# *Kaizen Chiropractic, P.C.*

*2710 Grand Ave.*

*Bellmore, NY 11710*

*Tel: (516) 781-9555 Fax: (516) 781-2871*


A) PATIENT MAJOR MEDICAL/ MEDICARE INSURANCE INTAKE FORM

1. Patient Name: _____

2. Home Phone number: (__) _____ Cell: (__) _____ Work: (__) _____

3. Address: _____
City, State, Zip Code

4. Gender: M F 5. Date of Birth (DOB): ___/___/____ *EMAIL: _____

6. Marital Status: Single: ___ Married: ___ Divorced: ___ Widowed: ____

7. Emergency contact: _____Relation: _____Phone #:_____

8. Place of employment _____ 9. Type of Employment: _____

10. Who may we thank for referring you? _____

B) MAJOR MEDICAL/ MEDICARE INSURANCE INFORMATION

11. Health Insurance Name: _____

12. Policyholder's Name: _____ 13. Policyholder's DOB: _____

14. Insurance ID#: _____15. Phone #:_____

If applicable, please provide Secondary Insurance:

16. Health Insurance Name: _____

17. Policyholder's Name: _____ 18. Policyholder's DOB: _____

19. Insurance ID#: _____ 20. Phone #:_____

*Assignment and Release*

I hereby authorize and direct the medical office of Kaizen Chiropractic, P.C. and its related affiliates to furnish form CMS-1500, my referring physician(s) and/ or other attorney(s), my applicable insurance carrier(s) and/or any other entity (governmental, private, union and/or otherwise) necessary any requested information and/or other information needed to determine my applicable Medicare, Medicaid, and/or other insurance benefit(s) to which I may be entitled and/or to determine the benefits payable for related chiropractic/diagnostic services furnished by Kaizen Chiropractic, P.C. Further, I hereby authorize and direct that any and all payments of benefits of any kind and/ or nature on my behalf be made directly payable to Kaizen Chiropractic, P.C. for all chiropractic/ diagnostic services furnished to me by Kaizen Chiropractic, PC. I understand that I am fully responsible for payment at all times for any balances due to Kaizen Chiropractic, P.C. for these services if full payment is not made by Medicare, Medicaid and/or any other applicable insurer and/ or Union under the terms of my contract or otherwise. I agree to immediately remit to Kaizen Chiropractic, P.C. any payment that I may hereafter receiver at any time from Medicare, Medicaid and/or any other applicable insurer and/or Union for services provided by Kaizen Chiropractic, P.C.

X_____ _____ _____

Patient Signature Print Name Date

KAIZEN CHIROPRACTIC, P.C.
2710 Grand Avenue
Bellmore, NY 11710
www.KaizenNY.com

Phone: 516.781.9555 Fax: 516.781.2871

# Patient Care Text Messaging/Emailing Consent Form

## DECLARATION

I consent to the practice contacting me by text message/email for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text/email are an additional service and that these may not take place on all occasions, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message/email facility at any time.

Text messages are generated using a secure facility. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

Patient Name: _____
*Please print*

Signature: _____

Home telephone number: _____

Mobile telephone number: _____

Cell Carrier: _____

Email: _____

*The practice does not share mobile phone/email contact details with any external organization.*

☐ I DO NOT CONSENT TO THE PRACTICE CONTACTING ME BY TEXT MESSAGING

# Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

OCA Official Form No.: 960

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

**[This form has been approved by the New York State Department of Health]**

| Patient Name | Date of Birth | |
|---|---|---|
| Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

**Authorization to Discuss Health Information**

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

| 10. Reason for release of information:<br>❑ At request of individual<br>❑ Other: | 11. Date or event on which this authorization will expire: |
|---|---|
| 12. If not the patient, name of person signing form: | 13. Authority to sign on behalf of patient: |

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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***New Patient Medical History - Please complete this two-sided form prior to your first appointment***

Name: _____ Date of Birth: ___/___/_____ Age: ____ Sex: ___

How did you hear about our practice? _____

**♦ Please briefly state in the box below the reason for your visit ♦**

**♦ Past Medical History ♦**

| *Condition / Disease* | *Year Began* | *Condition / Disease* | *Year Began* |
|---|---|---|---|
| ☐ Hypertension | | Other(s): | |
| ☐ High Cholesterol | | | |
| ☐ Hypothyroidism (low thyroid) | | | |
| ☐ COPD, Emphysema or Asthma | | | |
| ☐ Diabetes | | | |
| ☐ GERD | | | |
| ☐ Depression or Anxiety | | | |
| ☐ Heart Problems - | | | |

**♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦**

| *Operation / Hospitalization / Injury* | *Month / Yr* | *Operation / Hospitalization / Injury* | *Month / Yr* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**♦ Other Physicians and Specialists ♦**

*List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)*

## ♦ Medication or Food Allergies or Intolerances ♦

*List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)*

| *Medication / Food* | *Reaction* | *Medication / Food* | *Reaction* |
|---|---|---|---|
| | | | |
| | | | |

