CONFIDENTIAL PATIENT CASE HISTORY

WORKERS COMPENSTATION

Please complete this questionnaire. This confidential history will be part of your permanent records.

Today's Date / / Signature of Patient _____

Signature of Parent/Spouse/Guardian _____

Patient Title: (check one) ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss ◯ Dr. ◯ Prof. ◯ Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home Email _____ Work Email _____

Which email address would you like us to use to communicate with you? (Check one)

◯ Home ◯ Work

Contact Method (Check one)

◯ Primary Phone ◯ Secondary Phone ◯ Mobile Phone ◯ Home Email ◯ Work Email

Date of Birth / Age _____ Gender (Check one) ◯ Male ◯ Female ◯ Unspecified

Marital Status (Check one) ◯ Single ◯ Married ◯ Other SSN _____

Employment Status (Check one)

◯ Employed ◯ FT Student ◯ PT Student ◯ Other ◯ Retired ◯ Self Employed

Race (Check one)

◯ White ◯ Black/African American ◯ Hispanic ◯ American Indian/Alaskan Native
◯ Asian ◯ Asian Indian ◯ Chinese ◯ Filipino
◯ Japanese ◯ Korean ◯ Vietnamese ◯ Native Hawaiian or other Pacific Island
◯ Samoan ◯ Guamanian or Chamorro ◯ Other_____ ◯ I choose not to specify

Multi-Racial (Check one) ◯ Yes ◯ No ◯ Unknown

Ethnicity (Check one) ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ I choose not to specify

Preferred Language (Check one)

◯ English ◯ Spanish ◯ American Sign Language ◯ Chinese ◯ French ◯ German
◯ Tagalog ◯ Vietnamese ◯ Italian ◯ Korean ◯ Russian ◯ Polish
◯ Arabic ◯ Portuguese ◯ Japanese ◯ French Creole ◯ Greek ◯ Hindi
◯ Persian ◯ Urdu ◯ Gujarati ◯ Armenian ◯ I choose not to specify

Verification Question (Choose only one question by checking the question, then give the answer to that question)

- ◯ What is the name of your favorite pet?
- ◯ What is your favorite movie?
- ◯ What was the make of your first car?
- ◯ In what city were you born?
- ◯ What is your mother's maiden name?
- ◯ When is your anniversary?
- ◯ What high school did you attend?
- ◯ On what street did you grow up?
- ◯ What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ◯ Yes ◯ Former smoker ◯ Never been a smoker

If yes, how often do you smoke: ◯ Current every day smoker ◯ Current sometimes smoker

If yes, what is your level of interest in quitting smoking? Date began smoking, even if former smoker?

◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

No interest Very Interested

Current medications, including dosage if known.
If there are no current medications, check here: ☐

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ☐

1) _____ 3) _____

2) _____ 4) _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ◯ Improved ◯ Unchanged ◯ Getting Worse

Is this condition interfering with your: ◯ Work ◯ Sleep ◯ Daily Routine Other _____

Other doctors or therapists who have treated THIS ____ condition _____

_____

_____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name : _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ◯Yes ◯No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ◯Yes ◯No If yes, what kind? ◯Type I ◯Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ◯Yes ◯No ◯Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back_____ spine in the past 28 days? ◯Yes ◯No

Have you had any X-rays, MRI's or CT Scans done in the past? YES NO

If yes, what was performed and at what facility? _____

To be performed by clinic staff:

Height: _____inches Weight: _____ pounds BP: _____ / _____

Your Insurance Information

Medical Insurance: _____ ID#: _____

Group #: _____ Policy Holder Name: _____

Relationship: _____ Policy Holder Date of birth: _____

Policy Holder's Employer:_____

REVIEW OF SYSTEMS Check only the ones you now have____ or have had__ in the past.

