WELCOME TO MARKET STREET CHIROPRACTIC & NUTRITION
We are happy to be taking care of you today!

W E L C O M E

CONFIDENTIAL PATIENT INFORMATION

Date: _____ DOB: _____ Patient SS#: _____

Name: _____

Address: _____ City/State/Zip: _____

Home/Work Phone: _____Cell: _____

E-mail Address: _____

I am: ☐ Single ☐ Widowed ☐ Married, Spouse Name & Occupation: _____

Do you have children? ☐ Yes ☐ No Names& Ages _____

Do you prefer calls at: ☐ Home ☐ Work ☐ Cell

Your occupation & employer: _____ Phone: _____

Whom may we thank for referring you to us? _____

Name & Address of Primary Care Physician: _____

HEALTH INSURANCE

Insurance Company: _____ ID#:_____

Group #: _____ Person Responsible for Account: _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with _____ and assign directly to *Market Street Chiropractic & Nutrition* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party: _____ Date: _____

ACCIDENT INFORMATION

Is your condition due to an accident: ☐ Yes ☐ No Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Date of accident: _____ Did you report this accident? ☐ Yes ☐ No

Name & Address of Insurance Company: _____

Claim #_____ Name & Phone # of Adjuster:_____

PATIENT CONDITION

Reason for visit: _____

How long: _____ Is the problem: ☐ Constant ☐ Random

What makes it worse?_____ What makes it better?_____

Is the problem getting ☐ progressively worse ☐ improving with time ☐ same over time

Rate the severity of your pain (0-10 scale; 0= no pain, 10= worst pain) _____

Type of pain (check all that apply): ☐ Dull ☐ Aching ☐ Throbbing ☐ Sharp ☐ Shooting ☐ Numbness ☐ Tingling ☐

Cramps ☐ Stiffness ☐ Swelling ☐ Other: _____

Does the pain interfere with (check all that apply): ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation/Sports

Activities that are painful to perform (check all that apply)

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Climbing stairs ☐ Other: _____

29 E. Market Street Corning, NY 14830
Tele: (607) 936-4141 Fax: (607) 936-4144

HEALTH HISTORY

What treatments have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical therapy
☐ Chiropractic services ☐ None ☐ Other: _____
Name of other doctor(s) who have treated your condition:
_____

Date of Last: Physical Exam: _____ Spinal Exam: _____ Spinal X-Ray: _____ Chest X-Ray: _____
Dental X-Ray: _____ MRI/CT Scan/Bone Scan: _____
Blood Test: _____ Urine Test: _____

Are you pregnant? ☐ Yes ☐ No

For the following list of conditions, please indicate: 1- have previously or occasionally had the condition
2- are currently experiencing the condition
Leave blank if none of the above applies

Neuro-Musculoskeletal Problems
(muscle/ligament/bone/nerve)

- ☐ Neck Pain
- ☐ Back pain
- ☐ Arm/ Hand/Wrist Pain
- ☐ Leg/ Foot/Ankle Pain
- ☐ Tension Headaches
- ☐ Migraine Headaches
- ☐ Herniated ("Slipped') Disc
- ☐ Sciatic Pain
- ☐ Pinched Nerve
- ☐ Carpel Tunnel Syndrome
- ☐ Osteo-Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Muscle Disease
  - o _____
- ☐ Bone Disease
  - o _____
- ☐ Nerve Disease
  - o _____

Internal/Organ System Problems

- ☐ Heart Disease
- ☐ Stroke
- ☐ Hepatitis/ Liver Disease
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Alzheimer's Disease/Dementia
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Depression/Anxiety Disorders
- ☐ Gastro-intestinal Problems
  _____
- ☐ Stomach Ulcers
- ☐ Acid Reflux (Heartburn)
- ☐ Menopausal Symptoms
- ☐ Endometriosis
- ☐ Female Reproductive Disorders
- ☐ Other: _____
  _____

Exercise
☐ None
☐ Light (1-2 days/week)
☐ Moderate (3-5 days/week)
☐ Heavy (6+ days/week)

