CHIROPRACTIC ASSOCIATES ROCHESTER

Tina Shores, D.C.
Colby Shores, D.C., CCSP
Kevin O'Hagan., D.C.

Welcome to our office.

190 Perrin Drive
Rochester, New York 14622
Phone (585) 544-1540
Fax (585) 544-1580
doctors@chiroroc.com

www.chiroROC.com

Patient Information

Date_____

Patient Name_____

Address_____

_____

City State Zip

Email Address: _____

Sex M F Age_____Date of Birth_____/_____/_____

Single Married Widowed Separated Divorced

Occupation_____

Spouse's Name_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

Family (Parents, Siblings) Health History_____

_____

_____

_____

_____

Insurance Information

Insurance Co._____

Policy Number: _____

Policy Holders Name:_____

Policy Holders Date of Birth: _____

How are you related to Policy Holder: Self / Spouse / Child

Lifestyle

Glasses of water per day_____

Kind of Shoes you wear most often_____

Do you wear orthotics? _____

How old is your mattress? _____

Sleep Position: (back) (side L / R) (stomach) (couch)

Contact Numbers

Home (___)_____ Cell (___)_____

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship_____

Home #_____ Work #_____

Accident Information

Is condition due to the accident? Yes No Date_____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Work Comp. Other

Attorney Name (if applicable)_____

Patient Condition

Reason for your Visit?_____

When did it begin?_____What do you think was the cause?_____Make's it better?_____ Worse?_____

Rate the severity of the pain on a scale of 0 (no pain) to 10 (excruciating pain) 0 1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramping Stiffness Swelling Other

_____

How often do you have this pain?_____ Is it constant or does it come and go?_____

Does the pain interfere with your Work Sleep Daily Routine Hobby/Recreation

Previous history of primary complaint?_____

Health History

Name: Date:

Primary Care Physician?_____Office Phone( )_____ Address:_____

Are you being seen by other specialists?_____ Who is your OB/GYN Physician?(Female Only_____

What treatment have you already received for your condition? Medications (list)_____

Have you seen a Chiropractor in the past? Who _____Date of last adjustment_____ None

Date of Last: Physical Exam_____ Blood Test_____ Urine Test_____

Spinal Exam_____ Spinal X-ray_____ Chest X-ray_____

MRI, CT, Scan_____ DEXA (Bone density_____ Prostate Exam_____

AIDS/HIV	Y N	Emphysema	Y N	Parkinson's Disease	Y N	Other:_____
Allergy	Y N	Epilepsy	Y N			_____
Anemia	Y N	Fainting	Y N	Pneumonia	Y N	_____
Appendicitis	Y N	Fractures	Y N	Polio	Y N	_____
Arthritis	Y N	Glaucoma	Y N	Prostate Issues	Y N	
Asthma	Y N	Gout	Y N	Psychiatric Care	Y N	
Bleeding disorder	Y N	Hernia	Y N			
		Herniated Disc	Y N	Rheumatoid Arthritis	Y N	
Breast Lump	Y N	High/Low Blood Pressure	Y N			
Bronchitis	Y N			Scarlet Fever	Y N	
Cancer	Y N	High Cholesterol	Y N	Stroke	Y N	
Cataracts	Y N	Kidney Disease	Y N	Thyroid Problem	Y N	
Chemical Dependency	Y N	Liver Disease	Y N	Tuberculosis	Y N	
		Migraine Headaches	Y N	Tumor/Growth	Y N	
Chicken Pox	Y N			Ulcer/Colitis	Y N	
Diabetes	Y N	Multiple Sclerosis	Y N	Whopping Cough	Y N	
Depression	Y N					
Difficulty breathing	Y N	Osteoporosis	Y N	Heart Attack	Y N	
		Pacemaker	Y N			

Exercise

Never
Seldom
Frequent
Daily

Work Activity

Sitting (desk)
Computer
Standing
Light Labor
Heavy Labor

Habits

Smoking Packs/Day_____For_____Yrs.
Alcohol Drinks/Week_____
Caffeine Cups/Day_____
High Stress Reason_____

Women Only

Are you pregnant? Y N
Number of pregnancies?_____.
How many deliveries?_____.
Vaginal C-section
Birth Control Pills? Y N

Injuries/Surgeries you have had: Please indicate actual dates or year.