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	_____	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	_____	
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type _____
Age at First Period _____
Duration of Cycle _____
Duration of Flow _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Menstrual Flow ☐Heavy ☐Mod ☐Light
Last Period _____
Last Pap Smear _____
Last Vaginal Exam _____
Last Mammogram _____
Last Prostate Exam _____

Patient Name_____ Number_____ Date_____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work ○Heavy ○Moderate ○Light Hours per day _____

Physical Work ○Heavy ○Moderate ○Light Hours per day _____

Exercise ○Heavy ○Moderate ○Light Hours per week _____ Type _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

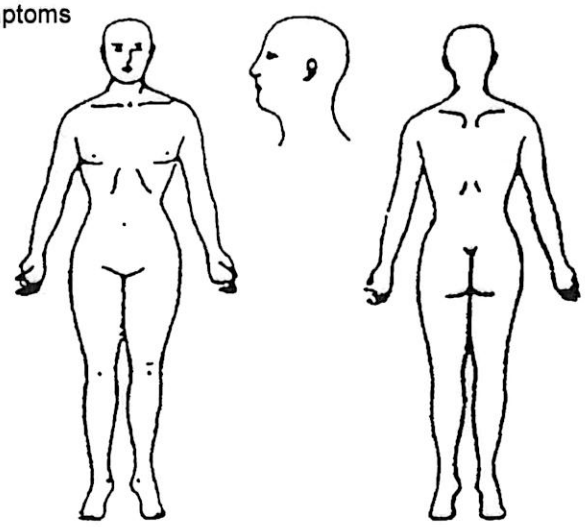
Caffeine Cups/Day _____ No. of Years _____
(Coffee, Tea, Cola)

Aspirin No./Day _____ No. of Years _____ Others _____

SYMPTOMS Mark the areas of your symptoms on the figure to the right.

Use the following symbols: Indicate where you have pain or other symptoms

Aches ⊠⊠⊠ Numbness oooo Pins/Needles ···· Stabbing ////
Burning ^^^^^^^ Tingling ####



Mark an "X" on the following two lines:

How often do you experience your symptoms? Circle One

How bad are your symptoms now?

Constantly (76-100%) Frequently (51-75%)

None Most Severe

Occasionally (26-50%) Intermittently (0-25%)

How bad have they been in the past? (Past 4 weeks) Circle One

0 1 2 3 4 5 6 7 8 9 10

None Most Severe

How are your symptoms changing? Circle One

Getting Better Not Changing Getting Worse

Patient Name_____ Number_____ Date _____

NEUROLOGIC	NOW	PAST
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

ENDOCRINE		
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION/VACCINATION	
DPT	☐
Mumps	☐
Smallpox	☐
Typhoid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

BLOOD TYPE			
A +	☐	A -	☐
B +	☐	B -	☐
AB +	☐	AB -	☐
O +	☐	O -	☐

Other _____

BLOOD TRANSFUSIONS

Date_____

Date_____

Date_____

Date_____

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

Hay Fever	☐	Parasites	☐
Mumps	☐	Epilepsy	☐
Rheumatic Fever	☐	Paralysis	☐
Allergies	☐	Polio	☐
Angina	☐	Mental Illness	☐
Cancer	☐	Alcoholism	☐
Tumor	☐	Depression	☐
Blood Disease	☐	Nervous Breakdown	☐
Leukemia	☐	Migraine	☐
Heart Trouble	☐	Gout	☐
Varicose Veins	☐	Hemorrhoids	☐
Phlebitis	☐	Prostate Problems	☐
Hypertension	☐	Sexual Problems	☐
Stroke	☐	Gonorrhea	☐
Ulcers	☐	Syphilis	☐
Jaundice	☐	Diabetes	☐
Skin Trouble	☐	Bladder Trouble	☐
Gallstones	☐	Kidney Stones	☐
Liver Trouble	☐	Kidney Infections	☐
Hepatitis	☐	Dysentery	☐

Date of Last Chest X-Ray _____ ◯Normal ◯Abnormal

Last TB Skin Test _____ ◯Normal ◯Abnormal

Allergies: _____

_____

_____

_____

_____

Patient Name_____ Number _____ Date _____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER		Address	
INSURANCE CARRIER		Address	

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completed and return to office.

