

Queens Chiropractic Associates, P.C.
865 Cypress Avenue
Ridgewood, NY 11385
Tel: 718-628-5300 Fax: 718-628-6297

Chiropractic Health Questionnaire

Name: _____ Social Security #: _____

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

Home Telephone: _____ Age: _____ Birth Date: _____ Marital Status: M S D W

Work Telephone: _____ Email Address: _____

Cell Telephone: _____ # of Children _____ Spouses Name: _____

Occupation: _____ FT PT Referred By: _____

What are your complaints? _____

How long have you had this condition? _____ Have you had this condition in the past? yes no

What activities aggravate your condition? _____

Is the condition getting worse? yes no Is the pain: Constant Comes and goes/Occasional

Have you had previous chiropractic care? yes no If yes, doctor _____

List surgical operations and years: _____

List of medications you are presently taking: _____

Age of mattress: _____ Comfortable yes no Uncomfortable yes no

Are you using any of the following? Heel lifts Sole lifts Inner soles Arch supports

Were you ever in an automobile accident? yes no If yes, give dates: _____

Were you ever injured at work? yes no If yes, give dates: _____

Have you had any other personal injuries or accidents? yes no If yes, give dates: _____

Date of your last physical examination: _____ Family Doctor: _____

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Have you ever suffered from the following?

- Dizziness Arthritis Neuritis Sinus Trouble
 Backaches Headaches Heart Trouble Digestive Disorders
 Neck Pain Asthma Nervousness Diabetes

Please list any other ailments or conditions: _____

Please list any treatments or physicians you have seen for these conditions: _____

Insurance Information

Is your condition due to an auto or job related injury? Yes No

Do you have Health Insurance? Yes No

If yes, please provide us with the name of your health insurance: _____

Policy #: _____ Plan Type (HMO/PPO/Senior Plan): _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that 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 will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

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LIEN FORM

I do hereby enter into an agreement with QUEENS CHIROPRACTIC ASSOCIATES, P.C. (provider) in order to assure compensation for service rendered. I authorize the PROVIDER to furnish my insurance carrier and/or attorney with copies of medical records and diagnostic test results as well as information regarding diagnosis, prognosis, and treatment.

I hereby authorize and direct payment to the PROVIDER such sums as may be due and owing for medical services rendered to me both by reason of my accident and by reason of any other bills that are due to the PROVIDER and to withhold such sums from my settlement judgment, or verdict as may be necessary to adequately protect the PROVIDER. Furthermore, I hereby give a lien on my case to the PROVIDER against any and all proceeds of my settlement, judgment, or verdict which may be paid to my attorney or to myself as a result of the injuries for which I have been treated. I will make myself available to appear or correspond on behalf of the PROVIDER in any collection effort that is undertaken. All bills deemed owing and payable to the PROVIDER shall be collectible at the prevailing fee schedule at the time services were rendered.

I fully understand that I am directly and dully responsible to the PROVIDER for all medical bills submitted for services rendered and that this agreement is made solely for additional protection and in consideration of pending payment. I further understand that such payment is not contingent on my settlement, judgment, or verdict by which I may eventually recover and fee.

I agree never to rescind this document and that a rescission will not be honored by any attorney, I hereby instruct that in the event another attorney is substituted in this manner, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as is were executed by him/her. I have been advised that if my attorney does not wish to cooperate in protecting the PROVIDER'S interest, the PROVIDER will not await payment but may in writing declare the entire balance due and payable at which time said balance is to be paid within thirty days.

(Patient's signature)

(Date)

The undersigned being the attorney of record for the above name patient does hereby agree to observe all the terms of the equitable lien and agrees to withhold such sums from any settlement, judgment, verdict as may be necessary to adequately protect the PROVIDER. The attorney accepts notice that a portion of their client's personal injury claim has been assigned to the PROVIDER and agrees to disburse the funds to the PROVIDER in order to satisfy any outstanding lien or to act as an escrow prior to disbursing any proceeds from their client's settlement. The attorney further acknowledges that they may be liable to client's assignees if they pay out money in disregard of this lien. Furthermore, the attorney agrees that if another attorney is substituted, this equitable lien will be forwarded to the substituted attorney and the PROVIDER will be notified in writing of the same within thirty days. Alternatively, if the patient's legal action is discontinued or resolved, the PROVIDER will be notified in writing of the same within thirty days.

(Signature of Attorney/Representative)

(Date)



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: _____ Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials

Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law. Date: _____

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.