Lake Shore Chiropractic Center

A Chiropractic Rehabilitation Facility **5449 Southwestern Blvd. Hamburg, NY 14075 1829 Maple Ave., Suite 110 Williamsville, NY**
716-646-4000
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Confidential Health History

Date_____

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you and enable us to provide you with the best possible care. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name _____
(First) (MI) (Last)
Address _____
(Street) (City) (State) (Zip)
Home Phone: _____ Cell Phone: _____
E-Mail:_____ Emergency Contact: Name/Phone: _____
Date of Birth: _____ Age: _____ Sex: male female _____
Employer_____ Work Phone #:_____
Employer's Address_____
Occupation: _____
Marital Status: Married Single Divorced Widowed Other
Spouses Name_____ # Children _____

Who is responsible for Your Bill?
___ Self ___ Spouse ___ Work Compensation ___ Auto Ins. (no-fault)
___ Personal Health Insurance name:_____
Subscriber's Name_____ Other: _____
Previous Chiropractic Care:
___ None.
___ Yes. Dr.'s Name and Approximate Date of Last Visit.
_____
Family/Primary Physician: _____
Have You Had Any Diagnostic Studies (X-ray, MRI, CT, Bone Scan, etc...) in the last 2 years?
___No ___Yes: ___X-ray ___MRI ___CT ___Other: _____
Approximate Date and By Whom? _____
Who Referred You to Our Office?
___MD ___Chiropractor ___Physical Therapist ___Friend/Relative ___Advertisement
___ Buffalo Spine and Sports Medicine ___ Other: _____
Who Referred You? _____

Pain Drawing

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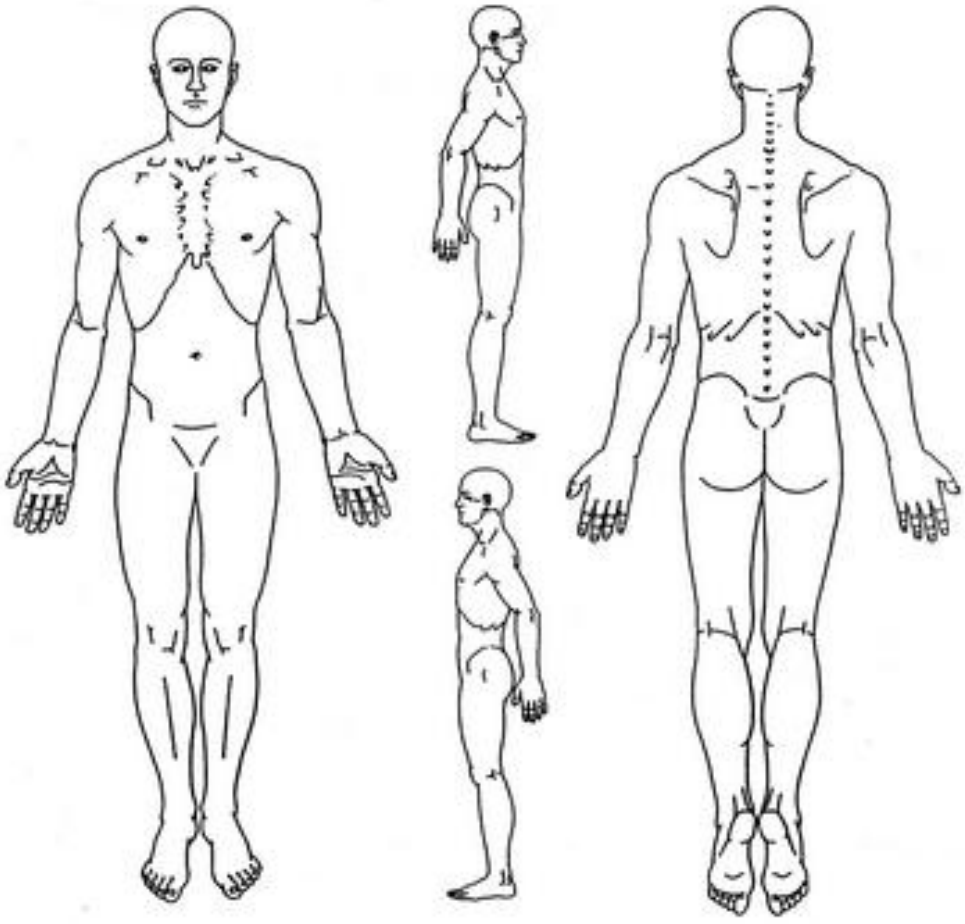
Name: _____ Date: _____

Instructions: Mark the drawings below according to where you hurt. Indicate which sensations you are feeling by referring to the key below:

SS Stabbing **BB** Burning **PP** Pins & Needles **NN** Numbness **AA** Aching **OO** Other _____



Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Put a (✓) above the **Best** and **Worst** your pain has been and **Circle** your **Current** Pain Level

