Massage Therapy Intake Form

Name_____ Date_____

Address_____
Street City State Zip

Date of Birth_____ Home Number _____ Cell Number_____

Emergency Contact _____
Name Relationship Number

Are you presently taking any medication? _____Yes _____No

Please Explain:

_____

_____

Have you had a recent major surgical procedure or injury? ____ Yes ____ No

Please Explain:

_____

_____

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

____ Yes ____No

Please Explain:

_____

_____

Please circle your stress level:

Low 1 2 3 4 5 High

Please circle desired massage: Swedish Deep Tissue Cupping Reflexology Hot Stone

Please circle desired pressure: Soft Medium Hard

Are you allergic to any Lotions or Oils? ____ Yes ____ No

Please Explain:_____

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/Fractured bones
Strains/Sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other:_____

Circulator/Respiratory

Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart condition
Allergies
Asthma
High blood pressure
Low blood pressure
Other:_____

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Crohn's Disease
Colitis
Other:_____

Nervous System

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Other:_____

Reproductive System

Pregnancy

Skin

Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophelia

Other

Loss of Appetite
Depression
Difficulty concentrating
Hearing Impaired
Visually Impaired
Diabetes
Fibromyalgia
Post/Polio Syndrome
Cancer
Tuberculosis
Other:_____

I understand that a massage Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times and that breast massage will not be administered on female clients. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. I understand that the massage Therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's signature_____ Date_____

Consent for Therapy and Waiver of Liability

The undersigned ("Client") hereby freely consents to receipt of massage services from:

_____

Licensed Massage Therapist's Name

Client agrees as follows:

Client understands and agrees that they will provide the Therapist with complete and accurate health information, and a written referral from Client's primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manually therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.
2. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part, will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.
3. Client hereby assumes fully responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist , to the fullest extent allowed by law.
4. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Therapist

_____ _____

Client Signature Client Printed Name

_____

Date

_____ _____

Massage Therapist Signature Massage Therapist Printed Name

_____

Date

NOTARO
CHIROPRACTIC

NOTIFICATION CONSENT:

Notaro Chiropractic will now be sending reminder texts and calls for your convenience on upcoming appointments as friendly reminders.

Notaro Chiropractic will also be sending emails monthly for our new monthly promotions on supplies.

*By signing this form, you agree to receive text messages, phone calls and emails regarding appointments and promotions from Notaro Chiropractic, its management company Chiropractic Office Solutions, agents, contractors, and assignees.

Audio and video recordings may be used at the front desk for quality assurance. The recordings are kept secure and are destroyed pursuant to a routine deletion policy.

Thank you.

Signature:_____

Date:_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME

2. PHONE NOS. HOME BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)

4. DATE OF BIRTH

5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. P.M.

7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK:	AMOUNT OF TIME LOST FROM WORK:
_____	_____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

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.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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

AUTOMOBILE ACCIDENT QUESTIONAIRE

Name:_____ Date of accident: _____
Approximate Time: _____Location of accident (city): _____
Your Auto Insurance Company: _____
Policy #: _____Claim #:_____
Agents Name: _____Phone: _____
Have you retained an attorney?: Yes or No
If yes, name & address: _____
Was the driver of either vehicle under the influence of alcohol?: Yes or No
Driver of the other vehicle name: _____
Insurance company of other vehicle:_____
Were there any witnesses?: Yes or No Names:_____

NATURE OF ACCIDENT: PLEASE BE SPECIFIC
Were you in the front seat:_____ or back:_____
Number of people in your vehicle: _____
Number of people in other vehicle: _____
Were any others injured?: _____
If yes, please explain:
_____
_____
What direction were you headed? North_____South_____East_____West_____
Name of street you were on:_____
Make and model of vehicle you were in: _____
Your approximate speed at the time of the accident: _____
Make and model of other vehicle: _____
Were you struck from Behind_____ Front_____ Left Side_____ Right Side _____
Please describe, in detail how the accident happened:
_____
_____
_____
Were you knocked unconscious?: Yes or No If yes, how long?:_____
Were the police notified?: Yes or No
Were you able to get out of the vehicle by yourself?: Yes or No
For this condition, were you taken to the hospital?: Yes or No
If yes, please give name and address of the hospital:
_____
_____
Were you admitted?: Yes or No Name of physician: _____
Name all tests & x-rays performed and where since this accident:
_____
_____
Please list all doctors treating you for this condition:
_____
_____
Are you presently working? Yes or No Have you lost time from work?: Yes or No
The date of the last day you worked: _____
Did you have any physical complaints before the accident?: _____
If yes, please describe in detail: _____
Please describe how you felt: During the accident: _____

Immediately after: _____ Later that day: _____
The next day: _____
What are your present complaints & symptoms?:

_____

_____

Did you have any congenital(from birth) factors, which relate to this problem?: Yes or No
Please describe: _____
Did you have any previous illness which relate to this case?: Yes or No
If yes, please describe: _____

PLEASE CIRCLE:

Since the accident occurred, are your symptoms:

Improving Getting Worse Same

Symptoms you have noticed since the accident:

