NOS. HOME	BUSINESS
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE, AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET) CITY OR TOWN, AND STATE	

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?		
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?		
WERE YOU A PEDESTRIAN?		
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?		
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?		

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?
YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSONS:

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?
YES ☐ NO ☐

20. LIST NAMES AND ADDRESSES OF YOUR EMPLOYER ANDOTHER EMPLOYERS FOR ONEYEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?
YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY.

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.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION, OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY, OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION, OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS, AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE* _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

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)