DR. MARK A. FERRY
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WWW.WNYCHIROPRACTIC.COM

Name: _____ Sex: _____
First Last Middle Initial

Home Address _____ Home Phone: _____
Street & Number City State Zip Code

Birth date: ____/_____/_____ Age: _____ Cell Phone: _____

E-Mail Address: _____ Marital Status: S M D W Spouse; _____

Employer _____Occupation _____

Will this case be covered by any insurance company? Y N (circle) BC/BS / Univera / W. Comp / N. Fault / IHA

Insurance Card ID #: _____Group #: (BC/BS Only) _____

How did you hear about WNY Chiropractic? Referred By: _____

Your Chief Complaint: _____ Other complaints: _____

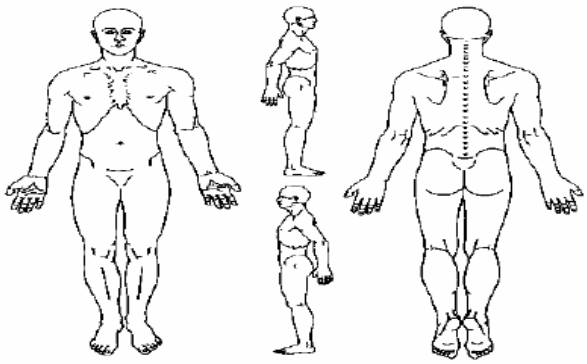
How & when did this occur: (must be specific)_____

Have you been treated by anyone else for this condition? Y N If yes, by whom? _____

Is this condition interfering with ____ Work ____ Sleep ____ Daily living routine?

Treatment Objective: (circle) Relief Correction Strengthen/Rehab Prevention Maintenance of Health/Wellness

A = ACHE
B = BURNING
N = NUMBNESS
P = PINS & NEEDLES
S = STABBING
O = OTHER_____



On the diagram, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (See next to diagram) over the area of the body where those symptoms are occurring.

My Pain Level right now:

No Pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand and grant permission and authority to the doctors and staff of Western New York Chiropractic, LLC to provide chiropractic evaluation, treatment and other clinical office procedures. I understand that results are not guaranteed. I understand that chiropractic treatment, like all forms of healthcare, while offering considerable benefit, may provide some level of risk. I have had the opportunity to discuss with office personnel regarding the aforementioned benefits, risks, and alternatives. I agree to authorize any treatment which may be necessary, covering the entire course of care for which I seek. I realize that I will be included in the treatment and planning of my chiropractic care and compliance to my outlined course of treatment and other recommendations is commensurate with case success.

SIGNATURE_____ **DATE**_____

THIS IS A CONFIDENTIAL HEALTH REPORT

Please circle any of the following symptoms which you now have or have had previously

ALLERGIES □ None

□ Environmental _____
□ Food _____
□ Medications_____
□ Other _____

Gastro-Intestinal □ None

□ Abdominal Pain
□ Black Stool
□ Bloody Stool
□ Constipation
□ Diarrhea
□ Gall Bladder
□ Hemorrhoids
□ Liver Trouble
□ Nausea
□ Poor Appetite
□ Vomiting Blood
□ Vomiting Food
□ Excessive Weight loss

Genital-Urinary System □ None

□ Bladder Trouble
□ Burning
□ Cloudy Urine
□ Discharge
□ Discolored Urine
□ Dribbling
□ Excessive Urination
□ Impotence
□ Painful Urination
□ Scanty Urination

Eyes □ None

□ Blurred Vision
□ Burning Eyes
□ Cataracts
□ Dryness
□ Glasses
□ Glaucoma
□ Itchy Eyes
□ Tearing
□ Vision Headaches

Respiratory System □ None

□ Congestion
□ Coughing up Blood
□ Difficulty Breathing
□ Inhalant Exposure
□ Non Productive Cough
□ Phlegm
□ Productive Cough
□ Short of Breath
□ Wheezing

Cardiovascular □ None

□ Chest Pain
□ Coughing Blood
□ Coughing Phlegm
□ Difficulty Breathing
□ Heart Problem
□ High Blood Pressure
□ Low Blood Pressure
□ Lung Problem
□ Pain over heart
□ Persistent cough
□ Rapid Heart Beat
□ Varicose Veins

Ear, Nose, Throat □ None

□ Bleeding gums
□ Dental Problems
□ Deviated Septum
□ Dry Mouth
□ Ear Discharge
□ Ear Noises
□ Ear Pain
□ Eye Inflammation
□ Eye Strain
□ Hearing Loss
□ Hoarseness
□ Nose Bleeding
□ Nasal Discharge
□ Recurrent infections
□ Sore Gums
□ Sore Throat
□ Throat Pain
□ Ulcers

Nervous System □ None

□ Confusion
□ Convulsions
□ Depression
□ Dizziness
□ Fainting
□ Hand Trembling
□ Headaches
□ Loss of Feeling
□ Loss of Balance
□ Loss of Memory
□ Numbness
□ Paralysis
□ Seizures
□ Tingling
□ Weak grip

FAMILY HISTORY: Have you, your mother, father, brother or sister had any of the following:

