# SUFFOLK PHYSICAL THERAPY & CHIROPRACTIC, PLLC
# PRIVATE INSURANCE INTAKE FORM

**Date:** _____

**First Name:** _____ **MI:** _____ **Last Name:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Cell:** _____ **Work:** _____ **Home:** _____

**Sex:** _____ **Age:** _____ **Date of Birth:** _____ **Social Security #:** _____

**Occupation**_____ **Referred by**_____

**Employer** _____

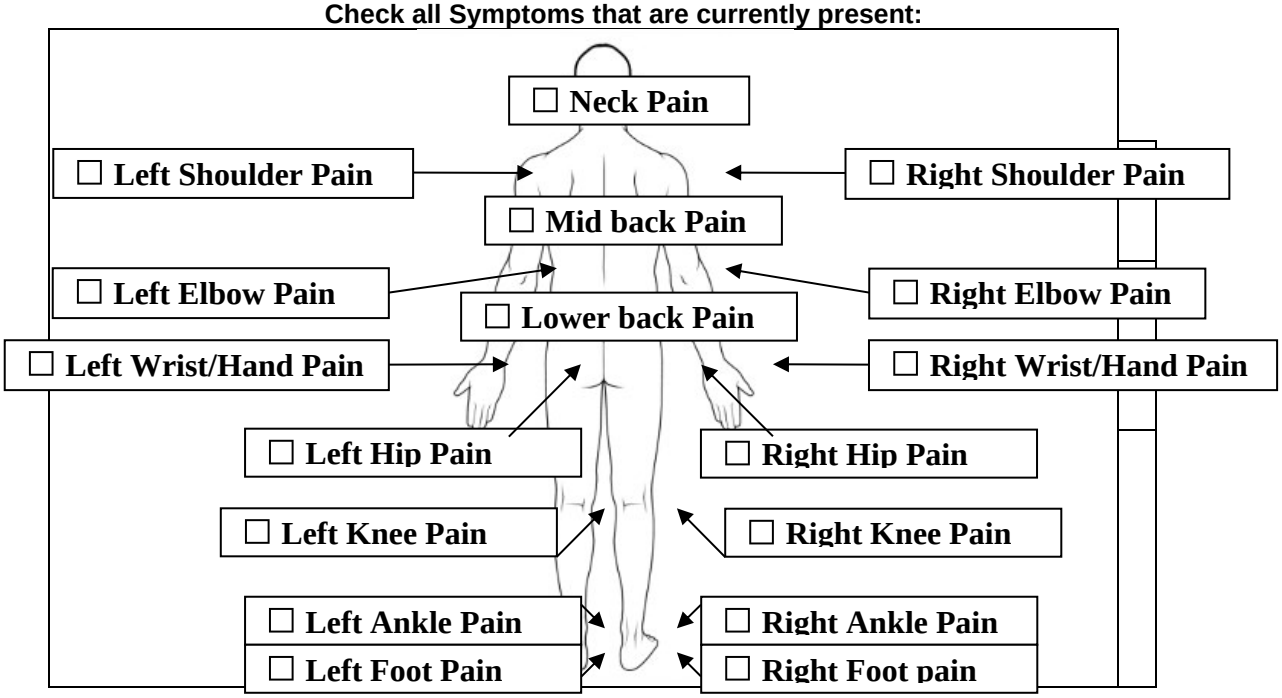
**Spouse's Name** _____ **Spouse's phone number**_____

**Marital Status** _____ **Number of Children** _____

**Referred by** _____

**Email Address** _____

**Check all Symptoms that are currently present:**




| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Dizziness | ☐ Memory Loss | ☐ Blurred vision |
| ☐ Ringing in the Ears | ☐ Difficulty Sleeping | ☐ Fatigue | ☐ Jaw Pain |
| ☐ Clicking of the Jaw | ☐ Numb Fingers | ☐ Numb Toes | |
| ☐ Chest Pain | ☐ Nausea | ☐ Other_____ | |

