Knight Chiropractic Center

PATIENT REGISTRATION

Today's Date________________

Last Name__________________________ First Name_____________________________ Initial_____

Street ______________________________City______________________ State______ Zip________

Home Phone #(____)________________ Work Phone #(____)________________

Cell Phone # (____)_________________ E-Mail____

Date of Birth _____/_____/______Sex _________ SS#______-_____-_______ Marital Status_________

Employer________________________________Occupation___________________________________

Street ______________________________City______________________ State______ Zip________

How did you hear about our practice? ____

Is your current condition related to Employment? NO ☐ YES ☐

Is your condition related to an Auto Accident? NO ☐ YES ☐

Other Accidents? NO ☐ YES ☐ Please describe___________________________________

When did your present symptoms appear? ____

Have you ever had any complaints in the involved area before? NO ☐ YES ☐
If yes, please explain: ____

INSURANCE INFORMATION

To ensure all billing is submitted properly, please provide us with the following information. The front office will also need to make a copy of your insurance card for our records.

Insurance Company ________________________________ Phone #(_____)____________________

Street _____________________________City________________________ State______ Zip________

Name of Insured________________________ SS#______-_____-_______ Date of Birth____________

Policy #______________________ Group #___________________ Contract #____________________

Employer of the Insured_________________________ Relation (patient/insured)______________

Street _____________________________City________________________ State______ Zip________

In case of emergency, who should be notified? _____________________________

Phone # (_____)_______________ Relationship to patient_____________________

Knight Chiropractic Center

Chiropractic health care stresses the treatment of the *WHOLE* person, not just your back and neck.
To help us understand your health history, we ask that you fill out this questionnaire.

Please check any boxes that apply to you NOW…

Symptoms	*Symptoms*
☐ Headaches	☐ Loss of Balance
☐ Neck Pain	☐ Fainting
☐ Back Pain	☐ Loss of Smell
☐ Trouble sleeping	☐ Loss of Taste
☐ Nervousness	☐ Diarrhea
☐ Tension	☐ Cold Hands
☐ Irritability	☐ Cold Feet
☐ Chest Pain	☐ Arthritis
☐ Dizziness	☐ Muscle Spasms
☐ Shoulder/Arm/Neck Pain	☐ Frequent Colds
☐ Pins & Needles in Arms	☐ Upset Stomach
☐ Pins & Needle in Legs	☐ Constipation
☐ Numbness in Fingers	☐ Cold Sweats
☐ Numbness in Toes	☐ Fever
☐ High Blood Pressure	☐ Sinus Problems
☐ Difficulty urinating	☐ Diabetes
☐ Allergies	☐ Hemorrhoids
☐ Weakness in the Arms	☐ Leg Cramps
☐ Weakness in the Legs	☐ Colitis
☐ Shortness of Breath	☐ Gall Bladder
☐ Fatigue	☐ Indigestion
☐ Depression	☐ Vomiting
☐ Light Bothers Eyes	☐ Shoulder Pain
☐ Loss of Memory	☐ Knee Pain
☐ Ringing in the Ears	☐ Hay Fever
☐ Face Flushing	☐ Menstrual Problems
☐ Buzzing in the Ears	☐ Positive for HIV or AIDS

Have you ever had chiropractic care before? **Yes** ☐ **No** ☐

If so, when and with whom? ______________________________

Do you have any Allergies? **Yes** ☐ **No** ☐ **If so, to what are you allergic?** ___________

____

Have you ever broken any bones? **Yes** ☐ **No** ☐ **If so, which ones and when?**

____

Patient's Name: ______________________________

Knight Chiropractic Center

Have you dislocated any Joints? Yes ☐ No ☐
If so, which joints? ______________________________

Please list any operations you have had:

1. Year ________ Operation ______________________________
2. Year ________ Operation ______________________________
3. Year ________ Operation ______________________________
4. Year ________ Operation ______________________________

Have you been treated by a physician for any other health conditions in the last year?
Yes ☐ No ☐ If so, for what condition? ______________________________
____

Have you lost or gained weight in the last year? Yes ☐ No ☐

Are you currently taking any medications? Yes ☐ No ☐
If so, what medication? ______________________________
(Please list dosage) ______________________________
____

Do you take vitamins or herbs? Yes ☐ No ☐
If so, what type and how much? ______________________________
____
____

Who is your Primary Care Physician? ______________________________
Where are they located? ______________________________ Phone: ______________

When was your last:

	0-6 Months	6-12 Months	Over 12 Months	Never
Physical Exam:	☐	☐	☐	☐
Blood Test:	☐	☐	☐	☐
Urine Test:	☐	☐	☐	☐
X-rays:	☐	☐	☐	☐

Do you have any of the following habits?

