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:

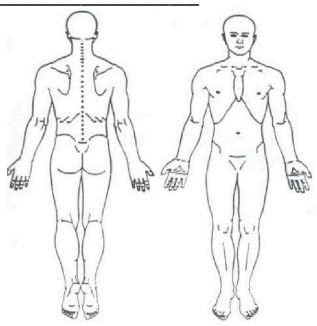
_____ Phone: _____ Name of Person on insurance:_____

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 charge 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 call 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

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: _____

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AUTOMOBILE ACCIDENT QUESTIONNAIRE

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 Ring Fever 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

or Notaro Chiropractic 603 Division St. North Tonawanda, NY. 14120

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 and associates, all locations*

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 one copy to the doctor's office at once.

Keep one copy for your records

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Thomas J. Notaro, D.C.
Michael C. Baase, D.C.
Curtis Gordon, D.C.
Megan Lafave, D.C.
Warren Marranca, D.C.
Scott Arends, D.C.
Emily Patrick, D.C.
April Williams, D.C.
Jake Eberth, D.C.
Michael Buziak, D.C
Joseph Schwartzott, 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 <u>are still covered</u> 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

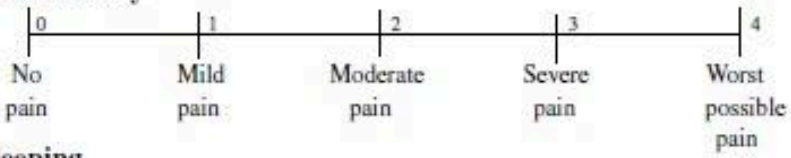
_____Witness

Functional Rating Index

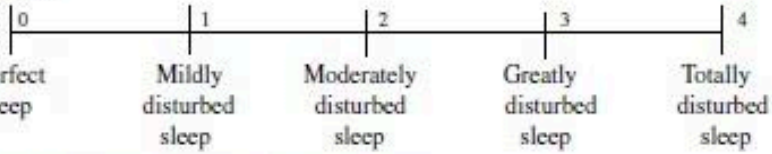
For use with **Neck and/or Back Problems** only.

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.**

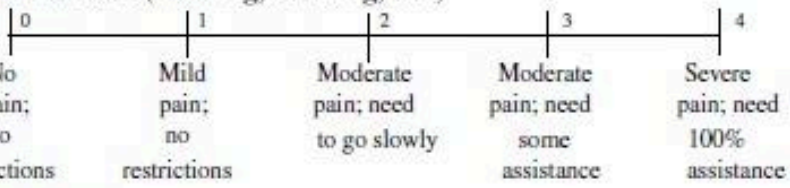
1. Pain Intensity



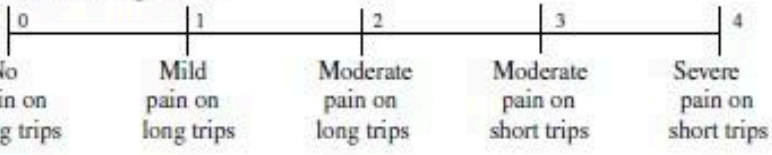
2. Sleeping



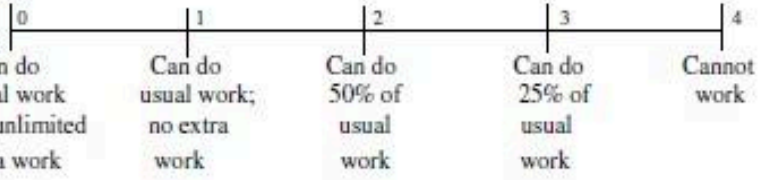
3. Personal Care (washing, dressing, etc.)



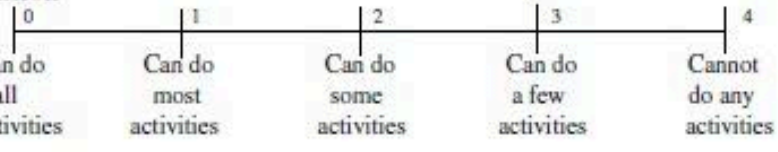
4. Travel (driving, etc.)



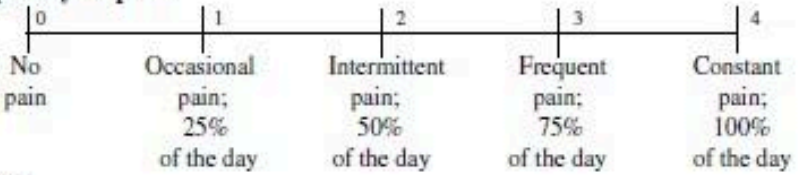
5. Work



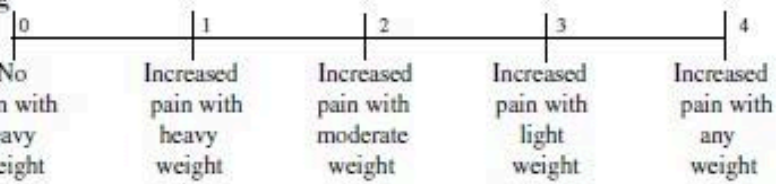
6. Recreation



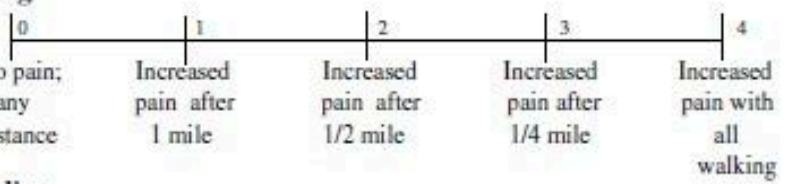
7. Frequency of pain



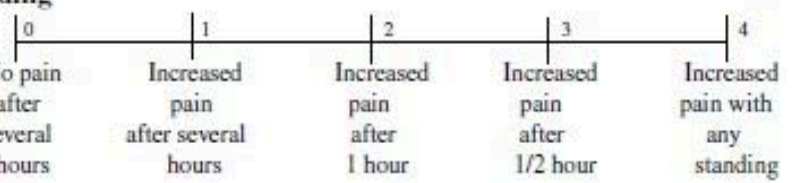
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

