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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Chiropractic Health Questionnaire – Page 2

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 PROVERDER 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)

OCA Official Form No.: 960

AUTHORIZATION FOR RE' ASE OF HEALTH INFORMATION RSUANT 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: ☐ At request of individual ☐ 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.

____________________ Date: ____________

Signature of patient or representative authorized by law.

* 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.

For Workers' Compensation Patients Only

PATIENTS NAME: ______________________________

DATE OF ACCIDENT: ______________________________

ADDRESS OF ACCIDENT (COUNTY): ______________________________

____

NAME OF YOUR EMPLOYER: ______________________________

EMPLOYER'S ADDRESS: ______________________________

____

EMPLOYER'S PHONE#: ______________________________

POSITION WITH CO. AT TIME OF ACCIDENT: ______________________________

USUAL WORK ACTIVITIES: ______________________________

____

NAME OF PERSON ACCIDENT WAS REPORTED TO: ______________________________

____

HOW DID YOUR INJURY HAPPEN (please give full description): ______________________________

____

____

____

ARE YOU WORKING NOW? ☐ YES ☐ NO

IF NO – LAST DATE YOU WORKED: ______________________________

WERE YOU SEEN AT ANY OTHER CHIROPRACTOR? ______________________________

____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS APT. NO.
EMPLOYER		
INSURANCE CARRIER		

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature____________________ Date __________

Provider's Name and Address ____________________

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.