Motor Vehicle Accidents_____

Broken Bones/Fractures_____

Spinal Injuries (Neck, Back, Low Back, Pelvis)_____

Head Injuries/Concussions_____

Surgeries (include all, i.e. Tonsillectomy)_____

Medications

Anti-inflammatory_____

Muscle Relaxants_____

Pain Killer/Analgesic_____

Heart Medication_____ Coumadin_____

Other_____

Vitamin/Herb/Mineral

Multivitamin_____

Multimineral_____

Herbs_____

Other_____

_____

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ONE ABOUT YOU

NAME: _____

DATE: ____/____/____

TWO-A WORK RELATED ACCIDENT

DATE & TIME OF ACCIDENT:____/____/____
_____ A.M. / P.M.

On the date of injury what was your job title/description:

_____

On the date of injury/illness what were your usual work activities

_____

_____

Was your accident directly related to your work? .....
YES NO

Briefly describe where and how did the injury happen:

_____

_____

Address where accident occurred:

_____

_____

Did you report your accident to your employer?
..... YES NO

What recommendations did your employer make just after your accident?

_____

_____

Has this type of accident happened to you before?
.....YES NO

Explain: _____

_____

To the best of your knowledge, has this accident occurred in your workplace before? .....YES NO

IN GENERAL :.

Is your job physically stressful?.....YES NO
Is your job mentally stressful? .....YES NO
Have you changed jobs in the last year?.....YES NO

TWO-B AUTO RELATED ACCIDENT

Date & Time of Accident: ____/____/____
_____A.M. / P.M.

Were you the: .....DRIVER
....FRONT PASSENGER
.....REAR PASSENGER

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____
Did the police come to the accident site?.....YES NO
Was a police report filed? .....YES NO
Were you wearing your seat belt?.....YES NO
Was this vehicle equipped with airbags? .....YES NO
If yes, did the airbag inflate? .....YES NO

In relation to the base of your skull, where was the headrest? .....ABOVE
.....BELOW
.....AT BASE OF SKULL

What did your vehicle impact?
.....ANOTHER VEHICLE
.....OTHER

If other please explain:

_____

_____

Did any part of your body strike anything in the vehicle? .....
YES NO
If yes please explain: _____

_____

Make and Model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveling?

_____

_____

In which direction were you headed?
NORTH / SOUTH / EAST / WEST

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:
FRONT / REAR / RT. SIDE / LF. SIDE / OTHER

During impact were you facing…
RIGHT / LEFT / FORWARD

In your words, please describe the accident:

_____

_____

PATIENT NAME: _____ DATE: ___/___/___

THREE AFTER INJURY

Did accident render you unconscious? .....YES NO
If yes…for how long? _____
Please describe how you felt physically after the accident:

_____

_____

_____

Have you gone to a hospital or another doctor? .....YES NO

If yes…when did you go? .....JUST AFTER ACCIDENT
.....THE NEXT DAY
.....TWO DAYS PLUS
How did you get there?.....PRIVATE TRANSPORT
.....AMBULANCE
Name of hospital and/or attending doctor:

_____

Was he/she a:..... .....D.C. / M.D. / D.O. / D.D.S

Describe any treatment you received:

_____

_____

Were x-rays taken?.....YES NO
Was medication prescribed? ..... YES NO
Have you been able to work since this injury? .....YES NO
Are you work activities restricted as a result of this injury?
YES NO

Circle the symptoms that are a result of this accident:

Dizziness	Difficulty sleeping	Jaw problems
Memory loss	Irritability	Nausea
Headache(s)	Fatigue	Numb hands/fingers
Numb feet/toes	Arm/shoulder pain	Blurred vision
Back pain	Low back pain	Back stiffness
Neck pain	Stomach upset	Tension
Chest pain	Buzzing in ear	

