WELCOME

We here at Scotchtown Chiropractic & Physical Therapy are pleased to welcome you to our practice. Please take just a few moments to fill out this form as completely as possible. If you have any questions we will be glad to assist in any way we are able. We look forward to working with you in maintaining your health.

Name_____DOB_____SS#_____
Address_____
City_____ State_____ Zip _____ Phone (H) _____ (C)_____
Email Address_____ Gender M_____ F_____
Married_____Widowed_____ Seperated_____ Divorced_____ Single_____ Other_____
Emergency Contact_____Phone Number_____

Patient employed By_____Occupation_____
Business Adress_____
Business Phone_____ Business Email_____

Whom may we thank for referring you?_____

Primary Insurance

Insurance Company_____ Phone _____
Member ID#_____ Group#_____Subscriber#_____
Person responsible for account_____
Relationship to patient_____ Birthdate_____ SS#_____
Address (if different from patient)_____
City_____ State_____ Zip_____ (C)_____ (H)_____

Reason For This Visit

Have you ever been to a Chiropractic office? Y____ N____
If yes then why? _____
Your reason for this visit _____
_____
When did symptoms first appear?_____
How often do you experience this pain? _____
Have you been treated by a medical physician for this pain? Y____ N____
If yes then where?_____

*****This document has 2 sides*****

Activities that are difficult/ painful to perform: sitting____ walking____ bending____ lifting___ lying prone____ standing____ Other_____

Type of pain: sharp____ dull____ throbing____ burning____ tingling____ numbness____ Cramping____ Other_____

Is pain Interfering with: work____ Sleep____ daily routines____ recreation____

Please list any/ all medications (over the counter and prescribed) that you are currently taking

_____

_____

Please list any serious injury you have had in the last 10 years

Description Date

Falls_____

Head Injuries _____

Broken/dislocated bones _____

Surgeries_____

_

Other_____

Medical Conditions

Check yes or no whether you have had or are currently experiencing any of the following medical conditions

Y__N__ Heart Attack/Stroke
Y__N__Gout
Y__N__ Alcohol/Drug abuse
Y__N__ Faint/Dizziness
Y__N__ Epilepsy
Y__N__ Arm Pain
Y__N__ Leg Pain
Y__N__ Difficulty Breathing
Y__N__ Seizures
Y__N__ Asthma
Y__N__ Cancer
Y__N__ Congenital Heart Defect
Y__N__ Arthritis
Y__N__ Headaches
Y__N__ Jaw Pain
Y__N__Wrist Pain
Y__N__Shoulder Pain
Y__N__ Glaucoma
Y__N__Hepatitis
Y__N__Allergies
Y__N__Earaches
Y__N__Ringing in ears
Y__N__Ulcer
Y__N__ High Cholesterol
Y__N__ Immune Disorder
Y__N__ Diabetes
Y__N__Shingles
Y__N__ Emphysema
Y__N__ HIV positive / AIDS
Y__N__Tuberculosis
Y__N__Kidney Problems
Y__N__Colitis/IBS
Y__N__Menstrual Problems
Y__N__Mood Disorders
Y__N__Artificial Joints/Bones

Personal Habits

Alcohol Heavy__ Moderate__ Light__None__
Coffee Heavy__ Moderate__ Light__None__
Drugs Heavy__ Moderate__ Light__None__
Exercise Heavy__ Moderate__ Light__None__
Appetite Heavy__ Moderate__ Light__None__
Tobacco Heavy__ Moderate__ Light__None__
Sleep Heavy__ Moderate__ Light__None__

Authorization

I have reviewed the information that I have supplied on this questionnaire and have determined it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine a healthful and appropriate chiropractic treatment plan. If there should be any change in my medical status, I will notify the chiropractor immediately

Signature_____ Date_____

Patient Payment Arrangements

Scotchtown Chiropractic & Physical Therapy
633 Route 211 East,
Middletown, NY 10941

Patient Name:_____ Date:_____

Treating Specialist/Specialty:
Chiropractic:_____ Physical Therapy:_____ Massage:_____

Primary Insurance Company:_____

Payments arrangement method for services rendered:
Co Payments: Daily_____ Weekly_____
Deductible: Daily_____ Weekly_____
Cash(No ins.): Daily_____ Weekly_____

Prepaid Cash Plan: *As plan selected dictates*

****Please be advised****

Your insurance company may deny payment for your healthcare services. This also applies to insurance that require pre-authorization or prior approval for your treatment. There is NO guarantee of payment. The insurance company will make the final determination on your case when the bill is received and reviewed by them. Upon completion of the recommended treatment plan, if there is any remaining balance, it will be billed to you on monthly invoices. You agree to make regular and consecutive payments. (for any unpaid balance a minimum of $25 per month will be due promptly to pay down you debt.) Any account that is sent to a collection company will be subject to their outer agency fees.