## ♦ Medications, Vitamins and Herbal Supplements ♦

| *Medication* | *Strength* | *Number of pills taken & frequency* | *Medication* | *Strength* | *Number of pills taken & frequency* |
|---|---|---|---|---|---|
| ***Example:*** *Tylenol* | *500 mg* | *1 - twice daily* | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## ♦ Social, Educational and Work History ♦

| | | |
|---|---|---|
| Marital Status: | Age of children, if any: | |
| Work Status (circle one):<br>◯Employed ◯Unemployed<br>◯Retired ◯Disabled | Current or Prior Occupation: | Hours worked per week: |
| Highest Level of Education: | Completed at which institution / school: | |
| What type of exercises do you perform, duration & frequency? | | |
| In what type of residence do you live (i.e., house, assisted living, nursing home)? | | |
| What are your hobbies? | | |
| Do you drink alcohol? | What type of alcohol? | No. of drinks per week? |
| Are you a current smoker? | If you smoke, how many packs per day? | |
| Are you a former smoker? | If so, what year did you quit? | No. of years you smoked? |
| On average, how much did you smoke per day? | | |

## ♦ Family Health History ♦

*Please list below the health history of your blood (genetic) first degree relatives*

| *Relative* | *Living or Deceased* | *Current age or age at death* | *Cause of Death* | *Health Problems* |
|---|---|---|---|---|
| Father: | | | | |
| Mother: | | | | |
| Brother(s): | | | | |
| | | | | |
| Sister(s): | | | | |
| | | | | |

## ♦ Review of Systems ♦

**Please review the following symptoms and circle those items that are a problem for you**

| | | | |
|---|---|---|---|
| ☐ Chills | ☐ Frequent Urination | ☐ Low Blood Pressure | ☐ Bruise Easily |
| ☐ Depression | ☐ Lack of Bladder | ☐ Poor Circulation | ☐ Hives |
| ☐ Dizziness | ☐ Painful Urination | ☐ Rapid Heart beat | ☐ Itching |
| ☐ Fainting | ☐ Poor Appetite | ☐ Swelling Ankles | ☐ Change in Moles |
| ☐ Fever | ☐ Bloating | ☐ Varicose Veins | ☐ Rash |
| ☐ Forgetfulness | ☐ Bowel Changes | ☐ Bleeding Gums | ☐ Scars |
| ☐ Headache | ☐ Constipation | ☐ Blurred Vision | ☐ Sore that won't heal |
| ☐ Loss of Sleep | ☐ Diarrhea | ☐ Crossed Eyes | ☐ Breast Lump |
| ☐ Loss of Weight | ☐ Excessive Hunger | ☐ Difficulty Swallowing | ☐ Erection Difficulties |
| ☐ Nervousness | ☐ Excessive Thirst | ☐ Double Vision | ☐ Lump in Testicles |
| ☐ Numbness | ☐ Gas | ☐ Earache | ☐ Penis Discharge |
| ☐ Sweats | ☐ Hemorrhoids | ☐ Ear Discharge | ☐ Sore on Penis |
| ☐ Arm Pain | ☐ Indigestion | ☐ Hay Fever | ☐ Abdominal Pap Smear |
| ☐ Back Pain | ☐ Nausea | ☐ Hoarseness | ☐ Bleeding between periods |
| ☐ Foot Pain | ☐ Rectal Bleeding | ☐ Loss of Hearing | ☐ Breast Lump |
| ☐ Hand Pain | ☐ Stomach Pain | ☐ Nose Bleeds | ☐ Extreme Menstrual Pain |
| ☐ Hip Pain | ☐ Vomiting | ☐ Persistent Cough | ☐ Hot Flashes |
| ☐ Leg Pain | ☐ Vomiting Blood | ☐ Ringing in Ears | ☐ Nipple Discharge |
| ☐ Neck Pain | ☐ Chest Pain | ☐ Sinus Problems | ☐ Painful Intercourse |
| ☐ Shoulder Pain | ☐ High Blood Pressure | ☐ Vision - Flashes | ☐ Vaginal Discharge |
| ☐ Blood in Urine | ☐ Irregular Heart Beat | ☐ Vision - Halos | ☐ Other: |

***Check the box to the left if you have none of the above.***

## ♦ Disease Prevention and Health Maintenance ♦

*Please list below the most recent dates of your vaccines and health screening tests*

| | ***Month/Yr*** | | ***Month/Yr*** | | ***Month/Yr*** |
|---|---|---|---|---|---|
| Flu Vaccine | | Mammogram | | Eye Exam | |
| Pneumonia Vaccine | | Pap Smear | | Heart Catheterization | |
| Tetanus Vaccine | | Colonoscopy | | Endoscopy (EGD) | |
| Hepatitis B Vaccine | | Bone Density | | Heart Stress Test | |
| Shingles Vaccine | | EKG | | Ab Aneurysm Screen | |
| Gardasil Vaccine | | Chest X-Ray | | HIV Test | |