Other: _____

Is your condition getting worse?
YES / NO / CONSTANT / COMES & GOES

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Walking			
Running			
Working			
Lifting			
Bending			
Kneeling			
Pulling			
Reaching			

FOUR EMPLOYER INFORMATION

Name of employer:
_____
Address of employer:
_____

_____
Phone number: ( ) _____
Contact person: _____

FIVE INSURANCE INFORMATION

Name of Auto/Worker's Comp. Insurance company:
_____
Address of insurance company:
_____
Phone number/Contact Person: ( )_____
Claim number (if known):
_____

SIX RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal work day?_____

Please circle your daily job duties and any activities which you are occasionally asked to perform.

Standing	Driving	Operating equipment
Sitting	Twisting	Work w/arms above head
Walking	Crawling	Typing
Lifting	Bending	Stooping

What positions can you work in with minimum physical effort and for how long?_____

- Prior to the injury were you capable of working on an equal basis with others your age? YES/NO
- Do you work with others who can help you with any heavy lifting? YES/NO
- While in recovery, is there and light duty work you could request? YES/NO

Please remember you are ultimately responsible for your account.

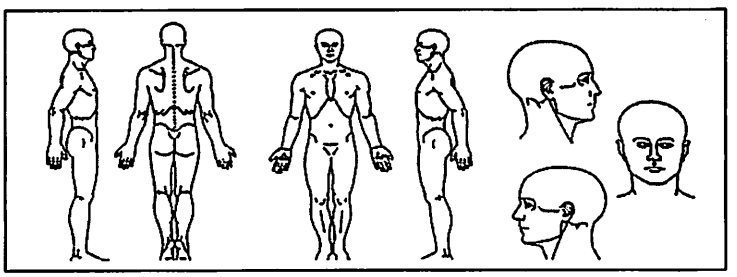
_____ ___/___/___
Signature Date

CHIROPRACTIC ASSOCIATES OF ROCHESTER

Patient Name _____ Date _____

☐ Regular ☐ Worker's Comp ☐ No Fault

On the diagram, please indicate the location of pain and the symbol that best describes what you are currently experiencing:



SHARP/STABBING	+++
DULL/ACHY	VVVV
PINS/NEEDLES	0000
NUMBNESS	////
OTHER	XXXX

Type of discomfort: (choose all that apply) ____ Sharp ____ Dull ____ Aching ____ Burning ____ Numbness ____ Tightness ____ Throbbing ____ Diffuse ____ Shooting ____ Tingling ____ Other

Frequency of Pain: ____ Constant (100%-75%) ____ Frequent (75%-50%) ____ Intermittent (50%-25%) ____ Occasional (25%-0%)

Discomfort increases with: ____ Movement ____ Applying Pressure ____ Sitting ____ Coughing

Discomfort decrease with: ____ Rest ____ Movement ____ Medication ____ Ice ____ Heat ____ Chiropractic Care

Region	At WORST	At BEST	TODAY
NECK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
MID/UPPER BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
LOW BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Other_____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Scale: 0=no pain or discomfort 10=most intense pain

-For office use only-

Notes:

_____

_____

_____

_____

	Cervical ROM	Lumbar ROM
Flexion	(90)	(90)
Ext	(70)	(35)
LLF	(40)	(25)
RLF	(40)	(25)
Lrot	(70)	(30)
Rrot	(70)	(30)

