NOTARO CHIROPRACTIC

Text: (716)534-8885

Fax: (866)907-6157

Grand Island:
2283 Grand Island Blvd
Grand Island, NY. 14072
(716) 773-2222

North Tonawanda:
603 Division St.
North Tonawanda, NY. 14120
(716) 693-0556

Niagara Falls:
10158 Niagara Falls Blvd
Niagara Falls, NY. 14304
(716) 298-0368

East Amherst:
4754 North French Rd.
East Amherst, NY. 14051
(716) 688-8815

Please use the back of this page to provide any additional relevant information.

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 Messages? YES NO (Please circle which phone number to call for appointment reminders)

How did you hear about us? (Please explain; we have a referral program!)_____

Insurance

Health Insurance Company Name: _____ Group #: _____

ID #: _____ Family Doctor Name: _____ Phone: _____

Name of Person on insurance: _____

Symptoms

Describe presenting complaint(s) in detail. Please indicate the current complaints you are experiencing by marking the areas on the image: _____

Approximate date your symptoms began: _____

Description of how your symptoms began: _____ _____

Are you currently working: YES NO

*If no, reason for unemployment: _____

Occupation & name of employer: _____

Address of employer: _____

Were you hurt at work: YES NO

Were you hurt in an automobile accident: YES NO

Would your employer be interested in complimentary safety lectures by our doctors? YES NO

Would you be interested in a nutritional program & supplements? YES NO

Have you ever seen a Chiropractor? YES & doctor's name is/was _____ NO

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? YES NO Please list all medications, vitamins, minerals, and herbs you take: _____

_____

Please list all allergies/reactions to drugs, foods or other substances you have:

_____

Have you been in or had ANY accidents or injuries: NO YES When: _____ Please describe: _____

_____

Have you had any surgeries or fractures: NO YES List with dates: _____

Please list any family history of illnesses or diseases and the family member associated: _____

_____

Emergency Contact – Name: _____ 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 for any services 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 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 determines to be not medically necessary. I have read and understand my obligations for payment for care in the absence of insurance coverage.

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

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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 visual 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: _____

Notaro Chiropractic & Massage Therapy Cancellation Policy

We require 24 hours notice for all canceled appointments so that other patients can be seen during those times.

If you cancel or no show with less than 24 hours notice, there were be the following fees:

Chiropractic $35

Massage $50

Thank you!

Signature: _____

Date: _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____