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AUTHORIZATION AND CONSENT

TO: _____ **FROM:** MORGANTE FAMILY CHIROPRACTIC
 _____ 1660 KENSINGTON AVENUE, SUITE 1
 _____ CHEEKTOWAGA, NY 14225
 _____ 716-833-2960

This authorization will permit you to furnish a copy of health records, notes and medical information in your possession regarding my condition while under your observation or treatment including the history obtained, x-ray and physical findings, diagnosis, and prognosis.

I hereby take full responsibility for these records received by your office. I hereby state that I have the right to review MFC's privacy policy. I also have the right to request any restrictions I deem appropriate on information released and the right to revoke consent of authorization at my request.

 Patient's Name (please print)

 Date of Birth

 Patient's Signature

 Date

 Witness

 Date

 Revocation of Authorization

 Date

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PATIENT REGISTRATION

MORGANTE FAMILY CHIROPRACTIC

Today's Date: _____

Personal Information:

Last Name _____ First Name _____ Middle Initial _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work phone _____

SS # _____ Date of Birth _____ Sex _____ Marital Status _____

Email Address _____

Who to contact in case of emergency _____

Who can we speak with regarding medical information? _____

SIGNATURE _____

Employment Information:

Occupation: _____ Employer _____

Street _____ City _____ State _____ Zip _____

Insurance Information:

Insurance Company _____ Phone _____

Name of Insured _____ SS # _____ Date of Birth _____

Policy # _____ Group # _____ Contract # _____

Employer of Insured _____ Relationship _____

Signature _____ Date _____

Primary Doctor _____ Phone _____

Primary Doctor Address _____

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PATIENT HISTORY

NAME _____ DATE _____
 DATE OF BIRTH _____ SS# _____

CHIEF COMPLAINT: NECK PAIN HEADACHES MID-BACK LOW BACK ARM
 SHOULDER LEG OTHER EXPLAIN: _____

PAIN RADIATES? YES NO IF YES - FROM _____ TO _____

ONSET: DATE _____ ONSET WAS : GRADUAL SUDDEN PROGRESSIVE OVER TIME
 HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HAS THIS PROBLEM IMPROVED REMAINED THE SAME WORSENERD ON AND OFF
 IS THE COMPLAINT INJURY RELATED? YES NO WORK AUTO
 EXPLAIN: _____

MODE OF ONSET: POSITIONAL TRIP/FALL OTHER _____

SEVERITY OF PROBLEM: 1 2 3 4 5 6 7 8 9 10
 (BEST) (WORST)

DURATION OF SYMPTOMS: INTERMITTENT (25% F THE TIME) OCCASSIONAL (25-50%)
 FREQUENT (50-75%) CONSTANT (100%)

CHARACTER OF PAIN: DULL/ACHE SHARP/STABBING BURNING THROBBING
 NUMBNESS/TINGLING OTHER _____

HAS THE PROBLEM AFFECTED: BOWEL OR BLADDER
 OTHER BODY SYSTEMS (EXPLAIN) _____
 NO APPARENT RELATIONSHIP

RELIEVING FACTORS: REST EXERCISE BRACING SITTING STANDING LYING DOWN HEAT COLD
 OTHER _____

AGGRAVATING FACTORS: COUGHING SNEEZING LIFTING BENDING PUSHING PULLING DRIVING
 RIDING SITTING STANDING WALKING RUNNING OTHER

MEDICATIONS/SURGERIES _____

PREVIOUS INJURIES OR ACCIDENTS _____

HAVE YOU EVER BEENT O A CHIROPRACTOR FOR THIS PROBLEM? YES NO

HAVE YOU EVER BEEN TO A CHIROPRACTOR FOR ANY OTHER PROBLEM? YES NO

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

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SYMPTOMS	YES	NO
HEADACHES		
IRRITABILITY		
NUMBNESS IN TOES		
NUMBNESS IN FINGERS		
FACE FLUSHED		
NECK PAIN		
CHEST PAIN		
SHORTNESS OF BREATH		
BUZZING IN EARS		
HANDS COLD		
STIFF NECK		
DIZZINESS		
FATIGUE		
LOSS OF BALANCE		
UPSET STOMACH		
SLEEPING PROBLEMS		
HEAD SEEMS TOO HEAVY		
DEPRESSION		
FAINTING SPELLS		
CONSTIPATION		
BACK PAIN		
PINS AND NEEDLES IN ARMS/LEGS		
LIGHT BOTHERS EYES		
LOSS OF SMELL		
TASTE		
COLD SWEATS		
NERVOUSNESS		
LOSS OF MEMORY		
FEVER		
TENSION		
COLD FEET		
EARS RING		
DIARRHEA		

OTHER _____

HAVE YOU LOST ANY TIME FROM WORK OR OTHER ACTIVITIES AS A RESULT OF THIS CONDITION?

