New York BRAIN SPINE & JOINT

Date: _____

Patient Demographics

Patient Name: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Non-Binary

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Reminders: ☐ Text ☐ Email

Employer: _____ Work Phone: _____

Employer Address: _____

Insurance Information:

1. Primary Insurance Information

Carrier: _____ Policy#: _____ Group#: _____

Policy Holder: ☐ Self (if checked, leave below blank) ☐ Child ☐ Spouse ☐ Other

Policy Holder Name: _____ DOB: _____

Policy Holder Address: _____

Policy Holder Phone#: _____

2. Secondary Insurance Information (if applicable)

Carrier: _____ Policy#: _____ Group#: _____

Policy Holder: ☐ Self (if checked, leave below blank) ☐ Child ☐ Spouse ☐ Other

Policy Holder Name: _____ DOB: _____

Policy Holder Address: _____

Policy Holder Phone#: _____

Who may we thank for your referral? _____

New York BRAIN SPINE & JOINT

Date: _____

Medical History

Primary Care Provider

Name: _____ Phone#: _____ Fax: _____

Have you been to a Chiropractor before? ☐ No ☐ Yes, Name: _____

Is there any chance you may be pregnant? ☐ No ☐ Yes, Expected Due Date: _____

When was your last: Physical Exam: _____ Xray: _____

Spinal Exam: _____ MRI/CT scan/Bone Scan: _____

What medications are you taking? ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers ☐ Blood Thinners

☐ Other: _____

How often do you exercise: ☐ Never ☐ Sometimes ☐ Weekly ☐ Daily

What is your work activity like: ☐ Sitting all day ☐ Standing all day ☐ Light Labor ☐ Heavy labor

Do you: ☐ Smoke? Packs/day _____ ☐ Drink Alcohol? Drinks/week _____

☐ Drink coffee? Cups/day _____ ☐ Have high stress levels? Reason _____

Have you had any recent injuries or surgeries? When were they and what did they involve? _____

_____

_____

What is the reason for your visit? Major complaints or concerns? How long have you had the symptoms?

_____

_____

_____

Are your symptoms: ☐ Getting worse? ☐ Getting better? ☐ Fluctuating?

What increases your pain: _____

What decreases your pain: _____

What treatments have you received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic ☐ None ☐ Other: _____

Have you seen any other doctors for this condition? ☐ No ☐ Yes, please fill out their information below:

Physician Name: _____ Care type: _____

Address: _____

Phone#: _____ Fax#: _____

On a scale of 1 – 10, how bad would you rate your pain today? _____

How often do you have this pain: ☐ Constant ☐ Fluctuating ☐ Random Flare Ups ☐ Induced

Does it interfere with: ☐ Work? ☐ Sleep? ☐ Daily Routines? ☐ Recreation?

Which of these are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐Bending ☐Lying down

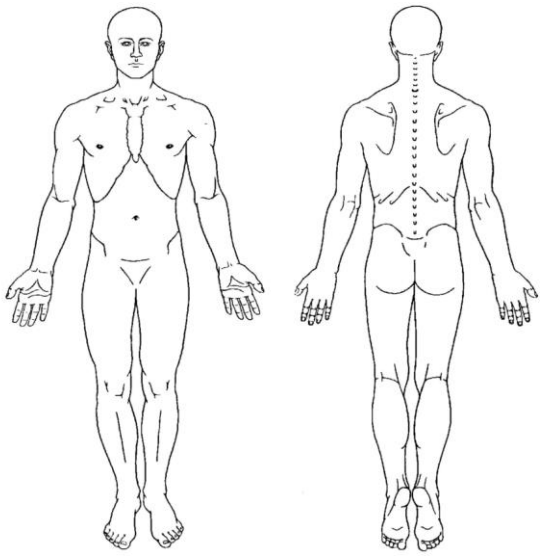
Check off "Yes" or "No" if you have had any of the following:

