

PERSONAL FINANCIAL AND INSURANCE INFORMATION
NOTE: A COPY OF YOUR INSURANCE CARD(S) WILL BE MADE FOR YOUR FILE.

PATIENT INFO:

TODAY'S DATE: _____

PATIENT NAME: _____ Male ___ Female

PARENT /LEGAL GUARDIAN (if patient is a child) _____

MAILING ADDRESS: _____

EMAIL ADDRESS: _____ PHONE: _____ CELL: _____

SOCIAL SECURITY # _____ DATE OF BIRTH: _____

EMPLOYER: _____ ADDRESS _____ PHONE _____

PRIMARY INSURANCE INFO:

INSURANCE CARRIER _____ ID # _____

PRIMARY HOLDER: _____ Male ___ Female

RELATIONSHIP TO PATIENT: (circle one) Self Spouse Parent Other _____

ADDRESS: _____

PHONE NUMBER: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE INFO: (if any)

INSURANCE CARRIER: _____ ID# _____

PRIMARY HOLDER: _____ Male ___ Female

ADDRESS: _____

PHONE NUMBER: _____ DATE OF BIRTH: _____

Patients or Authorized Individuals Signature

I authorize the release of any medical information necessary to process this claim.

Signed: _____ Date: _____

I authorize direct payment of medical benefits to **FAMILY CHIROPRACTIC CARE, P.C., DR. MANDY K. VASSALLO, D.C.** or **Dr. SAM VASSALLO, D.C.** as applicable.

Signed: _____ Date: _____

If your insurance has a copayment you are responsible for payment before treatment is rendered. The contract you have with your carrier requires payment at the time of service; therefore payment cannot be waived. You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance.

Signed: _____ Date: _____

Medicare Patients Only

Medicare will consider covering Chiropractic Treatments ONLY after your deductible has been met. Examinations are not applied to your deductible amount. Under most instances, Medicare will cover 80% of each office visit up to twelve (12) per year. Any charges for visits in excess of twelve (12) per year, examinations, x-rays or additional therapy ordered are the responsibility of the patient.

Signed: _____ Date: _____

Chiropractic Informed Consent

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I request and consent to the performances of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do expect the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the risks are not guaranteed.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known I have also had opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

Print Name: _____

Signature: _____ Date: _____

Consent of Disclosure

I hereby give consent to Family Chiropractic Care, P.C. and all health care providers furnishing care within Family Chiropractic Care, P.C. to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that others or we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

We reserve the right to amend the terms of our Posted Privacy Policy.

Print Name: _____

Signature: _____ Date: _____

If you are signing as a patient's representative:

Print your name: _____

Relationship: _____

Cancellation

I hereby void the consent given above.

Print Name: _____

Signature: _____ Date: _____

If you are signing as a patient's representative:

Print your name: _____

Relationship: _____

Address for cancellation: Your cancellation will be effective, upon receipt at the following address:

Family Chiropractic Care, P.C.
24304 NYS Rt. 37
Watertown NY 13601



Family Chiropractic Care, PC

Financial Policy

Welcome to Family Chiropractic Care P.C. As one of our patients, we feel it is important to advise you of FCC financial policy.

Insurance: Please bring your insurance card with you at each appointment. We cannot obtain your insurance information or bill for your services unless we have your health insurance information. Failure to present your insurance card could result in your visit being rescheduled.

If your insurance has a copayment you are responsible for payment before treatment is rendered. The contract you have with your carrier requires payment at the time of service; therefore payment cannot be waived. You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance.

Referrals: If your insurance requires an authorization or referral it is the responsibility of the patient/parent to obtain this information from your primary care physician (PCP) before your appointment. FCC reserves the right to reschedule your appointment without this information.

Payment Methods: FCC will accept payments by the following methods: Cash, check, Visa, MasterCard, Discover and debit cards. FCC will also accept debit/credit for patients/parents with flexible spending or health savings accounts.

Medical Records: FCC will mail or fax a copy of all or a portion of your medical records once a request is received in writing. Records more than 5 pages are subject to a fee of \$.75 per page as allowed under the Public Health Law. If you wish for your records to be mailed, there may be an additional fee to cover the mailing cost. Any person picking up records will need to sign a letter of release and show proof of identity.

Financial Charges: A \$30.00 charge will be added to your account for any check returned by your bank for any reason. In the event your account is turned over to a Collection agency you may also be liable for attorneys' fees and court cost.

Non-compliance: This is an agreement between FCC as the provider of service and creditor, and patient/debtor named on this form. I have read and understand this policy and all my questions have been answered to my satisfaction.