Chiropractic Associates of Rochester

Patient's Name_____ Date _____

OVERALL HEALTH HISTORY

Do you have vertigo (dizziness)?	YES_____	NO_____
Do you pass out easily (faint, loss of consciousness)?	YES_____	NO_____
Do you have double vision or have you lost sight in one eye?	YES_____	NO_____
Do you have any slurred speech or difficulty in arranging words properly?	YES_____	NO_____
Have you had any difficulty walking, with coordination or falling to one side?	YES_____	NO_____
Do you have any nausea or vomiting?	YES_____	NO_____
Do you have numbness on one side of you face or body?	YES_____	NO_____
Do you have any visual disturbances or rapid eye movement?	YES_____	NO_____
Do you have a headache or head pain that is unlike any you have had before?	YES_____	NO_____
Do you have headaches for hours or days?	YES_____	NO_____
Do you have history of stroke in the family?	YES_____	NO_____
Do you have chest pain?	YES_____	NO_____
Do you have any change in bowel or bladder habits?	YES_____	NO_____
Do you have a sore that does not heal?	YES_____	NO_____
Do you have any unusual bleeding or discharge?	YES_____	NO_____
Do you have any thickening in your breasts or elsewhere?	YES_____	NO_____
Do you have indigestion or difficulty swallowing?	YES_____	NO_____
Do you have a change in any wart or mole?	YES_____	NO_____
Do you have a nagging cough or hoarseness?	YES_____	NO_____
Do you have night sweats?	YES_____	NO_____
Do you have pain in the neck, jaw or face?	YES_____	NO_____
Do you have a drooping eyelid or changes in your pupils?	YES_____	NO_____
Do you have any ringing in your ears?	YES_____	NO_____
Do you take birth control pills?	YES_____	NO_____

PROBLEM SPECIFIC

Head: headaches y / n location_____
Neck: difficulty with: turning L—R—forward—backward—tilt right—tilt left
Midback: pain with cough, sneeze of bowel movement
Low Back: pain down the buttock—legs pain with cough sneeze or bowel movement
Shoulder:_____
Elbow:_____
Wrist:_____
Hand/Fingers:_____
Hip:_____
Knee:_____
Ankle:_____
Foot/Toes:_____

Bournemouth Questionnaire
Back Pain (BQ-back)

Name: **Date:**

*Please circle **ONE** number for each of the following statements that best describes your neck pain and how it is affecting you **NOW**. Please read each question carefully before answering:*

1. Over the past few days, on average, how would you rate your back pain?	**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Possible Pain**
2. Over the past few days, on average, how has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving, sleeping)?	**No Interference** 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry-on with normal day-to-day activities**
3. Over the past few days, on average, how has your back pain interfered with your normal social routine including recreational, social, and family activities?	**No Interference** 0 1 2 3 4 5 6 7 8 9 10 **Unable to participate in any social and recreational activities**
4. Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?	**Not Anxious At All** 0 1 2 3 4 5 6 7 8 9 10 **Extremely Anxious**
5. Over the past few days, on average, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling?	**Not Depressed At All** 0 1 2 3 4 5 6 7 8 9 10 **Extremely Depressed**
6. Over the past few days, how do you think your work (both inside the home and/or employed work) has affected your back pain?	**Makes It No Worse** 0 1 2 3 4 5 6 7 8 9 10 **Makes It Very Much Worse**
7. Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your back pain on your own?	**I Can Control My Pain Completely** 0 1 2 3 4 5 6 7 8 9 10 **I Have No Control Whatsoever**

THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Source: Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in back pain patients. J Manipulative Physiol Ther 1999;22(8):503-10.

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The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** pick your response to the following questions:

		Disagree 0	Agree 1
1	My back pain has **spread down my leg(s)** at some time in the last 2 weeks	☐	☐
2	I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks	☐	☐
3	I have only **walked short distances** because of my back pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of back pain	☐	☐
5	It's not really safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time	☐	☐
7	I feel that **my back pain is terrible** and **it's never going to get any better**	☐	☐
8	In general I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all	Slightly	Moderately	Very much	Extremely
☐ 0	☐ 0	☐ 0	☐ 1	☐ 1

Total score (all 9): _____ **Sub Score (Q5-9):**_____

CARE PLAN GOALS:

1. Pain Reduction by _____
2. TX Duration_____
3. Improve ROM_____
4. Resume ADL_____
5. Resume Work_____
6. Other GOALS_____

Funded by Arthritis Research UK

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care, spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years that have been demonstrated to be a highly effective treatment for spinal pain, headaches and other symptoms. Maintaining spinal alignment through chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical treatment, medications and procedures given for the same condition.