YES _____ FROM _____ TO _____ NO _____

SIGNATURE _____

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Morgante Family Chiropractic

Terms of Acceptance

The practice of chiropractic in this office consists of:

1. Analysis of the spine for the purpose of locating vertebral sublimations (spinal misalignments causing nerve interference).
2. Adjustment of the spine for the purpose of correcting vertebral subluxations.
3. Education and encouragement of our patients/practice members to become aware of and responsible to their well being.
4. Empowerment of our patient/practice members as to the inherent healing capabilities of the human body.

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of treating or curing diseases or conditions.

Signature:

Name (please print):

Witness:

Date:

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FINANCIAL POLICY

Morgante Family Chiropractic

SCHEDULING

All appointments during regular hours must be scheduled so as to reduce waiting time for you and others.

You are free to stop in at any time. However, you will have to wait until all scheduled appointments are seen. You will be fit in as soon as possible

Cancellations require 24 hour notice.

PAYMENT

Payment in full is expected at the time services are rendered. This includes all co-payments.

For your convenience we accept cash, checks, Master Card, and Visa.

Patients with deductibles will pay the full visit amount until the deductible is met.

Should you discontinue care for any reason other than discharge by the doctor, any outstanding balances will become immediately due and payable in full by you.

INSURANCE

Our office will verify your insurance coverage in an effort to help you determine exactly what chiropractic coverage is available under your policy.

It is your responsibility to provide us with all the appropriate insurance forms, insurance cards, addresses, and information so that proper filing can be submitted.

We are not obligated to accept your insurance payment on assignment although for your convenience we may based on our experience with your insurance carrier.

You are always responsible for the portion of your bill the insurance company may not cover and for your annual deductible.

**ACCEPTED
INSURANCES**

Medicare, Workers Compensation, No Fault, Blue Cross and Blue Shield,
and Independent Health.

Remember that your insurance coverage is a contract between you,
your employer, and your insurance company. We do not bill any
secondary insurance carriers.

FEES

Our fees generally fall within what is considered reasonable and
customary for this area.

Many insurers pay a percentage of this reasonable and customary rate.

LASTLY

You are responsible for all charges incurred as a patient in this office.

We will do all we can with your insurance claims. However, you
are ultimately responsible for payment.

Past due statements for unpaid balances will be mailed. Statements
unpaid for more than 30 days may be subject to an interest charge.

It is the goal of this office to provide you with the finest quality chiropractic care available.
If you have any questions with regard to your health or any of our policies, please let us know.

WE WELCOME YOUR REFERRALS and look forward to a doctor-patient relationship that works
for our mutual benefit.

I, the undersigned, have read and agree to the guidelines of the above stated financial,
insurance and office policies.

Patient's Signature _____ Date _____

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
- b) There are reported cases of stroke associated with many common neck movements including adjustment to the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment and may, on rare occasion, result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment including spinal adjustment has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20____

Patient Signature (or Legal Guardian)

Signature of Witness

Patient Name (please print)

Witness Name (please Print)

PRIOR CHIROPRACTIC TREATMENT INFORMATION

Name of Chiropractor _____ Location (city) _____

When was your last treatment? _____ Have you had x-rays? Yes _____ No _____

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CONSENT TO TREATMENT AND EXAMINATION OF A MINOR CHILD

I hereby authorize Dr. Theresa Morgante and/or Dr. Anthony Morgante and/or her/his staff to examine and treat my child in this office.

Full Name
of Child

Address

Parent or Guardian

Signature _____ Date _____

Staff

Witness _____ Date _____

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Who May we we with regarding medical informaton?

Spouse Name _____

Parent Name _____

Child(children) Name _____

Signature _____

Who can we contact in case of emergency?

Spouse_____ Parent_____ Children_____

Who referred you to our office ?
