CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date___________________

Patient_______________________________________

Address_______________________________________

____

City State Zip

E-MAIL_______________________________________

Sex: M F Age_______ Birth date________

Single Married Widowed Divorced Separated

Patient SS#_______________________________________

Occupation_______________________________________

Employer_______________________________________

Spouse's Name_______________________________________

Referred By_______________________________________

Primary Care Physician_____________________________

2 INSURANCE

Who is responsible for this account?_________________

Relationship to Patient: Self Child Spouse Other

Insured's SS#________________ Birth Date__________

Insurance Co._______________________________________

Group#_______________________________________

Is Patient covered by additional insurance? Yes No

Insurance Co._______________________________________

Group/Policy#_______________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with ____________________ and assign directly to Dr. Bernstein all insurance benefit, if any, otherwise is payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

___________________________ ________________

Responsible Party Signature Date

3 PHONE NUMBERS

Home___________ Work_____________ Ext______

Best time and place to reach you_________________

IN CASE OF EMERGENCY, CONTACT

Name____________________ Relationship________

Home Phone_______________ Work Phone________

4 ACCIDENT INFORMATION

Is condition due to accident? Yes No Date__________

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp Other

Attorney Name (if applicable)______________________

5 PATIENT CONDITION

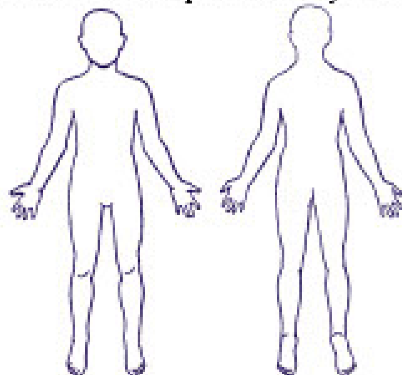
Reason for visit____

When did your symptoms appear? ____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)____________________

Mark an X on the picture where you continue to have pain, tingling, or numbness.



Type of pain: Sharp Dull Throbbing Numbness Aching Cramps

Shooting Burning tingling stiffness swelling

How often do you have this pain? ____________________________

Is it constant or does it come and go? ________________________

Does it interfere with your Work Sleep Daily Routine Recreating?

Activities/Movements that are painful to perform: Sitting Standing

Walking Bending Lying Down

6

HEALTH HISTORY

What treatment have you already received for your condition? (Please circle all that apply): Medical Surgery Physical Therapy Chiropractic None Other ________________________________

Name and address of other doctor(s) who have treated you for your condition______________________________

Have you ever received Chiropractic Care? Yes No If yes, when? ___________________________________

List Previous Surgeries you've has (with dates): ____

Family Health History:

Associated Health Problems of immediate relatives: ____

Deaths in immediate family (cause and age at death): ____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition			Condition			Condition		
AIDS/HIV	Yes	No	Emphysema	Yes	No	Measles	Yes	No	Tonsillitis	Yes	No
Alcoholism	Yes	No	Epilepsy	Yes	No	Migraines	Yes	No	Tuberculosis	Yes	No
Allergy Shots	Yes	No	Fractures	Yes	No	Mononucleosis	Yes	No	Tumors/Growths	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Multiple Sclerosis	Yes	No	Typhoid Fever	Yes	No
Anorexia	Yes	No	Goiter	Yes	No	Mumps	Yes	No	Ulcers	Yes	No
Appendicitis	Yes	No	Gonorrhea	Yes	No	Osteoporosis	Yes	No	Venereal Disease	Yes	No
Arthritis	Yes	No	Gout	Yes	No	Pacemaker	Yes	No	Whooping Cough	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No	Parkinson's	Yes	No			
Bleeding Disorders	Yes	No	Hepatitis	Yes	No	Pinched Nerve	Yes	No	**Females:**		
			Hernia	Yes	No	Pneumonia	Yes	No	Breast Lump	Yes	No
Bronchitis	Yes	No	Herniated Disc	Yes	No	Polio	Yes	No	Full-Term Pregnancy #____	Yes	No
Bulimia	Yes	No	Herpes	Yes	No	Prosthesis	Yes	No			
Cancer	Yes	No	High Blood Pres.	Yes	No	Psychiatric Care	Yes	No	Miscarriage	Yes	No
Cataracts	Yes	No	High Cholesterol	Yes	No	Rheumatoid Arth.	Yes	No	Vaginal Infection	Yes	No
Chemical Dependency	Yes	No	Kidney Disease	Yes	No	Scarlet Fever	Yes	No			
			Liver Disease	Yes	No	Stroke	Yes	No	**Males:**		
Chicken Pox	Yes	No	Loss of Bowel/ Bladder Function	Yes	No	Suicide Attempt	Yes	No	Prostate Problem	Yes	No
Diabetes	Yes	No				Thyroid Problems	Yes	No	Erectile Dysfctn.	Yes	No