Mother	Father	Brother / Sister	You	
				HIV
				Alcoholism
				Anemia
				Arteriosclerosis
				Cancer
				Diabetes
				Epilepsy
				Heart Disease
				High Blood Pressure
				Kidney Disease
				Scoliosis
				Stroke
				Thyroid Disease
				Tuberculosis
				Ulcers
				Sexually Transmitted Disease

Any surgeries / fractures: _____

_____

Medications:_____

_____

Give dates you have had any of the following: (if exact dates are unknown, give approximate date):

Physical Exam _____ Blood Test _____ X-ray _____ Urine Test _____

Habits: (please check)

	None	Light	Moderate	Heavy	
Alcohol	☐	☐	☐	☐	drinks/day _____
Smoke	☐	☐	☐	☐	pack/day _____
Tobacco	☐	☐	☐	☐	type _____
Coffee	☐	☐	☐	☐	cups/day _____
Drugs	☐	☐	☐	☐	type _____
Exercise	☐	☐	☐	☐	times/week _____
Soft Drinks	☐	☐	☐	☐	drinks/day _____

SIGNATURE_____ **DATE**_____

Western New York Chiropractic Associates
Medical Privacy Notice

Notice of western New York Chiropractic associates' Privacy Policy

At Western New York Chiropractic Associates, we share your concerns for privacy and security of personal information. Because we value your privacy, we do not sell or trade any personal information that you have entrusted to us. To help you better understand our privacy and practices; we have prepared this notice for you. This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review carefully

1. *Understanding Your Health Record / Information*

Each time you visit a hospital, physician or other health car provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care of treatment. It may also contain correspondence or other administrative documents. Your medical records are used by medical providers and facilities to bill for Western New York Chiropractic Associates, obtain preauthorization, and verify medical necessity.

Western New York Chiropractic Associates receives and stores this information to provide you with medical care. Personal health information (or PHI) is any personally identifying information which when linked to health data could be used to identify an individual. This information may be stored or transmitted in any form (for example, paper, electronics, verbal, etc.) All of this information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Mean of communicating among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Tool in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning and marketing
- Tool by which we can access and monitor the health care being provided and the outcomes achieved

2. *Your Health Information Rights*

Although your health record is the property of the health care practitioner or facility that compiled it, the information belongs to you. Federal law gives you the right to:

- Inspect and obtain a copy of you health record
- Amend your record
- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Obtain and accounting of disclosures of your health information (other than purposes of treatment, payment and health care operations)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

3. *Our Responsibilities*

Our organization is required to:

- Maintain the privacy of your health information
- Provide with the notice of our legal duties and privacy practices regarding information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We will not use or disclose your personal health information without your authorization, except as provided by law.

Federal Standards for Privacy of and Individual Identifiable Health Information go into effect on or after April 14, 2003. Therefore, we reserve the right to change our practices and make new provisions effective for all PHI we maintain. If our information practices change, we will make the new version available to you. We are required to abide by the terms of the written Privacy Notice currently in effect. We reserve the right to change the terms of our Privacy Notice from time to time and to amend or make new notice provisions effective for all PHI we maintain. Anytime Western New York Chiropractic Associates makes such revisions, we will distribute revised notices by mail to all members in any plans currently administered by Western New York Chiropractic Associates. A material change (except where required by law) may not be implemented before the effective date of the notice in which the material change is reflected.

4. *For More Information or to Report a Problem*

If you have any questions or if you would like additional information, you may contact Western New York Chiropractic Associates by telephone (716-674-4254) by mail (810 Center Rd. West Seneca, NY 14224) or by fax (716-674-4392)

If you believe your privacy rights have been violated, you can file a complaint with Western New York Chiropractic Associates or with the Office for Civil Rights (OCR). Complaints must be in writing and can be filed by mail. OCR will provide further information on its web site about how to file a complaint (www.hhs.gov/ocr/hipaa/) Please note; there will be no retaliation for filing a complaint.

5. *Examples of Disclosures for Treatment and Health Care Operations*

Pursuant to law and the authorization form which you have signed:

- Treatment, payment, and health care operations: We may use your health information for treatment, payment and health care operations. For example, information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We will use that information for Pre-authorization purposes.

We may use your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as you diagnosis, procedures and supplies used. In the event that payment is not made, we may also provide limited information to collect from agencies, attorneys, credit reporting agencies, and other organizations as necessary to collect for services rendered.

- Food and Drug Administration (FDA): we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement.
- Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- Public Health: As required by law, we may disclose your PHI to public health or authorities charged with preventing or controlling disease, injury, or disability.
- Correctional Institution: If you're an inmate of a correctional institution, we may disclose to the institution or agents thereof PHI necessary for your health and for the health and safety of others.
- Law Enforcement: We may disclose certain PHI for law enforcement purposes as required by law or in response to a valid subpoena.

I have read and fully understand the above outlined Medical Privacy Notice and have been provided a copy of this notice to keep for my records. The original signed Medical Privacy Notice will be made part of my permanent record.

Patient Name _____

Signed: _____ Date: _____