Weight loss or gain	☐Yes ☐No	Swollen glands	☐Yes ☐No	Calf pain w/ walking	☐Yes ☐No
Fever or Chills	☐Yes ☐No	Cough	☐Yes ☐No	Leg Cramping	☐Yes ☐No
Rashes	☐Yes ☐No	Shortness of breath	☐Yes ☐No	Dizziness	☐Yes ☐No
Itching	☐Yes ☐No	Wheezing	☐Yes ☐No	Seizures	☐Yes ☐No
Hair/Nail changes	☐Yes ☐No	Chest pain/discomfort	☐Yes ☐No	Weakness	☐Yes ☐No
Decreased hearing	☐Yes ☐No	Heartburn	☐Yes ☐No	Numbness	☐Yes ☐No
Earache	☐Yes ☐No	Diarrhea	☐Yes ☐No	Heat/cold Intolerance	☐Yes ☐No
Ringing in ears	☐Yes ☐No	Constipation	☐Yes ☐No	Nervousness/anxiety	☐Yes ☐No
Pain in eyes	☐Yes ☐No	Burning/pain urination	☐Yes ☐No	Depression	☐Yes ☐No
Blurry/double vision	☐Yes ☐No	Blood in Urine	☐Yes ☐No		
Sinus pain	☐Yes ☐No	Incontinence	☐Yes ☐No		

Check off the type of pain you feel: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting

☐ Burning ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Other: _____

Place an X to mark the areas of discomfort



_____ _____ _____

Printed Name **Signature** **Date**

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic treatment: A chiropractic adjustment is the specific application of forces to facilitate the correction of vertebral subluxation. Chiropractic adjustments are a "hands on" approach to patient wellness. Subluxation is a misalignment of one or more of the vertebrae in the spinal column. This subluxation can cause alteration of the functioning of the nerves, leading to pain and dysfunction. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, traction, passive and active exercise may also be used.

Permission for Physical Contact: I understand that, during various chiropractic examination procedures and treatment methods, the Doctor of Chiropractic or other clinical staff may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment and is prohibited. Nevertheless, I also realize that some chiropractic procedures may require that the doctor or clinician contact me in some physically sensitive areas, such as underarm areas, over buttock/hip areas, and/or upper thigh muscles. However, before any sensitive contact or procedure occurs, the doctor or other clinical staff member will explain to me what is to be done, how it will be performed, and why it will be performed. I may refuse that test or procedure, or alternatively I may request that another member of the staff be present.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, and/or injury to vertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications if you are allergic to latex, rubber, or cloth used in the towels. Please inform the doctor if you have any such allergies.

Probability of risks occurring: The risks of complications due to chiropractic treatment, cerebrovascular injury or stroke, or adverse reaction due to ancillary procedures is rare. Please inform the doctor if you have any pre-existing vascular conditions.
Other treatment options which could be considered may include the following: Over the counter analgesics, medical care, hospitalization, and/or surgery.

Risks of remaining untreated: Delay of treatments allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, making future rehabilitation more difficult.

I have read the following risks of care and explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

Consent To Request/Release Medical Records (HIPAA)

Patient Name: _____ Date of Birth: _____

Under the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to request or release any medical records or patient information without having exclusive permission from the patient.

This waiver, in accordance with your wishes below, authorizes **Link Medical Services PLLC,** parent company of **Fasulo Chiropractic,** to request/release your medical information as noted:

1. We may leave a voicemail recording regarding personal health information, appointment confirmations, treatments, disorder related information, lab or other results on: (select all that apply)
   ☐ Home Phone ☐ Cell Phone ☐ Work Phone

2. We may send an email, even is the email is not encrypted, regarding personal health information, appointment confirmations, treatments, disorder related information, lab or other results:
   ☐ Yes ☐ No ☐ Other: _____

3. Link Medical Services PLLC may request my medical history, laboratory reports, x-rays, and any other material regarding medical consultations and treatment I received. The request may be made to:

   Name: _____

   Address: _____

   Phone#: _____ Fax: _____

   If there are any questions concerning this request, you may contact our office at (631)289-3939. You may fax the records to (631)289-3934.

