CHIROPRACTIC REGISTRATION & HISTORY

Patient Information

Date: _____

SS/HIC/Patient ID # _____

Patient First Name: _____

Patient Middle Initial: _____

Patient Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Sex: ☐ Male ☐ Female Age: _____

Birthdate: _____

MARITAL STATUS ☐ Married ☐ Widowed ☐ Signle ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ Years

Occupation: _____

Patient Employer/School: _____

Employer/School Address: _____

_____

Employer/School Phone: _____

Spouse's Name: _____

Birthdate: _____ SS# _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co.: _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name: _____

Birthdate: _____ SS# _____

Relationship to Patient: _____

Insurance Co.: _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ (Name of Insurance Company(ies))

and assign directly to Dr. Bialecki / Krock

all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Companylies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

Phone Numbers

Home Phone: _____ Cell Phone: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other: _____

To whom have you made a report of your accident? ☐ Auto Insurance

☐ Employer ☐ Worker Comp. ☐ Other: _____

Attorney Name (if applicable): _____

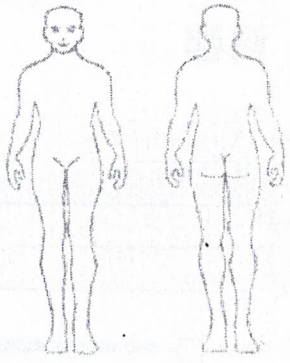
Patient Condition

Reason for Visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from I (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

☐ Other: _____

Name and address of other doctor(s) who have treated you for your condition: _____

Date of Last: Physical Exam: _____ Spinal X-Ray: _____ Blood Test : _____

Spinal Exam: _____ Chest X-Ray: _____ Urine Test: _____

Dental X-Ray: _____ MRI, CT-Scan, Bone Scan: _____

Place a mark on Yes" or "No" to indicate if you have had any of the following:

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV	○	○	Diabetes	○	○	Liver Disease	○	○	Rheumatoid Arthritis	○	○
Alcoholism	○	○	Emphysema	○	○	Measles	○	○	Rheumatic Fever	○	○
Allergy Shots	○	○	Epilepsy	○	○	Migraine Headaches	○	○	Scarlet Fever	○	○
Anemia	○	○	Fractures	○	○	Miscarriage	○	○	Sexually Transmitted Disease	○	○
Anorexia	○	○	Glaucoma	○	○	Mononucleosis	○	○	Stroke	○	○
Appendicitis	○	○	Goiter	○	○	Multiple Sclerosis	○	○	Suicide Attempt	○	○
Arthritis	○	○	Gonorrhea	○	○	Mumps	○	○	Thyroid Problems	○	○
Asthma	○	○	Gout	○	○	Osteoporosis	○	○	Tonsillitis	○	○
Bleeding Disorders	○	○	Heart Disease	○	○	Pacemaker	○	○	Tuberculosis	○	○
Breast Lump	○	○	Hepatitis	○	○	Parkinson's Disease	○	○	Tumors, Growths	○	○
Bronchitis	○	○	Hernia	○	○	Pinched Nerve	○	○	Typhoid Fever	○	○
Bulimia	○	○	Herniated Disk	○	○	Pneumonia	○	○	Ulcers	○	○
Cancer	○	○	Herpes	○	○	Polio	○	○	Vaginal Infections	○	○
Cataracts	○	○	High Blood Pressure	○	○	Prostate Problem	○	○	Whooping Cough	○	○
Chemical Dependency	○	○	High Cholesterol	○	○	Prosthesis	○	○	Other: _____	○	○
Chicken Pox	○	○	Kidney Disease	○	○	Psychiatric Care	○	○	Other: _____	○	○

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day: _____
- ☐ Alcohol — Drinks/Week: _____
- ☐ Coffee/Caffeine Drinks — Cups/Day: _____
- ☐ High Stress Level — Reason: _____

Are you pregnant? ☐ Yes ☐ No

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals

Pharmacy Name: _____

Pharmacy Phone: _____

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 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 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 chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

STATEMENT OF ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY DISCLAIMER, RELEASE OF MEDICAL INFORMATION FORM AND DECLARATION

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

I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review any/all documentation submitted by Dr. John M. Bialecki., for review for medical necessity and base their approval/denial upon this documentation.

I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my care is not approved by the insurance company. If a treatment plan is approved, this office will make me aware of the number of office visits allowed and the time frame of the authorization. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

This office may seek payment from you for any services your health insurance plan determines to be not medically necessary.

I have read and understood my obligations for payment for care in the absence of insurance coverage.

_____ _____

(Print Patient's Name) Date

_____

Signature (Patient, Parent or Guardian)

* I authorize Dr. John M. Bialecki. to release any medical information pertinent to my treatment plan to my insurance company or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy/policies. I certify that all insurance information given to this office is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

*I declare under penalty of perjury (under the laws of United States of America) that the foregoing is true and correct: I am not attempting to investigate Bialecki Chiropractic as a representative of any agent or entity, or any insurance company or other organizational entity or person.