Headache	Irritability	Numbness in Toes	Face Flushed	Feet Cold
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Hands Cold
Neck Stiff	Dizziness	Fatigue	Loss of Balance	Stomach Upset
Sleeping Problems	Depression	Head Seems too Heavy	Fainting	Constipation
Back Pain	Pins & Needles in Legs	Tension	Diarrhea	Numbness in Fingers
Pins & Needles in Arms	Loss of Smell	Nervousness	Lights Bother Eyes	
Ear RingFever	Cold Sweat	Loss of Appetite	Increased Appetite	

Did you notice any activity restrictions as a result of this injury?: Yes or No
If yes, please describe:

_____

_____

Any other pertinent information?: _____

PLEASE READ, SIGN AND DATE

Please Note: You may be responsible for your deductible under No-Fault. This sheet is for your protection in the event a court hearing is necessary. In the event I fail to prosecute to the claim under No-Fault for this condition, or it is determined that there is no case, I

_____
(full name)

hereby agree to pay the doctors of Notaro Chiropractic Offices their usual and customary fees and any collection fees plus a 10% surcharge for services to the about claimant in the identified case.
Signature: _____ Date: _____

ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR, FROM PRIVATE GROUP AND ACCIDENT AND HEALTH INSURANCE.
I hereby instruct and direct the _____ Insurance Company
(name of insurance company)
to pay by check; made out and mailed directly to:

Grand Island Chiropractic 2283 Grand Island Blvd, Grand Island, NY 14072
or Notaro Chiropractic 10158 Niagara Falls Blvd, Niagara Falls NY 14304
or Notaro Chiropractic 4754 N. French Rd, East Amherst NY 14051

If my current policy prohibits direct payment to Doctor then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O Thomas J. Notaro D.C., Michael Baase D.C., Curtis Gordon D.C., Dr.
Jack Saia, Dr. Megan Lafave, Dr. Nicholas Ryan, Dr. Aaron Boedekcer, Dr. Warren Marranca
Grand Island Chiropractic 2283 Grand Island Blvd, Grand Island, NY 14072
or Notaro Chiropractic 10158 Niagara Falls Blvd, Niagara Falls NY 14304
or Notaro Chiropractic 4754 N. French Rd, East Amherst NY 14051

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charge for professional services rendered. "This is a direct assignment of my rights and benefits under this policy". This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Signature of Policy Holder: _____ Date: _____
Signature of Claimant, if other than policy holder: _____
Witness: _____ Date: _____

TERMINATION OF CARE WAIVER:
I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my attending Doctor at this office he/she has full and complete right to suspend my personal injury case with my third party carrier and relinquish any disability granted to me within a reasonable period of time.
Signature: _____ Date: _____

LIEN FORM:
I hereby authorize the above doctor office to furnish you; my attorney, with a full report of his examination, diagnosis, treatment, prognosis etc of myself in regard to the accident in which I was involved. I hereby authorize and direct you, my attorney, to pay directly to said doctor such sum as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due at the office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said doctor, I hereby give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement judgment or verdict by which I may eventually recover said fee.

Patient's Signature: _____ Date: _____
Street _____
City, State, Zip _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequate to protect the said doctor name above.

Attorney's Signature _____ Date: _____

Attorney: Please date, sign and return on e copy to the doctor's office at once.
Keep one copy for your records

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)

NOTARO CHIROPRACTIC

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

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

THOMAS J. NOTARO, D.C.
MICHAEL C. BAASE, D.C.
CURTIS GORDON, D.C.
JACK SAIA, D.C.
MEGAN LAFAVE, D.C.
NICHOLAS RYAN, D.C.
AARON BOEDECKER, D.C.
WARREN MARRANCA, 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

FINANCIAL DISCLOSURE STATEMENT

This Financial Disclosure Statement is intended to memorialize the notice provided to _____ (print name), the patient, that your medical provider (Doctor, Chiropractor, Physical Therapist, etc.), will receive certain compensation from **Elite Medical Supply of New York, LLC** ("Elite"), for specified time and work ("Services") provided regarding the:

1. Collection of complete and accurate demographic information and all other information required by Elite in order for Elite to submit and/or collect on claims for the durable medical equipment prescribed and provided to you, including but not limited to, a New York No-Fault Assignment of Benefits Form, Medical Rebuttal Letters (if applicable), and Medical Chart Notes;

2. Measurement and recordation of accurate patient measurements, and another information required for Elite to determine the proper size/configuration of the prescribed and provided durable medical equipment;

3. Handling, storage, and/or timely delivery of the prescribed durable medical equipment;

4. Timely patient fitting and adjustments, if needed, of the prescribed durable medical equipment;

5. Proper education and instructions on the proper care and use of the prescribed durable medical equipment, including a review of all warnings, side effects, and contraindications; and

6. Timely securement and retention of a fully-executed Patient Agreement/Acknowledgment of Receipt and this Financial Disclosure Statement.

It is further disclosed to you that the compensation your medical provider will receive does not exceed fair market value for the above Services, and is not varied or directly or indirectly based upon volume or value of any referrals.

_____ _____

Patient Acknowledgement/Signature Medical Provider/Signature

_____ _____

Date Date