I acknowledge that I have received information regarding my condition and proposed chiropractic treatment as well as alternative courses of care, the benefits, the risks, the side effects of treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to: muscle strains & sprains, fractures, dislocations, disc injuries and strokes. I wish to rely on the doctor to exercise judgment during the course of the treatment that he feels at the time based upon the facts then known, is in my best interests.

My doctor has responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to apply to all my present and future chiropractic care in this office.

Patient Signature_____Date_____

Witness_____Date_____

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PATIENT ACKNOWLEDGEMENT & CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change the Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand the practice is not required to agree to my requested restrictions, but if the practice does agree then it is bound to abide by such restrictions.

This notice is in effect as of the date signed below. By signing below, I certify that I have received this notice and all of my questions have been answered to my satisfaction with language that I can understand.

Patient Name _____

Relationship to Patient _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement and consent on this Notice of Privacy Practices Acknowledgement/Consent Form, but was unable to do so as documented below:

Date	Initials	Reason

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Phone (585) 544-1540
Fax (585) 544-1580
doctors@chiroroc.com

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OFFICE FINANCIAL AGREEMENT-2024

It is your responsibility to know what your insurance policy covers. Insurance covers acute, medically necessary care. If your insurance denies payment for our services at any time, you agree to take full financial responsibility. Some insurance companies will not allow multiple family members to be treated on the same day in the same office.

Please sign and initial designated insurance line.

____Excellus BC/BS, Aetna and United
Deduct- Referral may be needed. Until your annual deductible is met the office fee will be procedure dependent. Fee is due at time of service. Once the deductible is met, you will be responsible for co-insurance policy dependent. Supplements, orthotics, supports, etc. are not covered.
Co-Pay- Your co-pay is due at the time of service and will range from $10-$70 depending upon your contract. Supplements, orthotics, cushion are not covered and are the patient's responsibility. Blues cover acute care and not maintenance care.

____ Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United
Authorization is required on some Ins. Your insurance sets number of visits allowed. There are some costs that are out of pocket per Medicare. Please refer to the ABN agreement. Your insurance covers acute care not maintenance care.

____Medicare: No referral needed. Until your annual estimated Deductible of $226.00 is met the office fee is $40.00 - $80.00. You will be responsible for any usual and customary fee (ABN)

____MVP/CIGNA/OTHER: The doctors in this office are out of network providers. Initial consultation fee, history and examination is $80.00. Subsequent visits thereafter are $40.00. Depending on your contract you may have out of network coverage. We will supply you with a claim form so that you can submit to your insurance company.

____Usual & Customary Office Fees: First visit for consultation, history and examination is $80.00. Subsequent visits thereafter are $40.00. Initial Spinal scan fee included in $80.00 charge.

Rock Tape (Kinesio Tape):
__ Option 1: Free application with purchase of roll (for life of roll)
__ Option 2: $5.00 charge per region application

____Worker's Compensation: If you require treatment for an injury that occurred while performing your normal employment, you may be eligible for 100% coverage by your employer's worker's compensation insurance. In such cases, to ensure your coverage, it is your responsibility to report your injury to your employer in writing and fill out the appropriate reports. Failure to do so will jeopardize your coverage. Should your case be denied you would become liable for services rendered. Mileage sheets will be available for $20.

____Auto Accidents/No Fault Insurance: If you are seeking treatment because of an auto accident, you may be eligible for 100% coverage by your No-Fault Insurance. Some companies have a deductible that must be met first. It is your responsibility to contact your insurance company and fill out the appropriate reports. Should your insurance decline to pay for your case, you would become liable for all services rendered. Mileage sheets will be available for $20.00

____ Maintenance Care: Elective healthcare defined as patient has achieved and maintained pre-complaint status, plateaued in improvement, and/or chronic symptoms show no progression in reduction or remain stable. Treatment intervals are at regular intervals (example: 1 time a week, every 2 weeks, every 4 weeks, etc.) Benefits of maintenance care include enhanced quality of life, improved health, prevention of future injury. This is a service not covered by the insurance company and you will be responsible for the office fee of $40. If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan until that condition has achieved pre complaint status or plateaued in improvement.

There may be additional services/products needed to supplement your care.