Alcohol	Yes ☐	No ☐	How Much? ______________________
Coffee/Tea	Yes ☐	No ☐	How Much? ______________________
Tobacco	Yes ☐	No ☐	How Much? ______________________
Exercise	Yes ☐	No ☐	How Much? ______________________

Is there anything else about your health history that you think we should know? ______________
____
____
____

Patient's Name: ______________________________

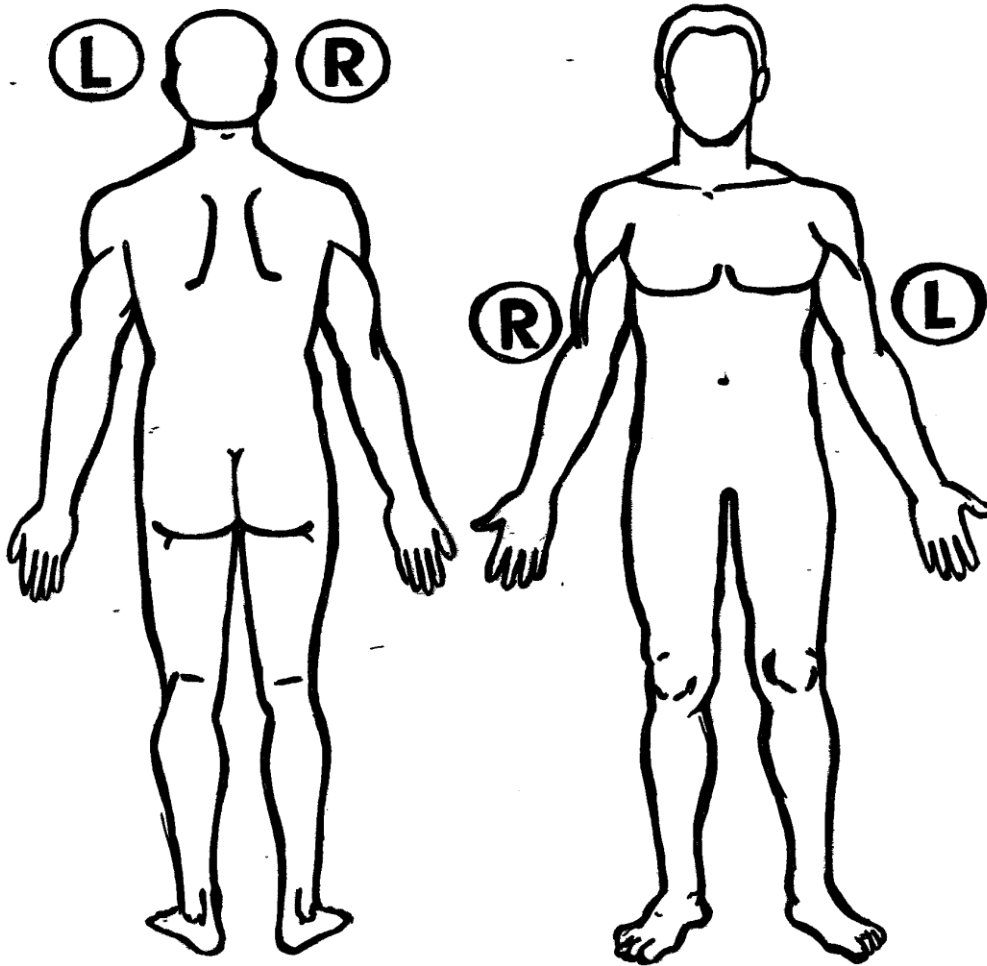
Current Pain Diagram

Name:____ **Date:**_______________________

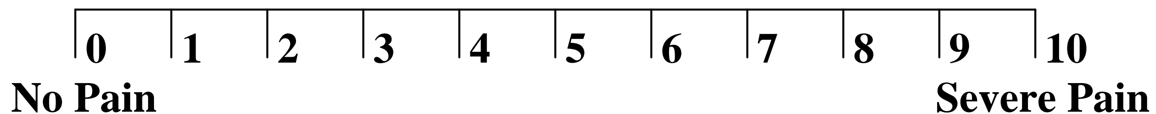
Mark all the areas of your body where you feel pain NOW.
Use the symbols below to describe the type of pain in the area of pain.

