LIBERTY WELLNESS & CHIRO

Tel: (212) 742-8000 Fax: (212) 742-1557
Monday - Friday 10:00 am - 7:00pm
30 Wall St #500, New York, NY 10005

New Patient Form

Please fill out completely, print, sign and date the form and bring with you to your first appointment

Patient Name: Last_____First_____M____SS#_____

Address_____City_____State_____Zip_____

Email Address:_____Home #_____Cell # _____

Date of Birth: ___/___/___ Referred By: _____ Status ❍ S ❍ M ❍ D ❍ W Gender ❍ M ❍ F ❍Non-Binary

Occupation_____Employer_____Work # _____

Employer's Address_____City_____State_____Zip_____

In Case of an Emergency:

Who should we contact?_____Relationship: _____

Home Phone #:_____Work Phone #:_____ext._____

Reason For Visit:

The reason for this visit is a result of: ❍ _____ ❍ Unknown ❍ Sports ❍ Trauma ❍ Chronic ❍ Auto / Work Comp

When did the condition begin:_____ Is this condition getting worse? ❍Yes ❍No ❍ Unchanged

Describe what happened: _____

Describe your main complaint & its location:_____

Grade your Primary Complaints (how you feel today):

❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍

0 1 2 3 4 5 6 7 8 9 10

No Pain *Unbearable Pain*

How often are your symptoms present?

❍ 0-25% ❍ 26-50% ❍ 51-75% ❍ 76-100%

Describe the secondary complaint & its location:_____

Grade your secondary complaints (how you feel today):

❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍ ❍

0 1 2 3 4 5 6 7 8 9 10

No Pain *Unbearable Pain*

How often are your symptoms present?

❍ 0-25% ❍ 26-50% ❍ 51-75% ❍ 76-100%

Have you been treated by another provider for this condition? ❍Yes ❍No_____

Have you had any spinal X-Rays, MRI or CT Scans for your area(s) of complaint? ❍ Yes ❍ No list areas taken:

_____

Please bring any films or reports related to your condition with you on your initial visit.

Have you ever been treated by a Chiropractor before? ❍ Yes ❍ No If so, whom? _____

Who is your Primary Medical Doctor?_____Phone #: _____

Lifestyle Information: Do you…

❍ Yes ❍ No smoke?_____packs/day

❍ Yes ❍ No exercise? How often?_____

❍ Yes ❍ No take Vitamins or Supplements? *(list below)*

❍ Yes ❍ No take Medications? *(list below)*

❍ Yes ❍ No drink alcohol?_____units/day

❍ Yes ❍ No wear heel lifts?

❍ Yes ❍ No wear orthotics?

❍ Yes ❍ No sleep well? How old is your mattress? — yrs.

List all medications and/or supplements you take _____

_____

For Women:

❍ Yes ❍ No take Birth Control? _____ ❍ Yes ❍ No Are you Pregnant? Weeks/LMP_____?

Patient Medical Health History:

List any allergies to foods, medications, etc.: _____

List any condition(s) you have or ever had: _____

List any past accidents with dates: _____

List any previous surgeries/treatments with dates: _____

Symptoms Survey:

Do you currently have or have you ever had any of the following conditions or diseases?

❍ Yes ❍ No Neck Pain or Stiffness
❍ Yes ❍ No Mid Back Pain or Stiffness
❍ Yes ❍ No Lower Back Pain or Stiffness
❍ Yes ❍ No Tension or Migraine Headaches
❍ Yes ❍ No Tingling or Numbness in Arms / Hands
❍ Yes ❍ No Tingling or Numbness in Legs / Feet
❍ Yes ❍ No Shoulder / Elbow / Wrist Pain *(Circle)*
❍ Yes ❍ No Hip / Knee / Ankle Pain *(Circle)*
❍ Yes ❍ No High/Low Blood Pressure
❍ Yes ❍ No Difficulty Breathing
❍ Yes ❍ No Asthma
❍ Yes ❍ No Sinus Problems
❍ Yes ❍ No Spine Surgeries/Artificial Joints

❍ Yes ❍ No Heart Disease / Stroke / TIA *(Circle)*
❍ Yes ❍ No Neurological Conditions
❍ Yes ❍ No Anemia
❍ Yes ❍ No Fainting/Seizures/Epilepsy
❍ Yes ❍ No Osteoporosis / Osteopenia
❍ Yes ❍ No Cancer, If yes, Please specify
❍ Yes ❍ No Chemotherapy / Radiation
❍ Yes ❍ No Alcohol / Drug Abuse
❍ Yes ❍ No Ulcers / Colitis
❍ Yes ❍ No Hepatitis
❍ Yes ❍ No Meningitis
❍ Yes ❍ No Diabetes/Tuberculosis
❍ Yes ❍ No Psoriatic Arthritis

Family Medical Health History:

Do any members of your immediate family have or ever had any medical conditions listed above? If yes, please list:

_____

Insurance Information:

Insurance Co. Name: _____ Tel# _____

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

Insured's Name: _____ Date of Birth: _____

Insured's ID#: _____ Group #: _____ Relationship _____

I hereby assign to the Provider all amounts payable by my insurance policy or plan for the services rendered by the Provider, including all applicable insurance benefits or reimbursements. I authorized such amounts to be paid directly to the Provider. It is the policy of some insurance companies to pay the subscriber (patient) directly in certain cases. I fully understand that if I receive any payment directly from my insurance company for services rendered by the provider, I am solely responsible to sign over such insurance checks. In the event that I deposit these checks into my account or negotiate them, I am responsible for reimbursing the provider that rendered these services for an equal amount. I also hereby assign to the Provider, to the greatest extent permitted by law, any legal claims I may have with respect to payment for the services rendered by the Provider, including any legal claims I may have under the Employee Retirement Income Security Act ("ERISA") or other state or federal laws.