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Chiropractic Associates of Rochester all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether 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 insurance submissions.

- **Please note that our office does not allow a personal balance over $100 (unless other financial arrangements have been made in writing). Should your account become 60 days delinquent a $10 charge per month will be assessed to the outstanding balance.**
- **Payment is due at the time of service. Payment in the form of cash, check, HSA, Credit Card is accepted.**
- **Returned Checks will have a $25 service charge.**

_____

Responsible Party Signature **Date**

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

_____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

ADVIERTA QUE USTED PUEDE LLEGAR A SER RESPONSABLE POR LOS COSTOS MÉDICOS EN CASO DE ABANDONO DEL PROCESO, O SI SE RECHAZA LA SOLICITUD DE INDEMNIZACIÓN, O SI SE APRUEBA UN ACUERDO EN VIRTUD DE LA LEY DE INDEMNIZACIÓN LABORAL WCL §32

Nº DE CASO WCB (si se conoce)	Nº. DE CASO DE LA ASEGURADORA (si se conoce)	FECHA DE LA LESIÓN	NATURALEZA DE LA LESIÓN O ENFERMEDAD	Nº SEG. SOC. DE PERSONAS LESIONADAS
RECLAMANTE	NOMBRE		DIRECCIÓN	APT. NO.
EMPLEADOR				
COMPAÑÍA DE SEGUROS				

Usted puede llegar a ser responsable por hacer el pago de los costos médicos del tratamiento de su enfermedad o condición al proveedor que se indica a continuación si (1) abandona el proceso de compensación laboral (2) si la institución Workers' Compensation Board (Junta de Compensación Laboral) determina que la enfermedad o condición que requería tratamiento no ocurrió por un accidente de trabajo indemnizable o enfermedad ocupacional o (3) si el acuerdo fue tramitado por usted y aprobado conforme a la Ley de Indemnización de Trabajadores WCL §32 ; en virtud de esta ley, usted renuncia a sus derechos de obtener los beneficios médicos de la compañía aseguradora de indemnizaciones laborales o del empleador auto asegurado para cubrir los tratamientos y servicios realizados después de la fecha en que se aprobó el acuerdo. Si ocurriera cualquiera de los hechos mencionados con anterioridad, el proveedor podrá cobrarle directamente el costo por los servicios recibidos en lugar de hacerlo al empleador o a la compañía aseguradora, y usted será responsable por hacer los pagos correspondientes.

Por medio de la presente reconozco que he leído el párrafo anterior y que entiendo las circunstancias bajo las cuales me hago responsable del pago.

Firma del reclamante _____ Fecha _____

Nombre y dirección del proveedor _____

AL RECLAMANTE
La Regulación 325-1.23 de la institución Workers' Compensation Board (Junta de Compensación Laboral) permite que su doctor o terapeuta le solicite que firme esta notificación A-9. Al firmar esta notificación, usted reconoce la obligación de pagar los honorarios al proveedor por los servicios que recibe en el supuesto caso que la ley no requiera que su empleador o aseguradora de indemnización laboral pague tales honorarios y si tales honorarios no están cubiertos por otro seguro. Es posible que el empleador o aseguradora no deba pagar los honorarios médicos si, por ejemplo, usted no presenta una solicitud de indemnización laboral, o si no notifica su lesión o enfermedad a su empleador, o si no asiste a la audiencia de la institución Workers' Compensation Board si su empleador desafía sus derechos a los beneficios. Aun cuando hubiese realizado todos los trámites necesarios para procesar su solicitud, la institución Workers' Compensation Board puede decidir que usted no tiene derecho a los beneficios. En tal caso, esta notificación le aconseja a su proveedor de servicios de salud que usted reconozca su responsabilidad personal por el pago de sus cuentas.

