CONFIDENTIAL PATIENT INFORMATION

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D

Cell Phone _____ Email Address _____ Occupation _____

In case of emergency, who may we contact? _____

Whom may we thank for referring you? _____

HEALTH INFORMATION

Have you had previous Chiropractic Care? ☐ Yes ☐ No Physical Therapy? ☐ Yes ☐ No

Main Complaint _____

_____

Other Complaints _____

How long have you had this condition? _____

Have you had similar conditions in the past? _____

Does this condition affect your work? Yes ☐ No ☐

Does this condition affect your family or social life? Yes ☐ No ☐

What aggravates this condition? _____

_____

Other Doctors seen for this condition _____

_____

Are you taking any medication? _____

_____

What helps your symptoms? _____

Have you had any surgery, falls or accidents? Yes ☐ No ☐

When? _____ Please describe _____

_____

Date of last physical examination _____

INSURANCE INFORMATION

Is this condition due to Work related injury? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

If you answered yes to either of the above questions, please complete other side of form.

Are you covered by Medicare? ☐ Yes ☐ No Medicaid? ☐ Yes ☐ No

Do you have Major Medical Health Insurance? Yes ☐ No ☐

Insurance Carrier _____

_____

_____

Do You Suffer From

	YES	NO
Headaches	☐	☐
Neck Pain	☐	☐
Arm or Shoulder Pain	☐	☐
Back Pain	☐	☐
Hip or Leg Pain	☐	☐
Chest Pain	☐	☐
Abdominal Pain	☐	☐
Sinus Trouble	☐	☐
Heart Trouble	☐	☐
Palpitation	☐	☐
Circulatory	☐	☐
High or Low Blood Pressure	☐	☐
Female Problems	☐	☐
Prostrate Disorder	☐	☐
Kidney Problems	☐	☐
Bladder Problem	☐	☐
Lung or Bronchial Disorder	☐	☐
Digestive Disorder	☐	☐
Constipation	☐	☐
Loose Stool	☐	☐
Diabetes	☐	☐
Swollen Joints	☐	☐
Insomnia	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Nervousness	☐	☐
Depression	☐	☐
General Fatigue	☐	☐
Morning Fatigue	☐	☐
Anemia	☐	☐
Poor Memory	☐	☐
Hot Flashes	☐	☐

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Robert Gelman, D.C., PLLC and or Dr. _____
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.

_____ _____
Signature of Insured/Guardian Date

Complete only for:

JOB INJURY INFORMATION: Date _____ Time _____ Location _____

Description of accident _____

_____

_____

Workman's Compensation Case # _____

Insurance Company _____ Address _____

Insurance Company Case # _____

Employer's Name _____ Address and Phone _____

Hospitalized? _____ Name of Hospital _____ X-Rays Taken _____

Other Doctors seen _____

Are you working now? _____ Time lost from work _____

Do you have an attorney? Yes ☐ No ☐ Attorney's Name, Address, Phone #: _____

_____

Complete only for:

ACCIDENT INFORMATION: Date _____ Time _____ Location _____

Description of accident _____

_____

_____

If auto accident, were you ☐ Driver ☐ Passenger ☐ Pedestrian

If auto collision, were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was Parked

Did your car strike the other(s) involved? ☐ Yes ☐ No

Or did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

Do you have an attorney? ☐ Yes ☐ No

Attorney's Name, Address, Phone # _____

_____

_____

_____

Did you require hospitalization: ☐ Yes ☐ No

Check symptoms you have noticed since accident:

☐ Headache	☐ Dizziness	☐ Light Bother Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ Other
☐ Chest Pain	☐ Depression	☐ Loss of Taste	

Symptoms other than above _____

MEDICARE AUTHORIZATION

I request that payment of authorized medicare benefits be made either of me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

Dr. Robert Gelman

Patient Name:_____ Date of Birth:_____

Height:_____ Weight:_____

Medications:_____

_____

Medication Allergy List:_____

Race:_____ Ethnicity:_____

Primary Language Spoken:_____

Do you smoke cigarettes now?__ Did you ever smoke ?___ Date quit___

Do you have High Blood Pressure?_____ Do you have Diabetes?____

Family History	Diseases in the family? (Arthritis, Heart Disease, Cancer, Diabetes, Multiple Sclerosis?)	Living or deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother(s)		
Grandfather(s)		

Spouses Name _____

Signature_____ Date_____

Informed Consent

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 is anything that is unclear.

The nature of the chiropractic adjustment. The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment - As part of the analysis, examination, and treatment, you are consenting to the following procedures: (patient should initial procedures they are consenting to)

__ spinal manipulative therapy	__ palpation	__vital signs
__ range of motion testing	__ orthopedic testing	__ basic neurologic testing
__muscle strength testing	__ postural analysis	__ EMS
__ Ultrasound	__hot/cold therapy	__radiographic studies

__ other (please explain)

The material risks inherent in chiropractic adjustment- As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients feel stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me.

The probability of those risks occurring- Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options- Other treatment options for your condition may include:

-Self-administered, over-the-counter analgesics and rest

-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers

-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.

The risks and dangers attendant to remaining untreated- Remaining untreated may allow the formation of adhesions and 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.

Do Not Sign Until You Have Read And Understand The Above. Please Check The Appropriate Block And Sign 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. Robert Gelman 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 that treatment.

Dated:_____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian
(if a minor)

Dated:_____

_____
Doctor's Name

_____
Signature

HIPAA Acknowledgement of Receipt of Robert Gelman, DC, PLLC Notice of Privacy Practices

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq. and regulations there under, as amended from time to time (collectively referred to as "HIPAA"). This authorization affects your rights in the privacy of your personal healthcare information.

By signing this authorization, you acknowledge and agree that Robert Gelman, DC, PLLC ("Practice") or its Business Associates may use or disclose your Protective Health Information (PHI) for the purpose of providing treatment, for purposes of relating to the payment of services rendered, and for the Practice's healthcare operations purposes.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand Robert Gelman, DC, PLLC Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Robert Gelman, DC, PLLC has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available and can be received by sending a written request with return address to the center where you were seen.

By signing below, you are acknowledging that you have received, reviewed, understand and agree to the Notice of Privacy Practices of Robert Gelman, DC, PLLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of your Personal Health Information created, received, or maintained by the Practice.

Acknowledged and agreed to by:

Patient

By: _____ Date: _____

Print Name _____

OR, ON BEHALF OF PATIENT

By: _____ Date: _____

Print Name _____

Information about you, your appointment time or your examination results cannot be disclosed to persons other than you, unless you authorize us to do so. If you wish for use to disclose information to persons other than you, please indicate who they are below.

NAME	Relationship	Telephone Number

Signature: _____

Date: _____

Robert Gelman, D.C., PLLC
P.O. Box 591
Hempstead Turnpike, NY 11010
TIN# 26-1798597

DATE: _____

PATIENT: _____

Insurance Company: _____

Patient ID#: _____

ASSIGNMENT OF BENEFITS

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to:

Robert Gelman, D.C., PLLC PO Box 591 Franklin Square, NY 11010

This is for the medical or professional expense benefits allowable, and otherwise payable to me under my current insurance policy towards the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

***Patients Printed Name:_____Date:_____

***Patients Signature: _____Date:_____