Welcome to

EAST 53RD STREET

CHIROPRACTIC AND WELLNESS STUDIO

Patient Intake Form

Patient's Name: ______________________________ Home Phone #: (______) ______________
Last Middle First

Home Address: ____
Street Apt. City State Zip

Social Security Number: ____ - ____ - ____ Email Address: ______________________

Date of Birth: ___ / ___ / ___ Age: ____ Sex: Male / Female Marital Status: S / M / D / W / Sep

Chief Complaint: ____ Are you in pain? Yes / No

Work-Related Injury? No / Yes (________________) Accidental Injury? Yes / No (________________)
Details Details

Referred by: Insurance Co. Directory / Ad (__________) / Friend (__________) / Other (______________)
Which one? Who? Please specify.

How long has this condition existed? ______days ____ weeks ______ months other: ____________

Have you ever been treated for this condition before? No / Yes ____________________________
Where? When?

Person to contact in case of an emergency: ______________________________________
Last First

Contact Phone #: (______)______________________ Their relation to you: ______________

Employer's (or School) Name:________________________ Occupation:____________________

Work/Daytime Phone #: (______) ______________ Work/Daytime Fax #: (______)______________

Work Address: ____
Street Apt. City State Zip

THIS SECTION TO BE COMPLETED BY THE OFFICE

Name of Ins. Co.: ______________ Ins. Phone #: ______________ Group #: __________

Policy No. (ID#):______________ Insured's SSN: ______________ DOB: __________

Insured's Name:______________ Their relation to the patient: ______________________

What company do they work for?________________________ Phone #: (______) ________

Company's Address: ____
Street City State Zip

Any secondary insurance? No / Yes (________________) Policy No.: ______________
Which company?

Dr. John J. Belmonte
211 East 53rd Street
New York, NY 10022
(212)980-4211

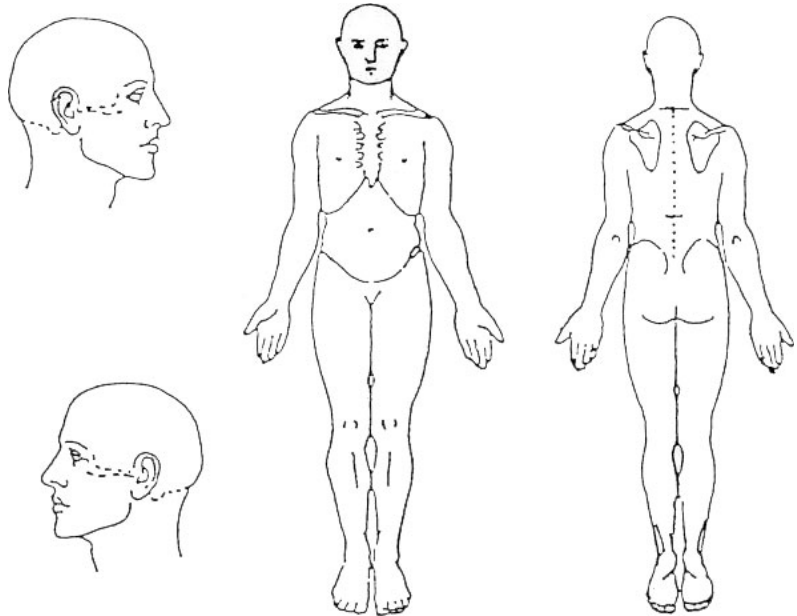
Pain Assessment

Patient's Name: ______________________________ Date:____________________
Last Middle First

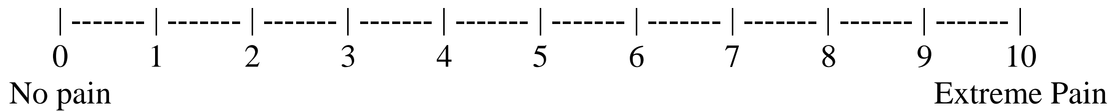
If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS

V V	Ache
= =	Burning
/ /	Numbness
OO	Pins & Needles
+ +	Stabbing, Sharp
X X	Scars, Bruises or Open Wounds



Please mark the severity of your pain on the scale below:



Describe any changes in your conditions or any new concerns:

____

____

____

____

Patient Signature: ______________________________

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Assignment of Benefits

I hereby authorize ______________________ to pay directly to
Name of insurance company

Dr. John Belmonte all insurance benefits under the terms of this insurance policy: __________________ due me, as financial obligations due and
Insurance ID number

owing to the said medical office, John J. Belmonte, D.C., P.C., but not to exceed my indebtedness.

I hereby make this assignment in full recognition of my financial obligations to the above-named medical office and for the purpose of settling and paying my medical bills and accounts to he said chiropractic office.

I further authorize the above-named physician to release any and all medical and/or chiropractic records.

Dated: ______________________________________

Patient Signature: ______________________________

Dr. John J. Belmonte
211 East 53rd Street
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Insurance Assignment Policy Statement

Dear Patient:

You have selected "Insurance Assignment" as the method of choice to take care of your financial obligations with this office.

It is important that you realize that in this office we offer the option of "Insurance Assignment" strictly as a courtesy to our patients. And, as such, our patients must understand and agree to the following:

1. That you are considered a cash patient until you bring in complete insurance forms and this office qualifies and accepts coverage.
2. That you are ultimately responsible for full payment of any and all services rendered.
3. That you must pay all deductible in full.
4. That co-insurance must be paid. A schedule of payments can be arranged with the insurance administration if there is any difficulty in payment.
5. That if your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of claim.
6. That, in the event you discontinue your program of care prior to doctor's consent, you are responsible for making sure that all insurance and payment obligations have been met.

This insurance assignment policy must be followed and we ask that you sign this form as acknowledgment that our policy was explained to you, that you understand and that you accept full responsibility.

Dated: ____

Patient Signature: __________________________________

Dr. John J. Belmonte
211 East 53rd Street
New York, NY 10022
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JOHN J. BELMONTE D.C.P.C.

HIPPA COMPLIANCE
AUTHORIZATION FOR DISCLOSURE AND USE OF MEDICAL RECORDS

● **I HEREBY AUTHORIZE** my Primary Care Physician or other specialist to release to **John J. Belmonte D.C.P.C.** medical information such as

LAB REPORTS, X-RAY REPORTS, MRI REPORTS and all related medical information as appropriate to assist with the diagnosis and your Chiropractic treatment at **John J. Belmonte D.C.P.C**.

● **I HEREBY AUTHORIZE John J. Belmonte D.C.P.C** to disclose my medical records to my insurance company for the purpose of assisting with the settlement of my insurance claims for Chiropractic Therapy.

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID UNTIL I REVOKE THE AGREEMENT THROUGH WRITTEN NOTICE TO JOHN J. BELMONTE D.C.P.C.

Name .... **Signature** ....

Date ....

HIPPA Privacy Statement

Our Practice is committed to maintaining the privacy of your protected health information (PHI), while providing high quality medical care. In accordance with the HIPPA regulations this notice explains:

- How we may use and disclose your PHI.
- Your Privacy rights regarding your PHI.
- Our Obligations concerning the use and disclosure of your PHI.

We may use and disclose your PHI for treatment, payment, and health care operations (TPO).
You have the right to inspect, copy, and amend your PHI. You have the right to request restrictions on the use of your PHI. You have the right to an accounting of the disclosures of our PHI for other than TPO.

You have the right to complain about alleged violation to this practice's privacy officer and the U.S. Department of Health and Human Services.

If you have questions, please feel free to meet our privacy officer for clarification or assistance.

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: ______________________________

Last name: ______________________________

Date of birth: _____ / _____ / _____

Email address: ___________________________

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Exercise and Fitness
- ❑ Diet and Nutrition
- ❑ Stress Management
- ❑ Wellness Topics
- ❑ Women's Health Issues

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	