Patient/Parent/Guardian

Date

Please Print

Patient Health Questionnaire

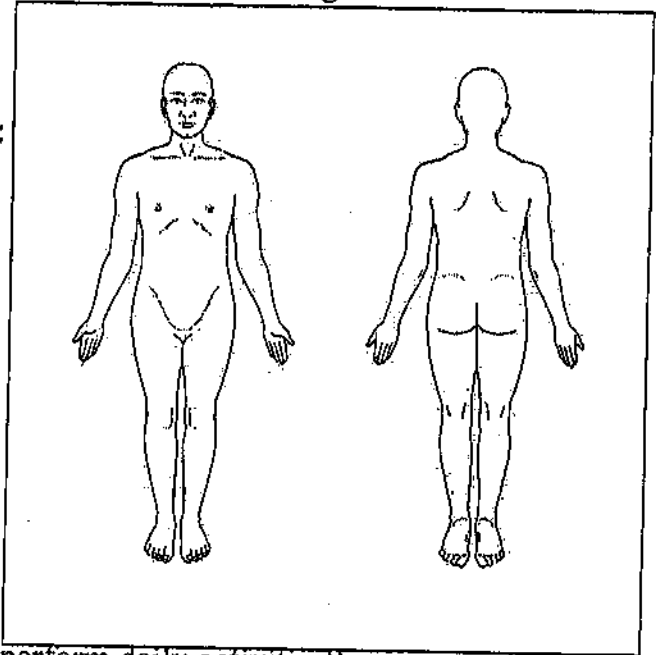
Name: _____ Date: _____

1. When did your symptoms start? _____ Describe your symptoms and how they began:

2. Symptoms are:

___ Occasional ___ Frequent
___ Constant ___ No Pain

Indicate where you have pain or other symptoms on the figures below:



3. What describes the nature of your symptoms:

___ Sharp ___ Numb
___ Burning ___ Dull ache
___ Shooting ___ Tingling

4. How are your symptoms changing?

___ Getting Better
___ Not Changing
___ Getting Worse

5. How do your symptoms affect your ability to perform daily activities? _____

6. What activities make your symptoms worse? _____

7. What activities make your symptoms better? _____

8. What at-home care have you tried? _____

9. How does your condition affect your sleep? _____

10. Who have you seen for this particular onset of your condition?

No One Other Chiropractor Medical Doctor Physical Therapist

a. When and what treatment? _____

b. What tests have you had for your condition and when were they performed?

Xrays Date: _____ MRI Date: _____ CT Scan Date: _____

11. If you have had similar symptoms in the past what did you do to obtain relief?

12. What is your occupation? _____

13. Do you have a medical doctor you normally see? _____

14. Have you seen a chiropractor before? ___ Yes ___ No Who? _____

15. Have you had any previous falls, traumas, car accidents or work accidents? Explain:

Family Chiropractic Care
Patient Health Questionnaire

Patient Name: _____ Date: _____

What type of regular exercise do you perform? ___ None ___ Light ___ Moderate ___ Strenuous

What are your overall health goals? ___ Weight loss ___ More Energy ___ Healthy Aging
___ Increased Performance ___ Enhanced Mental Clarity ___ Decrease Stress ___ Eliminate Bad Habits
___ Improve Lifestyle ___ Other _____

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If presently have a condition listed below, place a check in the present column.

Past Present	Past Present	Past Present
___ ___ Headaches	___ ___ High Blood Pressure	___ ___ Diabetes
___ ___ Neck Pain	___ ___ Heart Attack	___ ___ Excessive Thirst
___ ___ Upper Back Pain	___ ___ Chest Pains	___ ___ Frequent Urination
___ ___ Mid Back Pain	___ ___ Stroke	___ ___ Smoking/Tobacco Use
___ ___ Low Back Pain	___ ___ Angina	___ ___ Drug/Alcohol Dependence
___ ___ Shoulder Pain	___ ___ Kidney Stones	___ ___ Allergies
___ ___ Elbow Pain	___ ___ Kidney Disorders	___ ___ Depression
___ ___ Elbow/Upper Arm Pain	___ ___ Bladder Infection	___ ___ Systemic Lupus
___ ___ Wrist Pain	___ ___ Painful Urination	___ ___ Epilepsy
___ ___ Hand Pain	___ ___ Loss of Bladder Control	___ ___ Dermatitis/Eczema/Rash
___ ___ Hip/Upper Leg Pain	___ ___ Prostate Problems	___ ___ HIV/AIDS
___ ___ Knee/Lower Leg Pain	___ ___ Abnormal Weight Gain/Loss	___ ___ Females Only
___ ___ Ankle/Foot Pain	___ ___ Loss of Appetite	___ ___ Birth Control
___ ___ Jaw Pain	___ ___ Abdominal Pain	___ ___ Hormonal Replacement
___ ___ Joint Swelling/Stiffness	___ ___ Ulcer	___ ___ Pregnancy
___ ___ Arthritis	___ ___ Hepatitis	___ ___ Other Health Problems/Issues
___ ___ Rheumatoid Arthritis	___ ___ Liver/Gall Bladder Disorder	_____
___ ___ General Fatigue	___ ___ Cancer	_____
___ ___ Muscular Incoordination	___ ___ Tumor	_____
___ ___ Visual Disturbances	___ ___ Asthma	_____
___ ___ Dizziness	___ ___ Chronic Sinusitis	_____

Indicate if an immediate family member has had any of the following:
___ Rheumatoid Arthritis ___ Heart Problems ___ Diabetes ___ Cancer ___ Lupus

List all prescription and over-the-counter medications and supplements:

List all surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ Date _____