**INSURANCE INFORMATION;**

**Insurance Company:** _____ **Insurance Phone #:** _____

**Insurance Company Address:** _____

**Insured's Name:** _____ **Relation to you**_____

**Insured's Date of Birth:** _____

**Your Signature**_____

# HIPPA 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. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carryout treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## USES AND DISCLOSURES OF PROTECTED HEALH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers’ compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

# Your**Rights**

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply)** Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality. You have the right to request a restriction of your protected health information –This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications**–You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures**–You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

**You have the right to obtain a paper copy of this** notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

**COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the “Acknowledgment of Receipt” shown below. You are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Print Name:_____

Signature: _____

Date: _____

# **Assignment** of **Benefits**

PATIENT NAME: _____ _____ ____
LAST FIRST MI

In consideration of services rendered or to be rendered, I hereby assign Suffolk Physical Therapy & Chiropractic, PLLC, my first party insurance benefits and rights, attendant thereto, as shall equal the full amount of the bill for said services and Suffolk Physical Therapy & Chiropractic, PLLC, may secure same in my name.

I further understand if said sum is not collected, I will remain personally liable therefore.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN DATE

_____ _____
WITNESS DATE

Suffolk Physical Therapy & Chiropractic, PLLC

535 Broadhollow Rd
Melville, NY 11747
P: 631.249.0011
F. 631.249.1793

1050 Old Nichols Rd
Islandia, NY 11749
P: 631.249.0011
F. 631.249.1793

350 Vets Memorial Hwy
Commack, NY 11725
P: 631.249.0011
F. 631.249.1793

751 Broadway
Amityville, NY 11701
P: 631.249.0011
F. 631.249.1793

Dear Patient,

Welcome to our facility. Our goal is to provide you with the best chiropractic care possible, and at the same time, make it as easy as possible for you to be able to begin, continue, and complete your prescribed treatment plan.

Now that you understand that your co pay for each visit is _____, you must also understand that we will be submitting bills to your insurance company, that they may either pay us directly or they may send you the checks for the services that we have rendered to you.

If your insurance company sends you the checks to you, it is your responsibility to bring these payments and the corresponding paperwork into us. As a courtesy to you, we are simply awaiting payment from your insurance company instead of you having to pay the whole fee up front each visit.

If you do not bring these checks into us when you receive them, or cash them, you will be billed for any monies you received for our services, plus you will have to pay for each future visit in full prior to receiving services.

By signing below, you acknowledge that you have read our office policy and agree to bring in any insurance checks that you receive for services that we have rendered to you.

Patient's signature_____

Witness_____

Date_____

# INFORMED CONSENT

Patient Name: _____

**To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask any questions you may have, prior to signing, if anything is unclear.**

### The Nature of the Chiropractic Adjustment

As a Doctor of Chiropractic, the primary treatment method I use is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instruments upon your body in order to move your joints. This may cause an audible "pop" or "click," similarly to what you may have experienced if you "cracked" your knuckles. You may feel a sense of movement.

### Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures.

☐ Physical Examination and Analysis, to include:
Range of motion testing
Muscle strength testing
Palpation
Orthopedic testing
Basic neurological
Vital signs
Postural analysis

☐ Chiropractic Treatment, to include:
Spinal manipulative Therapy
Electric muscle stimulation
Ultrasound
Hot/Cold therapy
Massage therapy
Radiographic studies (x-rays)
other: _____

### The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injures to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients may feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

### The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying bone weakness, which I check for during the taking of your history and during the examination and via X-ray. Stoke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are generally described as rare.

### The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include
-Self Administered, Over-the-Counter Analgesics and rest
-Medical Care and Prescription Drugs such as anti-inflammatory, muscle relaxants, and pain killers.
-Hospitalization
-Surgery
Should you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

### The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**PLEASE DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**
**PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.**

**I have read [__] or have had read to me [__] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor listed below and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommending. I having been informed of the risks; I hereby give my consent to that treatment.**

**Dated:** _____

**Doctor's Name:** _____

**Business Name:** Suffolk Physical Therapy & Chiropractic, PLLC

**Doctor's Signature:** _____

**Patients Name:** _____

**Patients Signature:** _____

**Signature of Parent or Guardian (if a minor):** _____