NOTARO CHIROPRACTIC

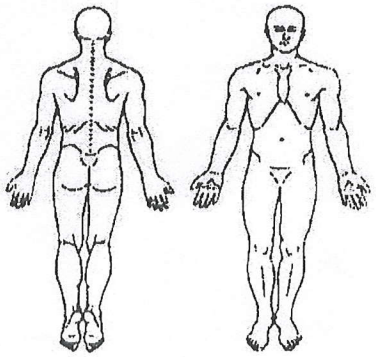
GRAND ISLAND CHIROPRACTIC
2283 GRAND ISLAND BLVD
GRAND ISLAND, NY 14072
(Town Hall Plaza)
(716) 773-2222
FAX (866) 907-6157

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 all 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 opportunity 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 care 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
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

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.

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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)

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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

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:_____

PAIN DIAGRAM AND VISUAL ANALOG SCALE

Patient Name:_____ Age:_____

Dear Patient,

New York State Workers' Compensation Board Medical Treatment Guidelines require us to document a positive patient response to treatment. Positive results are defined primary as functional gains which can be objectivity measured.

Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activates of daily living, cognition, psychological behavior and efficiency/velocity measure which can be qualified.

On the diagam below, please indicate where and what type of symptoms that you are experiencing right now. Write appropriate abbreviations (see key below) over the area of the body where those symptoms are occurring.

A= ACHE

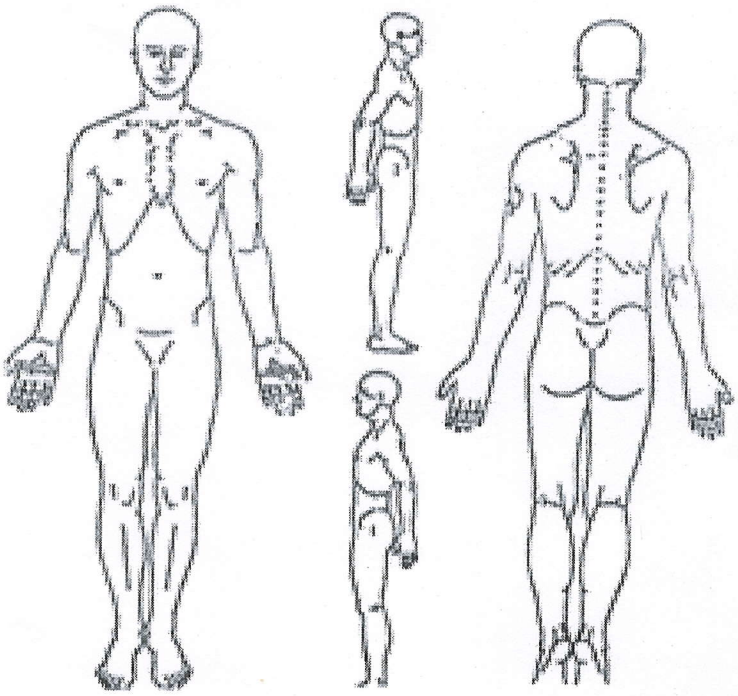
B= BURNING

N= NUMBNESS

P= PINS & NEEDLES

S= STABBING

O= OTHER_____



Instructions: Please ***circle*** that number that corresponds to the pain level that you are expecting.

Note: If you have more than one complaint, please indicate your pain levels for each complaint. Please indicate your pain level for

1. Your pain at its worst
2. Your pain right now
3. Your average pain level

Example:
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

1. My pain when it is at its worst is:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

2. My pain right now is:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

3. My average pain level is:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

MID AND LOWBACK OSWESTRY DISABILITY INDEX

Patient Name:_____ Age:_____

Dear Patient:

New York State Workers Compensation Board Medical Treatment Guidelines require us to document a positive patient response to treatment. Positive results are defined primarily as functional gains which can be objectively measured.

Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activities of daily living, cognition, psychological behavior and efficiency/velocity measures which can be quantified.

SECTION 1- Pain Intensity A. I have no pain at the moment B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment F. The pain is the worst imaginable at the moment.	SECTION 6- Standing A. I can stand as long as I want without extra pain. B. I can stand as long as I want but it gives me extra pain. C. Pain prevents me from standing for more than one hour. D. Pain prevents me from standing for more than half an hour. E. Pain prevents me from standing for more than ten minutes. F. Pain prevents me from standing at all.
SECTION 2- Personal Care A. I can look after myself normally without causing extra pain. B. I can look after myself normally but with pain. C. It is painful to look after myself and I am slow and careful. D. I need some help but manage most of my personal care. E. I need help every day in most aspects of self care. F. I do not get dressed, wash with difficulty and stay in bed.	SECTION 7- Sleeping A. My sleep is disturbed by pain. B. My sleep is occasionally disturbed by pain. C. Because of pain I have less then 6 hours of sleep. D. Because of pain I have less then 4 hours of sleep. E. Because of pain I have less then 2 hours of sleep. F. Pain prevents me from sleeping at all.
SECTION 3- Lifting A. I can lift heavy weights without extra pain. B. I can lift heavy weights but it gives extra pain. C. Pain prevents me form lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g., on a table. D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. E. I can lift only very lights weights. F. I cannot lift or carry anything at all.	SECTION 8- Social Life A. My social life is normal and gives me no extra pain, B. My social life is normal but increase the degree of pain. C. Pain has no significant effect on my social life apart from limiting any more energetic interests, e.g., dancing. D. Pain has restricted my social life and I do not go out as often. E. Pain has restricted social life to my home. F. I have no social life because of pain.
SECTION 4- Walking A. Pain does not prevent me walking any distance. B. Pain prevents me walking more than one mile. C. Pain prevents me walking more than a quarter of a mile. D. Pain prevents me from walking 100 yards. E. I can only walk using a stick or crutches. F. I am in bed most of the time and have to crawl to toilet.	SECTION 9- Traveling A. I can travel anywhere without pain. B. I can travel anywhere but it gives extra pain. C. Pain is bad but I manage journeys over 2 hours. D. Pain restricts me to journeys of less then 1 hour. E. Pain restricts me to journeys of less then 30 minutes. F. Pain prevents me from traveling except to receive treatment.
SECTION 5- Sitting A. I can sit in any chair as long as I like. B. I can sit in my favorite chair as long as I like. C. Pain prevents me from sitting for more than one hour. D. Pain prevents me from sitting for more than half an hour. E. Pain prevents me from sitting for more than ten minutes. F. Pain prevents me from sitting at all.	SECTION 10- Changing Degree of Pain A. My pain is rapidly getting better. B. My pain fluctuates but overall is definitely getting better. C. My pain seems to be getting better but improvement is slow at present. D. My pain is neither getting better nor worse. E. My pain is gradually worsening. F. My pain is rapidly worsening.

Patient Signature:_____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

COMMENTS: _____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____