Employee's name & address: _____

_____

_____

Phone number: _____

Occupation: _____

Age: _____ Sex: ☐ M ☐ F

Employer's name & address: _____

_____

_____

Phone number: _____

Type of business (retail, manufacturing, construction, etc.) _____

_____

Workers Compensation Insurance Carrier: _____

On what date did your injury occur? _____ What time? _____ AM PM

What address were you at when you were injured? _____

_____

Did you notify your employer of this injury? ☐ Yes ☐ No

Have you retained an attorney? ☐ Yes ☐ No

If Yes, please give name & address: _____

_____

_____

Are you currently in litigation for this injury? ☐ Yes ☐ No ☐ Maybe

Please explain how the injury or illness occurred: _____

_____

_____

What injuries did you suffer? _____

_____

_____

When was the last day you worked? _____

When did you return to work? _____

When was your first examination? _____

Who examined you? _____

_____

_____

Check one, if known: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

What was doctor's diagnosis? _____

(Please complete opposite side.)

Have you received any treatments prior to visiting this office? ☐ Yes ☐ No

What treatments did you receive? _____

_____

Have you ever injured this area before? ☐ Yes ☐ No

If Yes, when did the injury occur? _____

Did you lose time from work? ☐ Yes ☐ No

If you lost time from work with injuries prior to this injury, please list doctor or doctors consulted: _____

_____

_____

Do you have other injuries or illnesses that affect your employment? ☐ Yes ☐ No

If Yes. please explain: _____

_____

In your work, do you favor one part of your body more than others? ☐ Yes ☐ No

If Yes. please explain: _____

_____

Do you have a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No

Have you ever had a Worker's Compensation claim before? ☐ Yes ☐ No

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms: ☐ improving? ☐ getting worse? ☐ the same?

Lancaster Depew Chiropractic
345 Dick Road
Depew, NY 14043

Jason D. Cichocki, D.C.
Peter J. Guzinski, D.C.

Sarah L. Soper, D.C.

By Signing Below:

I authorize the office of Lancaster Depew Chiropractic and all of the doctors of Lancaster Depew Chiropractic to contact all phone numbers, including text messages and email addresses listed in my file.

In addition, I am requesting a **courtesy** appointment reminder or other non-personal office matters to be sent via text or email to the following:

Printed Patient Name: _____

□ I do NOT want to be contacted via text or e-mail

□ I choose to be contacted by (pick 1 only): □ Text □ E-mail

Cell phone #: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Cell Phone Carrier: _____

Email Address: _____

I may withdrawal authorization at anytime by submitting my request in writing to the office address listed above.

_____ _____

Patient/Parent/Guardian Signature Date

Activities of Daily Living

Name: _____ Date: _____

Please use the following scale to most accurately describe your current degree of pain and/or difficulty when performing the following activities.

0-No pain 1-Mild pain 2-Moderate pain 3-Severe pain NP-Not performed

1. Bathing/showering	0	1	2	3	NP
2. Bending forward/backward	0	1	2	3	NP
3. Brushing teeth	0	1	2	3	NP
4. Buttoning shirt	0	1	2	3	NP
5. Driving	0	1	2	3	NP
6. Drying hair	0	1	2	3	NP
7. Household chores	0	1	2	3	NP
8. Laundry	0	1	2	3	NP
9. Lifting less than 10 lbs	0	1	2	3	NP
10. Lifting more than 10 lbs	0	1	2	3	NP
11. Kneeling	0	1	2	3	NP
12. Making meals	0	1	2	3	NP
13. Prolonged sitting (> 30 min.)	0	1	2	3	NP
14. Putting pants on	0	1	2	3	NP
15. Putting shoes/socks on	0	1	2	3	NP
16. Reaching above the shoulder	0	1	2	3	NP
17. Restful night's sleep	0	1	2	3	NP
18. Seated to standing position	0	1	2	3	NP
19. Sexual activity	0	1	2	3	NP
20. Standing	0	1	2	3	NP
21. Squatting	0	1	2	3	NP
22. Taking out the trash	0	1	2	3	NP
23. Tying shoes	0	1	2	3	NP
24. Using lavatory	0	1	2	3	NP
25. Walking	0	1	2	3	NP

Patient Signature: _____ Date: _____

Lancaster Depew Chiropractic
345 Dick Road
Depew NY 14043
Jason D. Cichocki, D.C.
Peter J. Guzinski, D.C.

Sarah L. Soper, D.C.

PATIENT NOTIFICATION OF FINANCIAL RESPONSIBILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles and charges denied or not covered by my insurance company.