Are you pregnant? Yes No Due Date: ____________________________________

EXERCISE LEVEL	WORK ACTIVITY	SOCIAL HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_______
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/Day__________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason____________

MEDICATIONS/DOSAGES	ALLERGIES	VITAMINS/HERBAL/MINERALS
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________
_______________________	_______________________	_______________________

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PHYSICIAN

Private, Group, Accident and Health Insurance

I hereby authorize and direct the ____
Insurance Company to pay by check made out and mailed directly to:

Michael A. Bernstein, D.C.
3000 Hempstead Turnpike
Suite 112
Levittown, NY 11756

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

____________________________________ ____________________________________
Signature of Policy Holder Witness

____________________________________ ________________________
Signature of Claimant (if not policy holder) Date

Long Island Back & Neck Care ________________________________

Michael Bernstein, D.C.

Statement of Purpose: To assist our patients in their efforts to return their bodies to optimal health and normal function using a combination of chiropractic manipulative therapy and adjunctive modalities. We encourage a holistic view of healthcare and provide counseling about lifestyle improvements, exercise, and nutrition.

APPOINTMENT POLICY: Chiropractic care involves the reeducation of the body's structure and is therefore repetitive in nature. Recommended office visit frequency at this time is _____ office visits per week for ____ weeks, at which time reevaluation for further care will occur. It is anticipated that as your condition improves, your office visit frequency will decrease.

For your convenience and in an effort to minimize your waiting time, our receptionist will help you to schedule *multiple* appointments. It is very important that you keep your appointments. If for some reason you are unable to make you appointment, we urge you to contact out office as soon as possible so that your visit may be rescheduled. Remember, the success of your chiropractic care depends largely upon your active involvement in your treatment. We must all work together to attain *your* optimum health.

FINANCIAL POLICIES:

NYS Workers Compensation patients are covered by their employer's worker's compensation insurance carrier. If injured on the job, an employee must be covered by the compensation carrier. Please inform our staff if you were injured while on the job. The patient is responsible for account balances on cases deemed not to be work-related.

Auto No-Fault patients *may* be subject to deductibles. Deductibles are the responsibility of the patient. Once deductibles are satisfied auto no-fault insurance does cover chiropractic care in NY State. The patient is responsible for account balances on cases deemed not to be no-fault related.

Major Medical Insurance: We extend the courtesy of insurance assignment to those patients whose carriers provide chiropractic care and permit assignment of benefits. Our staff will contact the carrier and verify the extent of your coverage. Well will provide the most accurate benefit information attained from your insurance carrier. This information is not a guarantee of benefits.

Many insurance plans have *co-payments* and *deductibles*, which are the patient's financial responsibility. These vary from carrier to carrier, plan to plan, and year to year. We encourage patients to pay their bills at our front desk in the form of cash, check, or guaranteed money order. Although it is preferred that co-payments be made with each office visit, we understand that I may be more convenient for out patients to make payments for several office visits at one time. Please select an option below that reflects your payment preference.

