PRIME PERFORMANCE CHIROPRACTIC

352 Rosevale Ave Ronkonkoma, NY 11779

Phone: (631) 774-5241

Website: www.primeperformanceli.com

No Fault Patient Intake Form

Date:_____ Referred by:_____

Name:_____ MI: _____ E-mail:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Preferred Phone: Home Cell Work

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Height: _____ Weight: _____

Occupation:_____ Current Employer:_____

Emergency Contact Name:_____

Number:_____ Relationship to Patient:_____

Auto Injury Insurance Information

Date of injury: _____/_____/_____ Relationship to Insured: Self Spouse Child

Name of Ins. Co.: _____Ins. Phone: _____

Claim#: _____ Policy#: _____

Did you report injury? No Yes To whom? _____

Hospitalized? No Yes Where? _____

Were you working at the time of the accident? N Y Dates lost from work _____

Were you: Driver Passenger Pedestrian Number of people in vehicle? _____

Were you wearing a seat belt? N Y Did airbags deploy? N Y

Describe how accident happened: _____

_____

Name of Attorney: _____ Attorney Phone Number: _____

Past Medical History

Please list any other health problems, accidents, or surgical procedures you have had, no matter how insignificant they may be:

_____

_____

_____

_____

Current Problem

Chief Complaint (please specify side and body part):

_____

_____

Complaint began when and how:_____

_____

How would you describe the complaint/pain (circle all that apply): dull aching sharp shooting burning throbbing deep nagging other_____

Does the pain radiate/travel to any other areas of the body? Y N Where? _____

Any numbness or tingling in the body? Y N Where?_____

How frequent is your pain? (circle one) Occasional Intermittent Frequent Constant

Does anything make the pain worse? _____

Does anything make the pain better? _____

Other doctors seen for this condition? _____

_____

Imaging Studies (circle all that apply): X-ray CT scan MRI Bone Scan other_____

Body area imaged: _____ Facility: _____

Date of imaging: _____/_____/_____

Other tests: _____

Is this condition related to an accident? Y N

If yes, type of accident: Vehicular Work Related Slip/Fall

Smoking: Never Past Present If past or present, how long have you smoked?_____

Medications: _____

_____

Allergies: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA Notice that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health care records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Name of Patient Date

Assignment of Benefits

The undersigned patient and/or responsible party, assigns to our health care office the following rights, power, and authority.

Release of Information: I authorize any holder of medical information to release any and all past and present medical information about me to the office of Dr. Wilfredo Morales III, Prime Performance Chiropractic, located at 352 Rosevale Ave, Ronkonkoma, NY 11779. Our office is hereby authorized to furnish any insurance company, third party payer, hospital, or physician, any and all information it may have including but not limited to medical history, and reports pertaining to my case.
Irrevocable Assignment of Rights: You are assigned to the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of our bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and to prosecute and receive penalties, interest, court costs, or other legally compensational amounts, owed by insurance. I, as the patient, and/or responsible party, further agree to cooperate, provide information as needed to assist in the prosecution of such claims for benefits upon request.
Assignment of Benefits: To any insurance company providing benefits of any kind to me for treatment rendered at the address above, you are hereby tendered to pay in full the bill for services rendered directly to the appropriate Health Service Professional Corporations. Following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I owe personally which are not payable under the terms of your policy.
Patient Responsibility: I/we agree to pay the Health Service Professional Corporations at the above address the difference, if any between the amount of their charges and the amount paid to him by the attorney and/or insurance companies further understood that I agree to pay the full amount of my charge should my condition be such that it is not covered by my policy or if for any reason the insurance company refuses to pay my claim.

Informed Consent to Evaluation and Treatment

I do hereby request and consent to the performance of Health Care evaluations, therapy, treatments, diagnostic x-rays, and any other diagnostic procedures on me by the Doctors, Therapists, and Staff of Health care office of Dr. Wilfredo Morales III, Prime Performance Chiropractic located at 352 Rosevale Ave, Ronkonkoma, NY 11779.

I understand and am informed that in all health care modalities, there are some very slight risks to treatment including but not limited to: muscle strains, joint/ligament sprains, disc injuries, cardiovascular events, fractures, bruising, burns, and stroke. I do not expect the Doctors, Therapists, and Staff to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctors, Therapists, and Staff to exercise judgment during the course of the procedure which the Doctors, Therapists, and Staff felt at the time, based on the facts then known, is in my best interest. I also declare that the health history given by me is complete and in its entirety.

I have read the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the application of the above names procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I attest the above information is correct to the best of my knowledge.

_____

Patient Signature (Guardian if minor) Date

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

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APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

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