_____ _____

(Printed Name) Date

_____ _____

(Signature) Witness signature

John M. Bialecki DC
3140 Sheridan Dr. Suite 140 Amherst New York 14226

BIALECKI CHIROPRACTIC

3140 Sheridan Dr Suite 140 Amherst, New York USA 14226
PHONE: 716-240-9365 • FAX: 716-240-9368

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:
You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian:_____ Date:_____

Print Name of Patient or Legal Guardian:_____ Date:_____

Bialecki Family Chiropractic
3140 Sheridan Drive Suite 140 Amherst New York 14226
716-240-9365

No-Fault Questionnaire

Date:_____

Name:_____ Date of Birth:_____ SS#: _____-_____-_____

Address:_____ City:_____ State:_____ Zip:_____

Employer's Name:_____ Employer's Phone # ( ) _____-_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

Auto Insurance Company for the Vehicle **YOU** were in:_____

Auto Insurance Policy #:_____ Agent:_____

Auto Insurance Company address:_____ Phone: ( ) _____-_____

Date of Accident:_____ Claim#:_____ Time of Day:_____

Have you retained an Attorney:_____ If yes, Attorney's Name:_____

Attorney's Address:_____ Phone number: ( )_____-_____

Nature of Accident:

Where were you seated in the vehicle?_____ How many people were in the Car?_____

Which direction were you headed? (North) (South) (East) (West). Where did the accident occur?_____

_____

_____

Were you Struck from: (Behind) (Front) (Left Side) (Right side). Were the police notified?_____

Do you have a police report?_____ Were you seated belted?_____

Any injuries prior to this motor vehicle accident? _____ If, yes please explain:_____

_____

In your own words, please describe the accident:_____

_____

_____

_____

Name:_____ Date of Accident:_____

Where were you taken after the accident?_____

_____

_____

Have you been treated by another doctor since the accident?_____ If yes, please list names and addresses:_____

_____

_____

Since your injury occurred, are your symptoms: (Improved) (Worse) (The Same)

Do you have any activity restrictions as a result of this injury?_____ If yes, please describe in detail:_____

_____

_____

Circle any of the following symptoms you have noticed since the accident:

(Headache)	(Fainting)	(Irritability)	(Light bothers eyes)
(Face Flushed)	(Pins &Needles)	(Feet Cold)	(Nervousness)
(Chest Pain)	(Cold Sweat)	(Shortness of Breath)	(Loss of taste)
(Hands Cold)	(Loss of Memory)	(Neck Stiffness)	(Dizziness)
(Fatigue)	(Tension)	(Loss of balance)	(Depression)
(Sleeping Problems)	(Diarrhea)	(Constipation)	(Back Pain)
(Ears Ringing)	(Fever)	(Numbness in fingers)	
(Loss of smell)	(Stomach upset)	Other:_____	

Have you lost any time from work as a result of this accident?_____ If yes, what was your last day that you worked?_____

TERMINATION OF CARE WAIVER

I hereby acknowledge and understand that if I do not keep scheduled appointments as recommended to me by my attending doctor at this chiropractic office, Dr. John M. Bialecki has full and complete right to terminate my case that I am under his care for. Also, that any outstanding amount on my account are my responsibility. I , the undersigned also state that all information provided to Dr. John M. Bialecki is true to my knowledge.

Patient Signature	Date
Parent and/or Guardian Signature	Date
Provider/Staff Signature	Date

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I,_____, ("Assignor") hereby assign to Dr. John M. Bialecki/Dr. Catherine Krok ("Assignee")
(Print patient's name) (Print hospital or health care provider name)

all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWNIGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWNINGLY MAKES OR KNOWNINGLY ASSITS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURNACE COMPANY, COMMITS A FRADUDLENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH SUCH VIOLATION.

_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) (Signature of Provider)

3140 Sheridan Drive Suite 140 _____
(Date of Signature)

Amherst, New York 14226
(Address of Provider)

NYS FORM NF-AOB (REV 1/2004)

NYS FORM NF-AOB (5/2003)
03-00414NFAOB

Medical Records Authorization

I HEREBY AUTHORIZE: _____

to disclose the following protected health information: (Specially describe the information to be released.): ALL RECORDS REGARDING TREATMENT FOR D.O.I.

RELEASE RECORDS TO:

Name: John M. Bialecki D.C.
~~3140 Sheridan Drive, Suite~~ 140
Amherst, New York 14226

Address: _____

_____

Fax #: 716-240-9368

Disclosure of information is authorized for the following purposes: EVALUATION AND TREATMENT

_____

I UNDERSTAND that I may refuse to sign this authorization. My refusal does not affect my treatment. I may revoke this authorization at any time, in writing , and that if I choose to do so, my request to revoke will not affect any actions taken by the Bialecki Family Chiropractic before receiving my revocation.

I UNDERSTAND that there is a potential for information use or disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected by federal or state law.

THE EXPIRATION DATE cannot be greater than 90 days from the date of the request.

I fully understand and accept the terms of this authorization.

Patient's Name: _____

(Please print- If name was different due to martial status, please include previous name as well)

Patient's Full Address: _____

Telephone No: _____

Relationship: _____ **Patient's Birthdate:** ____/____/____

Signed: _____ **Date:** ____/____/____

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716-240-9365 Fax#: 716-240-9368