0	No Pain
1-2	Mild Pain. You are aware of it, but it doesn't bother you.
3	Moderate Pain that you can tolerate without medication
4	Moderate Pain that requires medication to tolerate
4-5	More Severe Pain. You begin to feel antisocial
6	Severe Pain
7-9	Intensely Severe Pain
10	Most Severe/Excruciating Pain

Name: _____Date:_____

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Why are you here? Please describe your <u>major complaint</u>: _____

_____

_____

_____

Please check if applicable: _____Work related Injury _____No-Fault/Auto Injury
When did your problem begin? (If not sure, give approximate date) _____
What Happened? How Did Your Problem Start _____

_____

_____

Description: (check those that apply)
___Sharp Pain ___Dull Pain ___Achy ___Throbbing ___Numb ___Shooting ___Gripping
___Burning ___Tingling ___Other_____ _____

Frequency of Pain/Discomfort:
___Constant (76-100%) ___Frequent (51-75%) ___Occasional (26-50%) ___Intermittent (25% or less)

Are Your Symptoms ___Decreasing ___Not Changing ___Increasing ___ Waxing and waning

Are Your Symptoms Worse in the:
___ Morning ___ Afternoon ___Night ___Increase during Day ___Same All Day

Have you been treated for this condition? ___Yes ___No
If Yes, by whom? ___Chiropractor ___MD ___Osteopath ____Physical Therapist ___other:_____
Are you currently being treated? ___Yes ___No
When and what treatment are you receiving? _____
_____

Have you been treated in the past for similar condition? ___Yes ___No
If yes, whom did you see and what did they do? _____
_____

What Makes Your Problem Better? _Nothing _Lying Down _Walking _Standing _Sitting _Movement _Inactivity _____
What Makes Your Problem Worse? _Nothing _Lying Down _Walking _Standing _Sitting _Movement _Inactivity _____
Are Your Complaints Affecting Your Ability to be Active?
__No Effect
__Some Physical Restrictions (able to perform light duty work and household tasks)
__Need Limited Assistance with Common Everyday Tasks
__Need Assistance Often
__Have a Significant Inability to Function Without Assistance
__Am Totally Disabled. I Cannot Care for Myself.

Physical Activity at Work:
__Sitting more than 50% of day __Light Manual Labor __Manual Labor __Heavy Manual Labor __Repetitive Motion
Do you like your job? _Yes _No _OK
Are you working? __Full Time __ Part Time __No If No, date last worked ___/___/_____
Has your work status changed because of your condition? __Yes __No Disability Rating ___ % body part_____
Who took you off of work/determined work restrictions? _____
What is your current work status?
__Full Time, no restrictions __Part Time, With restrictions __Unemployed __Other: _____
__Full Time With Restrictions __Off Work Due to Restrictions __Retired
__Part Time, No Restrictions __Full Time Homemaker __Full Time Student

Health History

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Please check (✓) those conditions that you've had in the past or presently suffer from:

Past	Present		Past	Present	
___	___	Neck Pain	___	___	Jaw Pain(TMJ)
___	___	Asthma	___	___	Kidney Stones
___	___	Shoulder Pain	___	___	Tinnitus (ringing in ear)
___	___	Prostate Problems	___	___	Rheumatoid Arthritis
___	___	Arm/Hand Pain	___	___	Abnormal Weight Gain/Loss
___	___	Loss of Bladder Control	___	___	HIV/AIDS
___	___	Upper Back Pain	___	___	Long term Steroid Use
___	___	Painful Urination	___	___	Sinusitis
___	___	Low Back Pain	___	___	High Blood Pressure
___	___	Leg/Ankle/Foot Pain	___	___	Heart Attack
___	___	Frequent Urination	___	___	Stroke Date:_____
___	___	Excessive Thirst	___	___	Cancer _____
___	___	Headaches	___	___	Allergies
___	___	Breast Tenderness/Lumps,	___	___	Diabetes
___	___	Dizziness	___	___	Pacemaker
___	___	Breast Implants	___	___	Other _____

Please check (✓) if a family member has had any of the following:

__Cancer __Diabetes __Back Problems __Chronic Headaches
__Heart Problems __Rheumatoid Arthritis __High Blood Pressure __ Stroke
__Other Conditions: _____ _____

Please check any of the following that apply to you:

Past	Present		Past	Present	
___	___	Pregnancy	___	___	Tobacco
___	___	Birth Control Pills	___	___	Alcohol
___	___	Hormone Replacement	___	___	Drug/Alcohol Dependence ___
___	___	Medications		___	Steroids
___	___	Hospitalization/Surgeries:	___	___	Heel Lift/Shoe Orthotic
_____			___	___	Fractures:_____
_____					

Present Weight: _____ lbs. Height:____feet _____inches Additional Notes:
Blood Pressure: High Low Normal? ____ /_____
Do You Have Any Permanent Disability Rating? Yes No
For What (Body Part)? _____
Date Rating Received? ___/___ /___ Rating _____%

BILLING POLICY:

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We participate with many insurance carriers and accept assignment from many others. Please remember, ultimately YOU are responsible for providing-sufficient billing information and determining WHETHER OR NOT our services are covered by your insurance contract.