Artículo 32 de la Ley de Indemnización Laboral (WCL 32)
La notificación A-9 también cubre las instancias en las que un reclamante por un caso de compensación laboral válido existente llega a un acuerdo con su empleador/a o su compañía aseguradora tras resolver su caso según el artículo 32 de la ley WCL. Un acuerdo según el Artículo 32 puede incluir una cláusula que libere al empleador/a o aseguradora de la responsabilidad de pagar en el futuro cuentas médicas asociadas con el caso. Su proveedor de servicios médicos puede solicitar que usted firme esta notificación A-9 para garantizar que reconoce su responsabilidad personal por el pago de sus cuentas si renunció al derecho de recibir beneficios médicos futuros mediante un acuerdo conforme al artículo 32.

Si tiene alguna pregunta, comuníquese con su abogado o representante autorizado para la audiencia, de tener uno. También puede comunicarse con la institución Workers' Compensation Board (Junta de Compensación Laboral) en la oficina de su distrito.

AL PROVEEDOR DE SERVICIOS DE SALUD
Esta notificación tiene el fin de avisar al reclamante de indemnización laboral que puede ser responsable del pago. Si el reclamante no firma este formulario, no libera con este acto al proveedor de su obligación de tratar al reclamante, ni tampoco anula la responsabilidad de pago por parte del reclamante.

Mantenga el original de este formulario en sus propios registros y entregue una copia al reclamante. **No lo presente en la institución Workers Compensation Board** (Junta de Compensación Laboral). Usted recibirá notificaciones de las decisiones en las que se incluirá si la solicitud es indemnizable, la autorización del tratamiento o el pago de cuentas médicas. También se le notificará si el reclamante presenta un acuerdo conforme al Artículo 32 para que lo apruebe la institución Workers' Compensation Board. No cobre al reclamante a menos que y hasta que usted reciba una decisión de la institución Workers Compensation Board que indique: 1) que el reclamante no procesará la solicitud, o 2) que la solicitud fue rechazada, o 3) que el tratamiento no tiene relación causal con las lesiones laborales, o 4) que se aprobó un acuerdo conforme al Artículo 32 liberando a la aseguradora de la responsabilidad por el tratamiento médico.

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

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

I, _____ (Print patient's name), ("Assignor") hereby assign to _____ (Print hospital or health care provider name), ("Assignee") 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 the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ (Print accident date), not withstanding any other agreement to the contrary.

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 KNOWINGLY 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, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT 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 VIOLATION.

_____ (Print name of Patient)

_____ (Signature of Patient)

_____

_____ (Date of signature)

_____ (Address of Patient)

_____ (Print name of Provider)

_____ (Signature of Provider)

_____

_____ (Date of signature)

_____ (Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

CHIROPRACTIC ASSOCIATES OF ROCHESTER

Tina Shores, D.C.
Colby Shores, D.C., CCSP
Kevin O'Hagan, D.C.

190 Perrin Drive
Rochester, New York 14622
Phone (585) 544-1540
Fax (585) 544-1580
doctors@chiroroc.com

www.chiroROC.com

NO FAULT APPOINTMENT POLICY

Dear Patient:

In accordance with New York State No Fault regulations, it is your responsibility as the patient to notify this office 24 hours in advance if you cannot keep your scheduled appointment.

If you fail to give prior notice, you will be charged the usual and customary fees. If you have any questions, please direct them to the office manager.

Thank you for your time and consideration to this matter.

NO FAULT CLAIM DENIAL POLICY

I, _____, understand in the event that my No Fault carrier denies any or all of my claim, I am responsible and obligated to pay the usual and customary fees for all services rendered.

I have read and understand the above explanations concerning my scheduled appointments and carrier denial.

_____ _____

Signature of patient Date

CHIROPRACTIC ASSOCIATES OF ROCHESTER

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AUTHORIZATION FOR RELEASE OF INFORMATION:

TO: _____

_____

_____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____ Medical Records regarding _____

_____ X-Rays and / or report of findings, CT Scans, MRI's

_____ Consult reports from specialists

_____ Test Results

_____ Billing Records

_____ Other _____

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials _____

I understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials _____

I understand that this authorization will expire one (1) year from the date of the original signature indicated below.

Initials _____

Patient Name: _____

Date of Birth: _____

Signature of Patient _____ Date: _____

If under age 18 Signature of Guardian: _____ Date: _____

Relationship to Patient: _____