PAIN DIAGRAM AND VISUAL ANALOG SCALE

Patient Name:_____ Age:_____

Dear Patient,

New York State Workers' Compensation Board and No-Fault 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 diagram 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

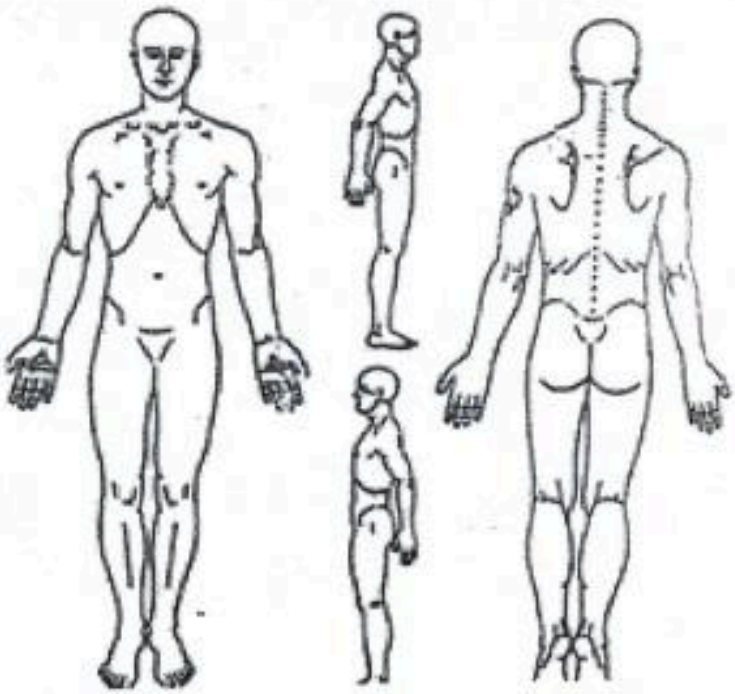
B= BURNING

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

NAME_____ DATE OF EXAM _____

COMPLAINT_____

WEIGHT_____ HEIGHT _____ BLOOD PRESSURE _____R RESPIRATIONS _____ TEMP _____ PULSE _____ _____L

PRESENTING COMPLAINT(S) _____

HOW CHIEF COMPLAINT BEGAN AND DATE _____

PAST MVA OR SERIOUS ACCIDENTS OR TRAUMA'S _____

PAST SURGERY _____

DISABILITY PERCENTAGE: _____%

PAST NEURO/MUSCULO/SKELETAL CONDITIONS _____

SIGNIFICANT SOFT TISSUE FINDINGS _____

CERVICAL ROM: WNL___

Flexion(65) _____
Extension (50) _____
R. Lat Flex (55)_____
L. Lat Flex (55)_____
R. Rotation (80) _____
L. Rotation (80) _____

LUMBAR ROM: WNL _____

Flexion (90) _____
Extension (30 _____
R. Lat Flex (35)_____
L. Lat Flex (35)_____
R. Rotation (30) _____
L. Rotation (30) _____

ORTHO:

Compression	R_____	L_____	SLR	R_____	L_____	Yeomans Test	R_____	L_____
Shoulder Depr.	R_____	L_____	Well Leg	R_____	L_____	Bil. Leg Raise	R_____	L_____
Soto Hall	R_____	L_____	Braggards Test	R_____	L_____	Becterews Test	R_____	L_____
Distraction	R_____	L_____	Kemps Test	R_____	L_____	Fabre Test	R_____	L_____
Valsalva	R_____	L_____	Valsalva	R_____	L_____			

NEURO:

Biceps	R_____	L_____	Patellar	R_____	L_____	Toe Walk	R_____	L_____
Brach Rad.	R_____	L_____	Achilles	R_____	L_____	Heel Walk	R_____	L_____
Triceps	R_____	L_____	Ext. Hallicus	R_____	L_____			
Myotomes	R_____	L_____	Dermatomes	R_____	L_____			
Dermatomes	R_____	L_____						

*CHIROPRACTIC FINDING: PALPATION

INSPECTION/POSTURAL_____

COMMENTS/FINDINGS/PRECAUTIONS/RECOMMENDATIONS: _____

BILLING REGIONS: 1-2, 3-4, +extremity

Examined By: _____ _____ _____ _____ _____

Dr Thomas Notaro | Dr Michael Baase | Dr Curtis Gordon | Dr. Megan Lafave | Dr. April Williams

_____ _____ _____ _____ _____ _____

Dr. Jake Eberth | Dr. Warren Marranca | Dr. Scott Arends | Dr. Brittany Gaston | Dr. Emily Patrick | Dr. Michael Buziak