Work Activity
☐ Sitting ☐ Standing
☐ Light Labor ☐ Heavy Labor
☐ Other: _____

Habits
☐ Smoking; Packs/day_____
☐ Drinking; Drinks/week _____
☐ Coffee/Caffeine; Cups/day _____
☐ High Stress; Reason _____

Injuries you have had:

	Description	Date
Auto	_____	_____
Slips/Falls	_____	_____
Broken Bones	_____	_____
Head Injuries	_____	_____
Sports	_____	_____

Surgeries/Hospitalizations you have had:

Description	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

Name	Condition/Use	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Pharmacy: _____

VITAMINS/SUPPLEMENTS

Name	Condition/Use	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Supplement Retailer: _____

FAMILY HEALTH HISTORY

A comprehensive family health history is needed to assess the role of genetic and environmental factors to your health and your current condition

Musculoskeletal Illness:

Please list all family members with known muscle, ligament, bone or nerve problems or disease

Family Member Name	Relation	Problem/condition	Is this a current condition (acute)	Is this a previous or ongoing condition (chronic)	Area of residence*

* Environmental factors in certain areas may contribute to health problems

Internal/Organ Illness:

Please list all family members with known organ or systemic problems or disease

Family Member Name	Relation	Problem/condition	Is this a current condition (acute)	Is this a past condition or ongoing condition (chronic)	Area of residence*

* Environmental factors in certain areas may contribute to health problems

Market St. Chiropractic & Nutrition

Informed Consent for Chiropractic Care

Patient name:_____ #_____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including x-rays, and other diagnostic tests on me (or the patient named above for whom I am legally responsible) at Market St. Chiropractic & Nutrition and by Dr. Scott Beres.

1. ***The purpose of chiropractic care is to contribute to health by the location, analysis and correction of neuro-musculo-skeletal abnormalities and dysfunction.***
2. Market St. Chiropractic & Nutrition uses chiropractic methods and appropriate techniques will be selected for my care based upon standard professional protocol.
3. My doctor will discuss my particular case during a report of findings procedure and document this discussion in my case record. Any questions that I have will also be addressed at this time. I am an active participant in my chiropractic care, and am therefore invited to ask any questions or express any concerns that I may have at this time.
4. I understand that there is a small force introduced into the spine during an adjustment/treatment that may lead to temporary minor musculoskeletal discomfort.
5. Chiropractic adjustments/treatments are exceedingly safe when applied properly. However, I understand there are some risks to care (the most serious potential side-effect being an extremely rare chance of damage to the vertebro-basilar artery in certain high-risk individuals). I do not expect the doctor to anticipate and explain all of the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of a procedure, based on the facts known and proper screening procedures, are in my best health interest.
6. I understand that the doctor or personnel at this office may communicate by telephone call regarding appointments, care information, or other details related to my care.
7. I understand that it is my responsibility to inform my doctor should I have a concern regarding the privacy of the area in which I receive care, my patient record or other details related to my care.
8. I understand that my records are the property of Market St. Chiropractic & Nutrition and Dr. Scott Beres.
9. I understand that a condition of acceptance of care at Market St. Chiropractic & Nutrition and by Dr. Scott Beres, is that I am not under the care of any other chiropractors at the same time.
10. I authorize Market St. Chiropractic & Nutrition and Dr. Scott Beres to release my information to any healthcare provider I am seeing and/or insurance company.

I have read, or have had this read to me, the above consent. By signing below, I agree to the above. I intend this consent to cover the entire course of care now and in the future.

_____	_____	___/___/____
Name of Patient	*Signature of Patient/Legal Representative*	*Date*

Market Street Chiropractic & Nutrition
FINANCIAL POLICY
Effective 1/1/09

Services

- Our fees vary upon the severity of your condition and the amount of time needed to help you. Listed below are the services we provide