I hereby appoint and designate the Provider as my Authorized Representative in connection with any claim, right, or cause of action that I may have under my insurance policy and/or benefit plan, including but not limited to administrative appeals or litigation. I specifically appoint and designate Provider to act as my Authorized Representative with respect to ERISA, as provided in 29 C.F.R. § 2560.503-1(b)(4). By signing this form, I understand that Provider is not assuming any obligation or duty to assert such rights and I agree to release any claim I might have relating to Provider's exercise of such rights or the decision not to exercise such rights.

I understand that I am financially responsible for all of the Provider's charges, including any deductibles, copays, coinsurance, or any other charges that are not fully paid by insurance.

We encourage you to inform the front desk if you want to discuss any questions you have regarding our services or billing practices. This promotes a greater confidence and trust between our patients and staff, thus resulting in a more comfortable experience and healing environment. I understand the information in this form and completed it truthfully to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in the provided information that may occur in the future.

As the parent or legal guardian of the minor listed above, I herby authorize the doctors at this office and their assistants to administer care as deemed necessary.

Patient's Signature	Relationship	Date

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Office Policies

- Your recommended treatment plan has produced the best results for our patients in the past based on our experience with your specific condition. Generally, more frequent treatment during the initial phase of care (first 2-4 weeks) produces better outcomes. Your objective and subjective findings should improve significantly if the treatment plan is complied with. As progress is made, we will taper down your treatment frequency.

Your well-being and satisfaction with our services is our top priority, so please keep all scheduled appointments, especially during the initial phase of care. We believe patient noncompliance results in suboptimal results and frustration for patients and providers. In the event you miss a scheduled appointment, please reschedule within the weekly treatment plan parameters so that we may provide you with the highest standard of care.

- Financial arrangements will be clearly discussed with you before beginning care. If you have any questions regarding finances or require a detailed explanation of insurance benefits please bring them to our attention ***as soon as possible***. Clear communication between you and our office staff will result in a more enjoyable healing experience. If you have questions regarding any aspect of your care or have any financial concerns please make an appointment to speak with Sean Cotter, D.C., Clinical Director of **Liberty Chiropractic**. He will discuss any questions and concerns you may have and work towards a resolution. **Liberty Chiropractic** accepts assignment of insurance benefits and handles submission of all your claims. This service allows you, the patient to focus on your health and wellness

- We encourage you to experience all providers of our practice (chiropractors and massage therapists). If you prefer one over another, feel free to request them for future appointments at the front desk. Every effort will be made to schedule you with him/her on subsequent visits. As the patient you will benefit from the expertise and specialization provided by other members of the **Liberty Chiropractic** Healthcare Team. We refer to this as an ***integrative approach to healing and wellness***.

- Most of our patients are referred to us from past or existing patients. If the care you receive at our office meets or exceeds your expectations, we ask that you recommend your friends, colleagues and family. We promise to provide them with the same high standard of care we provide to you.

- We make every effort to respect your time and we ask that you do the same. Massage therapy visits that are cancelled with less than 24 hours notice may be subject to a $40 cancellation fee, especially if cancellations occur on a regular basis. However, rescheduling (and keeping) an appointment within 24 hours of the original visit will avoid incurring this fee.

- We ask that you keep all of your personal information current, particularly your insurance information, address and phone numbers. If anything changes, please let us know as soon as possible.

We welcome you as a patient of
Liberty Chiropractic

Signature _____ Date _____

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Consent Agreement

I, _____ understand and accept that as part of my patient care at Liberty Chiropractic that this practice originates and maintains health records describing my health history, symptoms, examinations, test results, diagnosis, treatment, and any plans for future care or treatment as a standard of care. I understand that this information will be utilized for professional purposes to assist in developing an appropriate treatment plan and allow effective communication among other health care professionals who may participate in my care. This information will also be provided to third party payers (insurers) that will include the diagnosis, procedures performed and documentation of those procedures that serve as verification of services rendered. Periodic re-evaluations will be performed to monitor my progress and assess whether appropriate care is being given to me.

I understand that I have the right to object to the use of my health information for purposes other than those described in this document. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Liberty Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Liberty Chiropractic has already taken action in reliance thereon.

I wish to add the following restrictions to the use or disclosure of my health information.

_____

_____

_____

I fully understand and accept the terms of this consent.

_____ _____

Signature Date

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PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____
Patient Printed Name

_____
Patient Signature or legal representative

_____
If legal representative, state relationship

_____
Date

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

☐ the patient refused to sign
☐ we were not able to communicate with the patient
☐ due to an emergency situation it was not possible to obtain a signature
☐ other (please provide details): _____

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date

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NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:
You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:
You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-packet in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:
You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

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Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:

We can use and share your health information to run our practice, improve your care, and contact your when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:

We can use or share your information for health research.

Comply with the law:

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

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Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:
We can share heath information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain to privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

OPTIONAL Additional Items:
1) Open Room: We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested.

Contact information:

Compliance officer name, contact email, tel., & effective date of notice:

_____

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Date: _____

Dear: _____

We are pleased to welcome you to our facility and look forward to delivering you the highest quality healthcare. Upon verifying your insurance benefits we were informed that payment for the services being provided to you will be sent directly to your residence. We are asking that upon receipt of any such payments from **Empire Blue Cross Blue Shield** or any secondary insurer that you immediately deliver them to us either by person or by mail.

Do Not Cash these Checks

Please understand that by signing this letter you are not claiming yourself responsible for any charges we may bill your insurer, but that you are solely responsible for delivering us such payments accordingly. Once again we appreciate you choosing our office and look forward to serving you with utmost professionalism.

Sincerely,

_____

Patient's signature of agreement: _____