Patient Signature:_____ Date:_____

****This document has 2 sides****

Patient Consent Authorizations

CONSENT FOR TREATMENT/CARE: ***I voluntarily consent to the rendering of care, including treatment and performance of procedures by Scotchtown Chiropractic & Physical Therapy and their associates. I am aware that I may be asked to follow up my in-office treatments with out of office follow-thru recommendations that will promote a more rapid recovery. I have been informed of the possible risk factors associated with treatment that may include: bruising, soreness, and sprain/strain. The more serious factors may include: fracture or stroke, but are highly unlikely due to the examination and pre screening process. I am also aware that no one has made any guarantees about the results of my treatments, examinations or procedures.***

ASSIGNMENT OF BENEFITS: ***I hereby assign payment directly to the physician accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges, I understand that I am financially responsible for charges that are not covered by this assignment and that the insurance declines to pay for any reason. It is further agreed that any credit or balance resulting for payment of insurance or other sources may be applied to any other accounts owed to said physician/ healthcare provider by the insured or his/ her family.***

ATTENTION MEDICARE PATIENTS: ***I Certify that the information given by me in applying for the payment under Title XVIII and/ or Title XI of the Social Security Act is correct. I authorize any holder of medical records to release said information to the Social Security Administration or its intermediary carriers,needed for this Medicare claim. I request that payment of authorized benefits to be made on my behalf. I assign the benefits payable for physician's services. I understand that I am responsible for my health insurance deductibles and coinsurances or any care not deemed medically necessary.***

****X-rays are not covered under your Medicare benefits****

*******The physician/ healthcare provider may disclose all or part of the patients information to any person(s) which is or may be liable under contract to the provider or to the patient, family member, or employer of the patient for all or part of the provider charges******

Patient Signature:_____ Date:_____

For Women Only: ***By my signature on this form do I hereby attest to the best of my knowledge, that I am NOT pregnant, nor is pregnancy suspected at this particular time.***

Patient Signature:_____ Date:_____

Informed Consent Document

(please read each paragraph and initial the boxes that you understand)

Patient Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there if anything is unclear. The Doctor will review this document with you prior to treatment.

- **The Nature Of Chiropractic Adjustment.**

☐ The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy or mobilization. I will use that procedure to treat you, unless otherwise noted in the proposed treatment plan. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. That may cause an audible "pop" or "click". Much of what you feel when you "crack" your knuckles. You may feel a sense of movement.

Examination/Differential Diagnosis/Proposed Treatment Plan

☐ As part of the analysis, examination and treatment you are consenting to the following procedures: Manipulative therapy, palpation, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, ultrasound, hot/cold therapy, EMS, radiographic studies.

Differential Diagnosis:_____

Proposed Treatment:_____

- **The Risks Inherent In Chiropractic Adjustments**

☐ As with any healthcare procedure, there are certain complications which may arise with chiropractic manipulation and therapy. These complications include, but are not limited to: fracture, disc injuries, dislocations, muscle strains, cervical myelopathy, costovertebral strains or separations, and burns. Some types of manipulation of the cervical spine have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients may feel stiffness or soreness following the first few days after treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

- **The Probability Of Those Risks Occurring**

☐ Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history, and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on this topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote.

- **The Availability And Nature Of Other Treatment Options**

Other treatment options for your condition may include:

-Self-administered, over-the-counter analgesics and rest (if applicable)
-Physical therapy
-Ortho/Neuro consult
-Medical care- (M.D. or G.P.), prescription drugs such as anti-inflammatory, muscle relaxants, and pain-relievers
-Hospitalization
-Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. If the condition does not improve, condition changes or condition worsens this may result in a referral to any of these specialties.

- **The Risks And Dangers Attendant To Remaining Untreated**

Remaining untreated may allow the formation of adhesions or reduce mobility, which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

Consent To Treatment (Minor)

I herby request and authorize Dr. Laura Cruz/Dr. Walter Tonyes to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____. This authorization includes radiographic examination at the doctors' discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE SIGN THE APPROPRIATE LINE BELOW

I have read [ ] or have read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Laura Cruz/Dr. Walter Tonyes and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Dated: _____ **Dated:** _____

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Signature (Signature of Parent/Guardian [if a minor]) **Signature**