If WE PARTICIPATE with your insurance and a referral is necessary, it is **YOUR** responsibility to obtain a valid referral **AT THE TIME OF TREATMENT**. You are always responsible for applicable co-payments, deductibles, etc. as determined by your insurance company. Co-payments are always expected at the time of service unless prior arrangements-have been made with our billing department.

If WE DO NOT PARTICIPATE with your insurance, you will be responsible for payment in full at the time of your visit. Our office will bill your insurance carrier on your behalf.

If Workers' Compensation or No Fault/Auto is your primary insurance, you are responsible for providing us with accurate information regarding the date of injury, WCB and Carrier case number as well as your insurance company's name and address. It is also important that you have authorization to be treated. Be aware that if your case is DENIED, ALL outstanding balances and future services will be your responsibility unless you have a secondary insurance carrier. In order for our office to bill your private carrier, all information must be provided at your initial visit to insure timely filing of your claim.

I hereby authorize payment of benefits directly to the provider of benefits due me for services rendered. I further authorize the chiropractic physician to release any information required to process my insurance claims. I also understand that I am ultimately responsible for the payment my bill.

I fully understand, accept, and agree to the above policies.

_____ _____

Patient's Signature Date

If you have any questions please do not hesitate to ask at the front desk

No Show and Cancellation Policy

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Resolution of your injury/pain is best achieved when you comply with the treatment plan prescribed by the doctor. Each treatment tends to compliment and build upon the prior visit especially during the initial stages of your treatment regime. If you cancel or no show frequently it will hinder and delay the progress of your recovery and also negate valuable treatment time that could have been utilized by another patient requiring care.

We understand that life often deals us some unexpected surprises so there are of course legitimate excuses. We are here to serve you and appreciate the confidence you show in us by allowing us to care for you. However, due to the ever increasing problem of no shows and late cancelations and our desire to schedule others for treatment as soon as possible, we have implemented the following policy:

1. **Two No-Shows** may result in discharge from the practice. You may also be subject to a $10.00 charge (offices typically charge $25.00). This is especially important for those with no-fault or workers' compensation cases.
2. **Same Day Cancelations** (less than 24 hours) may be subject to a **$10.00 charge** if they occur regularly.
3. If you need to cancel or reschedule please call 646-4000 or after hours you may leave a short message on our answering machine stating:
    a. Your Name and Doctor you were scheduled with
    b. Date and Time of your Appointment
    c. Best phone # to reach you at
    d. We will call you back to reschedule your appointment
4. If you **arrive 10 minutes or later to your appointment** we may have to reschedule you due to other patient's appointments. If we can work you in we will certainly do so. New patients must arrive early enough to fill out the required paperwork prior to their scheduled appointment time.
5. If you apologize profusely we tend to forgive everyone for their oversight! 8")

ALL NO-SHOW/LATE CANCELATION'FEES WILL BE DONATED TO A NON-PROFIT/CHARITY OF OUR CHOICE.

I have read and received a copy of this cancelation/no show policy

_____ _____

Signature Date

LOCATIONS: HAMBURG | WILLIAMSVILLE
5449 Southwestern Blvd., Hamburg, NY 14075 P 716.646.4000 F 716.646.0694
1829 Maple Ave., Suite 110 Williamsville, NY P 716.529.6100 F 716.646.0694

Lake Shore Chiropractic Center

HIPAA Notice of Privacy Practice

Lake Shore Chiropractic Rehabilitation Center 5449 Southwestern Blvd. Hamburg, NY and 1829 Maple Ave., Suite 110 Williamsville, NY
(716) 646-4000

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
usesD 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 carry out treatment, payment or health care operation (TPO) and for other purposed that are permitted or required by law. It also describes you 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 related to your past, present or future physical or mental health or condition and related health care services.

1.Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of your office that are involved in your care and treatment for the purposed 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 used 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 with 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 activates of your physician's practice. These activities include, but are not limited to, quality assessment activates, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in 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. We may use of disclose your protected health information in the following situation 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, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Sections 164.500.

Other Permitted and Required Uses and Disclosures Will Be Make Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, expect to the extent that your physician or the physician's practice has taken as action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your right with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 for the purposes of treatment, payment or healthcare operation. 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.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protect health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications form us by alternative mean 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 alternative i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, 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 we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our privacy contract of your complain. We will not retaliate again you for filing a complaint.

This notice was published and becomes effective on. Or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have nay objection to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:
Print Name _____Signature_____ Date_____