NOTARO CHIROPRACTIC

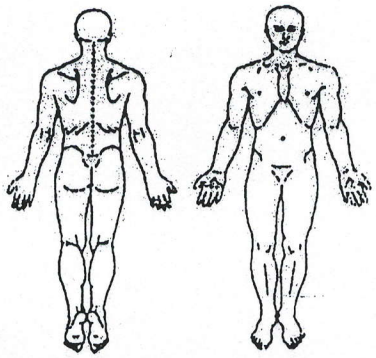
GRAND ISLAND CHIROPRACTIC
2283 GRAND ISLAND BLVD
GRAND ISLAND, NY 14072
(Town Hall Plaza)
(716) 773-2222
FAX (866) 907-6157

NOTARO CHIROPRACTIC
10158 NIAGARA FALLS BLVD
NIAGARA FALLS, NY 14304
(Como Airport Plaza)
(716) 298-0368
FAX (866) 907-6157

NOTARO CHIROPRAC TIC
4754 N. French Road
East Amherst, NY 14051
(The Commons)
(716) 688-8815
FAX (866)907-6157

PATIENT HISTORY (Please Print)
(Please feel free to add information to the back of this sheet)

Name: _____ Date of Birth: _____ Sex: M F
Address: _____
(Street) (City) (State) (Zip)
Marital Status: _____ Weight: _____ Height: _____
Social Security Number: ___-__-____ Email: _____
Home Phone: _____ Cell Phone: _____ Accepts Text Msg? YES NO
(Please circle which phone number to call for appointment reminders)
Health Insurance Company Name: _____ Group #: _____
ID #: _____ Family Doctor Name: _____ Phone: _____
Name of person on insurance: _____
How did you hear about us? (Please explain) _____
Describe presenting complaint(s) in detail. Please indicate the current complaints you are experiencing by marking the areas on the image below :



_____
Approximate DATE your symptoms BEGAN: _____
Give complete description of HOW your symptoms began:
_____
Are you currently working? Yes or No
*If no: Reason for unemployment: _____
Occupation & Name of Employer: _____
Address of Employer: _____
****WERE YOU HURT AT WORK? YES or NO
****WERE YOU HURT IN AN AUTOMOBILE ACCIDENT? YES or NO
Would your employer be interested in complimentary safety lecture by our doctors?_____
Would you be interested in a nutritional program & supplements?_____
Have you EVER seen a Chiropractor? YES or NO
If yes, who? _____
Have you had X-rays, MRI, CT-Scan, Bone Scan, or Blood Work (Please Circle?)
Where: _____ When: _____
Have you EVER been treated for or suspected of having cancer in the past or present?_____
List ALL medications, vitamins, minerals, and herbs you take:_____
_____
List ALL specific allergies/reactions to drugs, foods or other substances you have:
_____
Have you been in or had ANY accidents or injuries: YES or NO
If yes: When_____ Please describe in detail: _____
_____
Have you had ANY surgeries or fractures: YES or NO
Please list along with the approximate date: _____
Family History: Please list the illness/disease and the family member associated:

Who to contact in case of an Emergency: _____ Phone: _____

Signature: _____ Date: _____

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Patient Name: _____

AUTHORIZATION FOR RELEASE OF RECORDS:

To _____, I hereby authorize you to release to GRAND ISLAND CHIROPRACTIC any information including the diagnosis and records of any treatment or examination rendered to me during my period of treatment.

Date:_____ Signature:_____Date:_____ Witness:_____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I authorize payment of any medical benefits to be paid directly to GRAND ISLAND CHIROPRACTIC OFFICE for any service rendered to me.

Date:_____ Signature:_____Date:_____ Witness:_____

NOTICE OF PATIENT PRIVACY

By signing the below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand.

Name(Printed)_____ Signature:_____Date:_____ Witness:_____

_____ _____

Signature of Legal Representative Relationship
(ex.Attorney-In-Fact, Guardian, Parent if a minor)

CONSENT TO TREAT

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of benefits, the risks and the side effects of the treatment and consequences of not having the proposed treatment. I understand that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocations, disc injuries and strokes. I do not expect the doctor to be able to anticipate or explain all the risks. I wish to rely on the doctor to exercise judgment during the course of the treatments which they feel at the time, based upon what is known, is in my best interest. My doctor has responded to a of my requests for information about the proposed treatment. I have, or have had read to me, the above consent. I have also had the opportunit to ask questions about its consent. By signing below, I authorize treatment.