______ I prefer to pay my co-pay at each office visit

______ Please inform me of my balance at the end of each week. I understand that payment of the balance is expected at that time.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Should you discontinue care or be released from further service at out office, all outstanding balances will be due. If billing by mail is necessary, an additional service charge of $3.00 per mailing will be added to the bill. It is our policy that after 120 days any delinquent account will be referred to an outside agency for collection of the account. At that time, the delinquent accounts are subject to agency and interest fees in addition to the amount of the original bill.

We appreciate your cooperation and look forward to working with you to attain you optimum health.

Patient Signature: ____________________________________ **Date:** ______________________________

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS

____________________________ hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the privacy notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; and c) using email and/or text messages at the email address/phone number provided by me.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at anytime for *all future transactions*, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.

7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

____________________________	____________________________
Name of Individual (printed)	Signature of Individual
____________________________	____________________________
Signature of Legal Representative (e.g. Attorney-In-Fact, Guardian, Parent if a minor)	Relationship
________/________/________	____________________________
Date signed	Witness

Michael A. Bernstein, D.C., P.C.
3000 Hempstead Turnpike, Suite 112
Levittown, NY 11756

Office Policy

Thank you for choosing us as your chiropractic health care provider. We are committed to helping you achieve your treatment goals and returning to a more active lifestyle. The following is a statement of our Office Policy, which we recommend you to read and sign prior to any treatment. A copy of this signed policy will be given to you and the original will be retained in your records.

1. All patients must complete our Patient Information and Insurance Forms **BEFORE** seeing the doctor.

2. FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

3. WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

4. If you have health insurance coverage, we will accept assignment of your insurance benefits only after your insurance coverage has been verified by your insurance company. We cannot bill your insurance company unless you give us your correct insurance information as well as an authorized referral from your Primary Care Physician, if required. ***YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT***. Therefore, in the event we cannot accept an assignment of benefits from your insurance company, ***you will be responsible for all services rendered to you on the day of your treatment.***

5. Regarding insurance plans where we are a participating provider: All co-pays and deductibles are due **prior** to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

6. In order for you to achieve maximum results, we will set a specific course of treatment that requires a certain number of treatments in a specific amount of time. Therefore, unless cancelled at least **24 hours** in advance, our policy is to charge you **$25.00** for each missed appointment, as we have set this special time aside for you and you only. Please help us serve you better by keeping scheduled appointments and being considerate of our time. Likewise, we will always be considerate of your time.

7. Each month our patients are encouraged to attend one of our in-house Health Workshops. This is a casual, informative discussion on health care issues that affect you and your family. We ask you to attend at least one of these special events during the course of your treatment. There is no fee for the workshops and your friends and family members are welcome to attend with you. Please see the front desk for times and dates.

Thank you for understanding our Office Policy. Please let us know if you have any questions or concerns.

I have read the above Office Policy. I understand and agree to the above Office Policy:

X_________________________________ Date____________________
Signature of Patient or Responsible Party

X_________________________________ Date____________________
Signature of Co-Responsible Party

Long Island Back & Neck Care ____

Michael Bernstein, D.C.

Informed Consent For Chiropractic Adjustments And Care

D.C. INITIALS	PATIENTS INITIALS	
☐	☐	I have an opportunity to discuss with the doctor of chiropractic named below and/ or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.
☐	☐	I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and if necessary, diagnostic x-rays by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic listed below.
☐	☐	I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the number listed below 24 hours a day for emergency attention. If I am out of town or unable to contact the doctor, I can present myself to an emergency room.
☐	☐	I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish time, based upon the facts then known, is in my best interests.
☐	☐	If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.
☐	☐	I have read the above consent, as indicated by my initials. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

____
Patients name (Please Print)

____
Witness (Please Print)

____
Signature of Patient (or parent/guardian)

____
Signature of Witness

____
Relationship to Patient

____
Date Signed

Michael Bernstein, DC ~ 3000 Hempstead Turnpike, Levittown NY 11756 ~ Suite 112
Phone: (516) 579-4949 ~ Fax: (516) 579-5078