   I have received and reviewed this notice, which describes how my medical information may be used and disclosed and explains how I can get access to this information. I had an opportunity to raise questions regarding this policy and all my questions have been answered.
   The authorizations made above will remain in effect until such time as I notify Fasulo Chiropractic in writing of the requested changes.

_____	_____	_____
Printed Name	**Signature**	**Date**

Disclosure of Physician Ownership in Healthcare Entities

Dear Patient,

New York State requires that you be notified of any potential or existing financial relationships between our physicians and any other entities or individuals that are providing you with care. Mariwalla Neurosurgery has no financial relationships with any hospitals, emergency room physicians, anesthesiologists, pain management physicians, or other healthcare providers directly involved in your surgery care. As part of the safety and standard to be met for this region and for its patients, Mariwalla Neurosurgery has recruited top professionals in the fields of neurophysiology, neurology, and intraoperative neuromonitoring. Mariwalla Neurosurgery has spent considerable time and effort to ensure that you are as safe as possible during your surgery, and since neuromonitoring is not a service provided by the hospital, he has invested a financial interest in NeuroLink Monitoring, LLC. which is one of the many companies that you may elect to perform your intraoperative neuromonitoring. You have the right to choose the provider for your healthcare services, and this has absolutely no bearing on how you will be treated by Dr. Mariwalla or any of his associates. By signing this form, you acknowledge that you have been provided this information and have been explained all financial disclosure.

_____	_____	_____
Printed Name	**Signature**	**Date**

Guarantee of Payment Consent Form

Many insurance companies, including managed care organizations, require written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services.

If you have not received prior approval for the service or authorization has been denied, or if you do not have out of network benefits, you are fully responsible for all charges. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary."

Co-payments are collected at the time of service when they can be anticipated. All returned checks will incur a $50.00 service fee in addition to any fees assessed by our banking institution.

I understand that failure to pay a bill in a timely manner (after 3 bills have been sent) may result in a further review by a collection agency and I understand that I will further be responsible for any additional fees or legal fees associated with the collection of any balance of the visit and any related procedures will be collected at the time of the services rendered based upon the best information s available to the practice.

_____	_____	_____
Printed Name	**Signature**	**Date**

New York BRAIN SPINE & JOINT

Letter of Authorization to Charge Credit/Debit Card

Our practice has gone through many changes. We are happy to submit claims to your insurance company and accept payment from those insurance companies with whom we are out of network. As your provider, we want to continue providing you with excellent care, but to do so, it is necessary to ensure reimbursement for our services.
Please read and fill out with your initials the following:

1. I, _____, authorize Mariwalla Neurosurgery to charge the following described credit/debit card the amount equal to what my insurance states is my responsibility.

2. I, _____, understand the amount shall not exceed the amount my insurance deems as my responsibility.

3. I, _____, understand I will be sent an email/phone call/text informing me of the date of my visit and the amount to be charged to my credit/debit card **BEFORE** charging my card. A receipt will be sent upon request.

4. I, _____, understand that this Credit/Debit Card Authorization will only be used in the event my insurance does not pay for any services provided by Mariwalla Neurosurgery. This may include, but is not limited to, deductibles, co-insurances, co-pays, no show appointment charges, last minute cancellation charges, policy cancellations, and service not covered under my policy.

5. I, _____, understand that if my credit card is declined and/or does not process the payment, an invoice will be mailed to me with a $15 surcharge added to my balance.

Cardholder's Name: _____

Phone Number: _____

Email Address: _____

Cardholder's Address: _____

Card Type: ☐ Mastercard ☐ Visa ☐ AMEX ☐ Discovery ☐ Other

Card Number: _____

Expiration Date: _____

Security Code: _____

I fully understand the above authorization and give Mariwalla Neurosurgery consent to charge my credit card listed above.

_____	_____	_____
Printed Name	**Signature**	**Date**