Date: _____ Signature: _____ Date: _____ Witness:_____

ACKNOWLEDGEMENT OF FINANCIAL LIABILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles, all collection and/or legal fees on any unpaid account referred for collection, and charges denied or not covered by my insurance company. I realize my car 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 Grand Island Chiropractic for review for medical necessity and base their approval/denial upon this documentation. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals etc. I understand that this office agrees to notify me if a service is not covered and will notify me if the insurance company does not approve my care as soon as possible. If a treatment plan is approved, this office will make me aware of the number of office visits allowed. 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 the 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 determine to be not medically necessary.

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

_____ _____ _____

Print Name 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, _____, ("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 the 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 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)

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WORKERS COMPENSATION FORM

Name:_____ Date of accident:_____

Approximate time:_____ Location of accident (city):_____

WCB#_____ Carrier Case # _____

Place of employment at time of accident:_____

Address:_____ Phone #_____

Was this injury reported? Yes or No To Whom:_____

Was an accident report filled out? Yes or No

Please explain HOW you were injured and WHAT PART of your body was injured:

_____

_____

_____

Have you been on compensation for THIS condition before? Yes or No

If yes, please explain:_____

For this condition, were you taken to the hospital? Yes or No

If yes, please give name of hospital_____

Name all tests & x-rays performed and where for this injury:

_____

_____

_____

Please list all doctors treating you for this condition:

_____

_____

Are you presently working? Yes or No

Have you lost time from work due to this injury? Yes or No

If yes, please list dates:_____

Workers' Compensation Covers Chiropractic Care Completely. This sheet is for your protection in the event a hearing is necessary. In the event I fail to prosecute the claim for Workers' Compensation for this condition, or it is determined that there is no case, I _____ Agree to pay the treating doctors of Grand Island Chiropractic and/or Notaro Chiropractic her/her usual and customary fees and any collection fees plus a 10% surcharge for services to the above claimant in the identified case

Signature:_____ Date:_____

Termination of Care Waiver:

I hereby acknowledge and understand that if I do not keep appointment as recommend to me by my attending Doctor at this Chiropractic office, he/she has full and complete right to suspend my personal injury case with my third party carrier and relinquish and disability granted me within a reasonable period of time.

Signature:_____Date:_____

**If during the course of your case, your insurance company requires you to have an examination from any other doctor, you must notify us immediately.

OFFICE USE: Verified _____

NEW YORK STATE | Workers' Compensation Board

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ___ - ___ - ____ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ (First / MI / Last) DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration Date: ____/____/____

NEW YORK STATE | Workers' Compensation Board

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*:_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:_____-_____-_____
3. Mailing Address: _____
4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____
6. Current injury/illness, including all body parts injured:_____
   _____
7. Your legal representative's name and address (if any):_____
   _____

☐ *Check here if you allow your health care provider(s) to release* ***mental health care*** *information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____
Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____
Your name | Relationship to Claimant | Signature (ink only -- use blue ballpoint pen, if possible.) | Date

Versión en español al reverso de la forma.

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.

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THOMAS J. NOTARO, D.C.
ANDREW C. GREEN, D.C.
MICHAEL C. BAASE, D.C.
CURTIS GORDON, D.C.
JACK SAIA, D.C.
ANTHONY BUSCAGLIA, D.C.
MEGAN LAFAVE, D.C.

INFORMATION REGARDING WORKERS' COMPENSATION & NO-FAULT INSURANCE:

This office has established a Workers' Compensation/No-Fault case for you. You MUST maintain the prescribed schedule of visits in order for us to keep your case active. If you miss an appointment, it is required that you call and reschedule your appointment. MISSED APPOINTMENTS- more than three without notice will result in thee suspension of your case

IT IS VERY IMPORTANT TO NOTIFY THE FRONT DESK OF THE FOLLOWING:

1. When you return or are taken off work. After you return to work, you are still covered under Workers' Compensation/No-Fault and should continue to schedule appointments.

2. When you receive notification to see an Independent Examiner or any other correspondence from the insurance carrier.

3. When you receive notice that the insurance carrier will no longer pay for your treatment.

4. When you receive an assigned Workers' Compensation number from the Workers' Compensation Board.

PLEASE NOTE:

Under Workers' Compensation and No-Fault you are entitled to mileage reimbursement. YOU MUST KEEP TRACK OF YOUR OFFICE VISITS and mail them to your insurance carrier. Our office will gladly furnish you with a mileage form or make copies of your file if you need them. WE WILL NOT FURNISH THE VISIT DATES FOR YOU FOR ANY REASON. PLEASE KEEP TRACK OF THEM TO RECEIVE YOUR REIMBURSEMENT.

Please initial here that you understand these terms _____ Patient

_____ Witness