ACHE ####	**NUMBNESS ====**	**PINS& NEEDLES oooo**
BURNING xxxx	**STABBING ////**	**OTHER ^^^^ (please describe)**

Draw at the location of your pain TODAY



Rate Your Pain For TODAY



No Pain **Severe Pain**

Knight Chiropractic Center

FINANCIAL POLICY

SCHEDULING

- All appointments during regular hours must be scheduled so as reduce waiting time for you and others.
- You are free to stop in at any time, but you will have to wait until all scheduled appointments are seen. You will be fit in as soon as possible
- Cancellations require 24 hour notice. **THERE IS A $20.00 FEE OTHERWISE.**

PAYMENT

- Payment is expected in full at the time services are rendered. This includes all co-payments.
- For your convenience we accept Cash, Checks, MasterCard and Visa.
- Payments on your deductible will be made by paying our per visit charge until it is met.
- Should you discontinue care for any reason other than discharge by the doctor, any outstanding balances will become immediately due and payable in full by you.

INSURANCE

- Our office will verify your insurance coverage in effort to help you determine exactly what chiropractic coverage is available under your policy.
- It is your responsibility to provide us with all the appropriate insurance forms, addresses, and information so that proper filing can be done.
- We are not obligated to accept your insurance payment on assignment although for your convenience, we may based on our experience with your insurance carrier.
- You are always responsible for the portion of your bill that the insurance may not cover and for your annual deductible.
- Remember that your insurance coverage is a contract between you, your employer and the insurance company. We do not bill any secondary insurance carriers.

FEES

- Our fees generally fall between what is considered reasonable and customary for this area.
- Many insurers pay a percentage of the reasonable and customary rate, called the Co-Pay.

LASTLY

- You are responsible for all charges incurred as a patient of this office.
- We will do all we can with your insurance claims, but ultimately, you are responsible for payment.
- Past due statements for unpaid balances will be mailed. Statements unpaid for more than 30 days may be subject to an interest charge. In the effort to avoid expensive collection agency fees we hold the right to automatically bill any unpaid and outstanding balances, including interest payments to any credit card account on file in our office.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regards to your health or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I, the undersigned, have read and agree to the guidelines of this financial/insurance policy. I also fully acknowledge that I have insurance coverage with ______________________________ Insurance Company and assign directly to **Knight Chiropractic Center, LLP** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby, authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient's Signature:______________________________ **Date:**________________

Knight Chiropractic Center
3313 Chili Avenue
Rochester, NY 14624
(585) 889-3280

HIPPA - PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

(Name) ____hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent.1 The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request.2 The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.[3]

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice. In accordance with applicable law.[5]

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.[6]

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.[7]

5. I understand that I have aright to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations.8 However, the Practice is not required to agree to any restrictions that I have requested.9 However, if the Practice agrees to a requested restriction, then the restriction is binding on the Practice.[1o]

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation will not apply to the extent that the Practice has already taken action in reliance on this consent.[11]

I 7. understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.[12]

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.[13]

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

________________________________	________________________________
Name of Individual (Printed)	**Signature of Individual**
________________________________	________________________________
Signature of Legal Representative (e.g., Attorney-in-Fact, Guardian, Parent if a minor):	**Relationship**

____

Date Signed / / Witness:

(NEW YORK STATE CHIROPRACTIC ASSOCIATION AND HARTER. SECREST & EMERY. LLP. ROCHESTER, NEW YORK)

- Continuation -

HIPPA - PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

This is the signature page for the HIPPA Agreement:
(If you wish to read the whole article please ask our office staff and they will gladly provide you the correct reading material)

- **New York Civil Practice Law and Rule, Article 45, Evidence**
  - **§ 4504. Physician, dentist, podiatrist, chiropractor, and nurse**
  - **Rule 4518. Business records**
  - **Rule 4532-a Admissibility of graphic, numerical, symbolic, or pictorial representation of medical or diagnostic tests in personal injury actions**
  - **§ 4548. Privileged communications; electronic communication thereof**

(C) is required to abide by the terms of this Privacy Notice. [65]

(D) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains. [68]

(E) Will distribute any revised Privacy Notice to you prior to implementation. [67]

(F) Will not retaliate against you for filing a complaint. [68]

EFFECTIVE DATE

This notice is in effect today : ____/_____/____

By signing below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in a language that I understand.

______________________________	______________________________
Name of Individual (Printed)	**Signature of Individual**
______________________________	______________________________
Signature of Legal Representative (e.g., Attorney-in-Fact, Guardian, Parent if a minor):	**Relationship**

____

Date Signed / / Witness:

(NEW YORK STATE CHIROPRACTIC ASSOCIATION AND HARTER. SECREST & EMERY. LLP. ROCHESTER, NEW YORK)

I hereby give permission to Knight Chiropractic Center to leave messages on my home or cell number if applicable (please sign): ______________________________

Please provide the names of people you wish to give permission for us to correspond with regarding you and your care (and relationship to you) :

____

____

____