All copay's, deductibles, co-insurance, etc are required to be paid at the time of service. If a claim comes back with a balance that is still due the balance must be paid in full upon receipt of the bill or at the next visit, whichever comes first.

My signature below verifies my acknowledgement of the above policy. If I am unable to make payment in full I must make pre-arrangements with the billing department. The billing department reserves the right to make any exceptions to this policy on an individual basis.

_____ _____

Print Patient Name Signature of Patient or Parent/Guardian

_____

Date

Acknowledgement of understanding of notice of Privacy Practices for protected health information

I acknowledge that I understand Lancaster Depew Chiropractic's notice of Privacy Practices for protected health information. The original HIPPA form can be reviewed at the front receptionist desk.

_____ _____

Print Patient Name Signature of Patient or Parent/Guardian

_____

Date

I authorize the following individual(s) listed below to discuss my health information with Lancaster Depew Chiropractic.

1. Name:_____ Relationship:_____ Phone #:_____

2. Name:_____ Relationship:_____ Phone #:_____

3. Name:_____ Relationship:_____ Phone #:_____

Lancaster Depew Chiropractic
345 Dick Road
Depew NY 14043
Phone: 716-681-3333
Fax: 716-681-3037

Jason D. Cichocki, D.C.
Peter J. Guzinski, D.C.

Sarah L. Soper, D.C.

Office Policy on High Deductible Plans

Dear Patient:

"High Deductible" plans are becoming more common with insurance companies. The high deductible plans require the patient to pay for services out of pocket before the insurance plan picks up any liability. The deductible amounts can vary anywhere from hundreds to thousands of dollars. The deductible will start again each year when your plan renews.

It is our office policy to collect this deductible amount at the time of service if a deductible amount is remaining. The fees are based on the fee schedules provided by each insurance company. Once the claim has been processed, if there is a difference in the amount due you will be reimbursed or a bill will be sent to you for the additional amount owed.

It is ultimately the patient's responsibility to know if their plan has a high deductible and if it has been met for the year. If you have any questions about this please contact your insurance carrier and they can provide you with this vital information.

If you have any questions or concerns regarding this please do not hesitate to ask our staff members.

I HAVE READ THIS EXPLAINATON AND ACCEPT FINANCIAL RESPONSIBILTY FOR ANY CHARGES NOT COVERED BY MY INSURANCE.

_____
Date

_____
Print Name

_____
Patient's Signature

Lancaster Depew Chiropractic
345 Dick Road
Depew, NY 14043
Phone 716-681-3333
Fax 716-681-3037

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.
Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.
The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events

Lancaster Depew Chiropractic
345 Dick Road
Depew, NY 14043
Phone 716-681-3333
Fax 716-681-3037

of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I approve and direct Dr. _____, other doctors or others judged by him or her (including interns, assistants, and/ or preceptors) to perform the appropriate care and treatment not limited to adjustment. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive interaction or treatment as is deemed appropriate for my circumstance.

Patient Name	Signature	Date
Parent or Guardian	Signature	Date
Witness Name	Signature	Date

Doctors Checklist

- ☐ Benefits/ risks/ alternatives were discussed with patient and patient agreed to begin care.
- ☐ We discussed the possible side effects of the treatment performed in this office, that post treatment soreness is to be expected.
- ☐ The importance of performing all prescribed home care was discussed.
- ☐ The patient was made aware of the possibility of symptoms worsening improving.
- ☐ Diagnoses were shared with patient and the patient verbalized an understanding.
- ☐ Alternative treatment options for this condition were discussed with this patient.

Doctor's Initial _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____

Fax #: _____

I, _____ request the following information:
(Patient's name)

() records () reports () doctors notes () billing information

Concerning my: () Auto Accident () Work Accident () Other

To be released to: **Lancaster Depew Chiropractic**
345 Dick Road
Depew, NY 14043
Fax #: (716) 681-3037

For the purpose of: Treatment – this will allow the doctor to be well informed of my care outside of this office.

According to Section 25252 of the Health and Safety Code, these records must be provided within 15 days of receipt of this notice.

Signed: _____ Date: _____
Relationship to patient: _____
DOB: _____

LANCASTER DEPEW CHIROPRACTIC
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DEPEW, NY 14043
(716) 681-3333 (phone)
(716) 681-3037 (fax)