VEHICLE ACCIDENT QUESTIONNAIRE

Name:		Date:
Insurance Co:	Policy No:	Claim No:
Vehicle's Driver:	Other Vehicle's Driver:	
Other Vehicle's Insurance Co:		Policy No:

ACCIDENT INFORMATION

Give details of how accident occurred:

Date & Time of Accident:	Police notified ? Y N
What was your position in car ? ( ) Driver ( ) Passenger	
If passenger, were you sitting in ( ) Front ( ) Right rear ( ) Left rear	
Did your vehicle strike other car ? Y N	Was impact from ( ) the Front ? ( ) the left side ? ( ) the Rear ( ) the right side ?
Was your car struck by other car ? Y N	
At impact were you ( ) looking forward ( ) looking right ( ) looking left	
Both hands on steering wheel ? Y N	Was your foot on brake ? Y N
Were you braced for impact ? Y N	Were you wearing seat belt ? Y N
Did you strike	( ) Steering wheel ( ) Dashboard ( ) Windshield ( ) Side doo ( ) Arm rests ( ) Side window ( ) Other
State part of body: ( ) Chest ( ) Chin ( ) Knee ( ) Shoulder ( ) Head	
How did you feel immediately after accident ?	
Did you go to hospital ? Y N	Where ?
By ambulance ? Y N	When ?
Were Xrays taken ? Y N	What treatment did you receive ?
	Doctor's Name:
Have you seen any other doctors for this condition ? Y N	
If yes, who ?	

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number:_____

I, _____ (Print patient's name), ("Assignor") hereby assign to _____ (Print hospital or health care provider name), ("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ (Print accident date), not withstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ (Print name of Patient)

_____ (Signature of Patient)

_____ (Address of Patient)

_____ (Date of signature)

_____ (Print name of Provider)

_____ (Signature of Provider)

_____ (Address of Provider)

_____ (Date of signature)

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:_____
Street Address, City, State, Zip

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:_____
Street Address, City, State, Zip

PHONE NUMBER: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE INFO: (if any)

INSURANCE CARRIER:_____ID#_____

PRIMARY HOLDER: _____ ___Male ___Female

ADDRESS: _____
Street Address, City, State, Zip

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 come 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 mylopathy 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 herby 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.

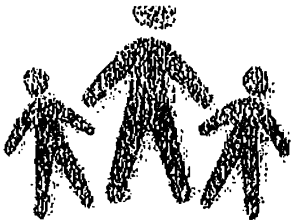
Print Name:_____

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:

_____

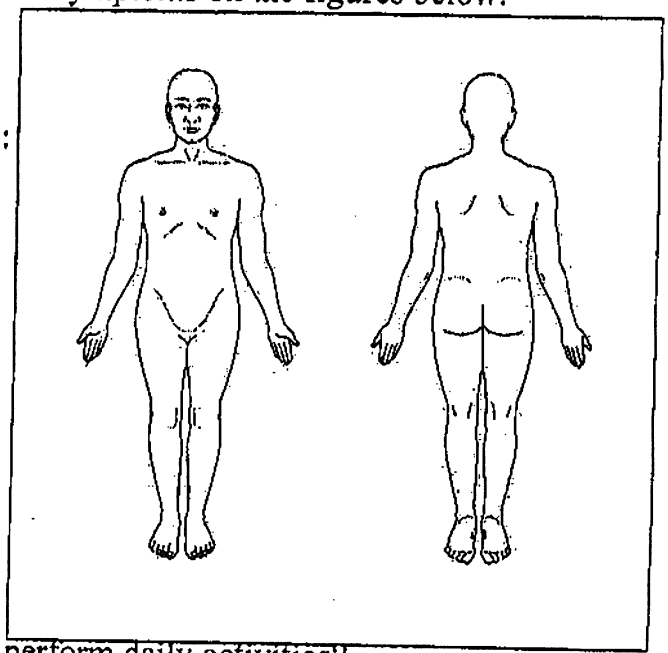
_____

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	
___	___	Headaches
___	___	Neck Pain
___	___	Upper Back Pain
___	___	Mid Back Pain
___	___	Low Back Pain
___	___	Shoulder Pain
___	___	Elbow Pain
___	___	Elbow/Upper Arm Pain
___	___	Wrist Pain
___	___	Hand Pain
___	___	Hip/Upper Leg Pain
___	___	Knee/Lower Leg Pain
___	___	Ankle/Foot Pain
___	___	Jaw Pain
___	___	Joint Swelling/Stiffness
___	___	Arthritis
___	___	Rheumatoid Arthritis
___	___	General Fatigue
___	___	Muscular Incoordination
___	___	Visual Disturbances
___	___	Dizziness

Past	Present	
___	___	High Blood Pressure
___	___	Heart Attack
___	___	Chest Pains
___	___	Stroke
___	___	Angina
___	___	Kidney Stones
___	___	Kidney Disorders
___	___	Bladder Infection
___	___	Painful Urination
___	___	Loss of Bladder Control
___	___	Prostate Problems
___	___	Abnormal Weight Gain/Loss
___	___	Loss of Appetite
___	___	Abdominal Pain
___	___	Ulcer
___	___	Hepatitis
___	___	Liver/Gall Bladder Disorder
___	___	Cancer
___	___	Tumor
___	___	Asthma
___	___	Chronic Sinusitis

Past	Present	
___	___	Diabetes
___	___	Excessive Thirst
___	___	Frequent Urination
___	___	Smoking/Tobacco Use
___	___	Drug/Alcohol Dependence
___	___	Allergies
___	___	Depression
___	___	Systemic Lupus
___	___	Epilepsy
___	___	Dermatitis/Eczema/Rash
___	___	HIV/AIDS

Females Only

___	___	Birth Control
___	___	Hormonal Replacement
___	___	Pregnancy

Other Health Problems/Issues

_____

_____

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_____

Spinal Decompression Table

Name: _____ Date_____

Spinal Decompression provides relief to severe back and neck pain sufferers and improves mobility in healthy spines by gently reducing the pressure within spinal discs. The state-of-the-art Non-Surgical Decompression Traction System utilizes a smooth method of cycling the spine through a series of slow pulls, holds and releases.
On average patients feel relief in as little as 6-10 sessions. Sessions last 15 minutes and should be repeated 1-2 times each week for maximum benefits.
As with any type of therapy, there is risk involved, however, the minimal risk that is involved with this therapy far outweighs the benefits. Studies show on average, you can expect one of the following during and after your treatments:

- 1% report a slight increase in pain
- 7% report no change in pain levels but an increase in spinal mobility.
- 92% report an improvement in pain and an increase in the range of motion of the spine.

This therapy is covered by some insurances.

Cash patients whose insurances do not cover are responsible for the cost of this therapy.

Prices for Spinal Decompression

$55 each

Buy 5 get one free ($275)

Buy 10 get 3 free ($550)

Buy 15 Get 5 free ($825)

By signing below, I acknowledge that I have read and understand the above information regarding Spinal Decompression.

Sign_____ **Date** _____