R

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 WORSENED 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 BEEN TO 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____

Morgante Family Chiropractic

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Terms of Acceptance

The practice of chiropractic in this office consists of:

1. Analysis of the spine for the purpose of locating vertebral subluxations (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 of 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

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Univera, GHI, Aetna, Medicare, Veterans Administration (with referral), 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 of 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______________

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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 bee 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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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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AUTOMOBILE ACCIDENT QUESTIONNAIRE

Today's Date ___________________

Last Name ____________________________ First Name ___________________________Middle Initial _______
Street ___________________________________City__________________________State_______Zip_________
Home Phone # __________________ Cell Phone # ____________________Work Phone # _________________
SS# _________________________Date of Birth _________________Sex___________Marital Status__________
E-Mail Address _________________________________Employer____
Street ___________________________________City__________________________State_______Zip_________

ACCIDENT INFORMATION

Insurance Company ____Phone # _____________________
Street ___________________________________City__________________________State_______Zip_________
Agent (Adjuster) ____Phone # _____________________
Policy # _________________________Claim # ________________________File # __________________________
Name of Policyholder __________________________________Your Relationship to Holder _______________
Date of Accident _______________ Time of Accident __________________Police Notified? Yes No
Did you report your accident to your insurance company? Yes No If yes, to whom? ___________________
Did you submit the "Application of No-Fault Benefits" to your insurance company? Yes No
If Yes, date? _____________ If No, please notify our front office immediately.
When did your present symptoms appear? ____
Have you ever had any complaints in the involved area before? Yes No If yes please explain: __________
____
Since the accident, are your symptoms: Improving Getting Worse Same
Have you retained an attorney? Yes No If yes, his/her name ____
Street ___________________________________City__________________________State_______Zip_________
Have you lost time from work? Yes No If yes, how long? Date From ____________Date To _____________

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for No-Fault is denied. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Patient's Signature ____Date __________________

Private Insurance Information

Insurance Company ______________________________________Phone Number ___________________
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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Auto Accident

Information Form

Name: ____ Date: ______________________

Date of Accident: __________________

Was there anyone else in the vehicle with you? Yes No If yes, please explain _______________________

____

1) Time of accident: _____________________
2) What was your position in the vehicle? Driver Passenger Backseat
3) What was your vehicle type? _____________________________________
4) What was the other vehicle type? _________________________________
5) What was your vehicle doing at the time of the accident?

   Stopped at an intersection Making a right turn Stopped at a light Parking

   Stopped in traffic Making a left turn Accelerating Constant speed
6) What was the visibility at the time of the accident?

   Good Fair Poor
7) What were the road conditions?

   Icy Wet Sandy/Rocky Clear/Dry
8) What was your speed?
9) What was their speed?
10) Did You hit the other vehicle or the other vehicle hit you
11) What was the point of impact?

    Head On Right Side Right Front Right Rear

    Back End Left Side Left Front Left Rear
12) Was there another collision? Yes No

    If so, was the point of impact

    Head On Right Side Right Front Right Rear

    Back End Left Side Left Front Left Rear
13) What direction was your head facing at the moment of the accident?

    Facing Forward Turned Right Turned Left
14) What was the position of your headrest at the time of the accident?

    No Headrest Even with the top of the head Even with the bottom of head Mid Neck

L 15) Did you have your hands on the steering wheel?

Right Hand Left Hand Both Neither

16) Did you see the accident coming? Yes No

17) Did you brace for impact? Yes No

18) What did you use to brace? Hands Feet Both

19) Did you have a seat belt on? Yes No

20) Did you have a shoulder harness on? Yes No

21) Did the seat bend or break? Yes No

22) Did your body hit the inside of the vehicle? Yes No

23) If so, what hit where? ____

____

24) Did you lose consciousness during the injury? Yes No

If so, for how long? Couple minutes Couple hours Not sure

25) Following the accident, how did you feel? ____

____

26) Did the driver side airbag deploy? Yes No

27) Did the passenger side airbag deploy? Yes No

28)` Did the side airbags deploy? Yes No

29) What was the damage to the vehicle? None Mild Moderate Total

30) What was the damage to their vehicle? None Mild Moderate Total

31) Did the police show up? Yes No

32) Was an accident report filled out? Yes No

33) Where did you go after the accident? Home Work Hospital ER Private Drive

34) How did you get there? Drove self Someone else Ambulance Police

35) have you gone to the hospital since the accident? Yes No

a) What hospital? ____________________________________

b) How long after the accident did you go to the hospital? _______________________

c) Were you admitted? Yes No

d) If so, for how long? ___________________________

e) Were x-rays taken? Yes No

36) Have you m issued work? Yes No

If so, how much? ___________________________

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Morgante Family Chiropractic

1660 Kensington Avenue
Cheektowaga, NY 14215
(716) 833-2960

Patient Name: ____

Phone #: _________________ Address: ___________________________
Date of Accident: ___________________

Policyholder: ____

Policy # : ___________________________________

Effective Date: _____________________________

Claim #: __________________________________

Insurance Company: _______________________________________

Billing Address: ____
____ -

Adjuster: ____

Telephone # _______________________ Fax # : ________________

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON OR AFTER 3/1/02)

I, ___________________________________, (assignor) hereby assign to **Morgante Family Chiropractic, LLP**

(print patient's name0) (Print hospital or health care provider name)

(assignee) all rights and 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 assignors lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWLINGLY 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 DOLLARSAND THA VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Print name of patient	Signature of patient
Address of patient	Date of signature
Print name of provider	Signature of provider
Address of provider	Date of signature

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DOCTOR'S LIEN

TO: Attorney ______________________________
____
____
____

FROM: **Morgante Family Chiropractic**
1660 Kensington Avenue, Suite #1
Cheektowaga, NY 14215
(716) 833-2960
(716) 833-4615 Fax

RE: ______________________________________
Patient's Name

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums 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 his 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 services rendered 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.

Dated ____________________ Patient's Signature ______________________________________

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 adequately to protect the said doctor named above.

Dated ____________________ Attorney's Signature ______________________________________

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

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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_____