Services	Purpose	When Performed	Fee
Consultation	Meet the doctor, discuss problems and health history	First Visit	**$30.00**
Structural Exams	Accurately determine the nature of your musculo-skeletal health problem and determine an appropriate course of action	First Visit & Re-evaluations	**$55.00**
Surface EMG	To objectively assess the balance and function of muscles and motor nervous system activity	First Visit & Re-evaluations, Re-injuries, progress examinations	**$30.00-$70.00**
Thermography	To objectively assess autonomic nervous system activity	First Visit & Re-evaluations, Re-injuries, progress examinations	**$25.00-$55.00**
Chiropractic Treatments	Reduce and correct, spinal distortion and vertebral subluxations to allow natural healing from within	As indicated by exam or office visit	**$36.00-42.00**
Nutritional Counseling	Personal counseling and programs offered.	Upon Request or doctor recommendation (either new or established patients)	**Ask us!**

Scheduling

- All appointments during regular hours must be scheduled to reduce waiting time for you and others
- You are free to stop in at any time; however, you will be seen after those with scheduled appointments are seen.
- ***Cancellations*** require **24-hour notice**. ***Missed appointments*** are subject to **$32.00 charge**. This is because time has been set-aside specifically for you and your visit with the doctor.

Payment

- Payment for all services is expected **at the time the service is rendered**, including all co-payments and deductibles. for your convenience we accept cash, check, MasterCard and Visa charge cards
- Market Street Chropractic and Dr. Scott Beres **do accept assignment with most managed-care insurance companies** (including No-Fault Motor Vehicle Accident Insurance, Medicare and Worker's Compensation). Your benefits may vary, so please check your chiropractic benefits with your insurance carrier prior to your first visit.
- For those patients who do not have health insurance, do not have chiropractic benefits in their health plan or have a high deductible, we offer ***pre-payment options*** and ***no-interest financing*** which affords our patients dramatic savings in their Chiropractic Care.
- All professional services are rendered and charged to the patient receiving care and not to the insurance provider. The patient retains the ultimate responsibility for all charges incurred.
- If you have out-of-network chiropractic benefits on your policy only will provide you with statements, reports or other documents to help you receive reimbursement from a third party.
- We will not become involved in disputes with your insurance company regarding any billing issues, other than to provide you with factual information.
- Should you discontinue care for any reason, any outstanding balance will become immediately due and payable in full.
- If you have an undisputed, out-standing bill for greater than 60 days and proper written and oral notification was attempted, your case will be transferred immediately to an outside collections agency.

Billing

- Should a condition arise wherein you have incurred an outstanding balance, it will be considered past due after the date of service or when special arrangements have not been met. Balances older than 30 days are subject to a $10.00 charge per month, plus any legal or collection fees.
- Returned checks are subject to a $25.00 fee. The bank, not by Market Street Chiropractic, imposes this.

Records

- There is a record duplicating charge of **0.75** per page.

Questions

- If you have any questions about this agreement, or your ability to comply with the provisions changes, please ask. We are here to help. Our mission and primary goal always remains to provide quality, affordable, Chiropractic Care to the Southern Tier.

Patient Agreement

- I have read, understand and agree to the terms of this agreement. (Photocopy available upon request)

_____ _____ ___/___/_____

Name of Patient *Signature of Patient/Legal Representative* *Date*

Notice of Privacy for
Patient Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can gain access to this information. Please review carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating healthcare providers regarding your healthcare
- To submit to insurance companies or Worker's Compensation Board to verify that treatment had been rendered.
- Releasing information required by state or federal Public Health Law
- To assist in overcoming language barrier when caring for a patient
- Business associates, providing written assurance of your privacy has been attained
- Emergency situations (at the treating doctor's discretion)
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign-in logs may be disclosed to verify office visits

Any other uses or disclosures will only be made with your specific written authorization.

You have the right to:

- Revoke authorization, in writing, at any time by specifying what you want restricted and to whom
- Speak to our privacy officer who is Dr. Scott Beres and can be reached at 607-936-4141 regarding privacy issues
- Inspect, copy and amend your protected health information and amend it as allowed by law
- Obtain an accounting of disclosures of your protected health information
- Render a complaint to our privacy officer or the Secretary of Health & Human Services

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

_____	_____	___/___/____
Name of Patient	*Signature of Patient/Legal Representative*	*Date*

With full respect to your right to privacy of your Personal Health Information, there are times we may wish or need to contact you via telephone, mail or e-mail for the following reasons: to schedule/reschedule appointments, emergency notification of office closure for weather conditions, birthday or holiday greeting card, patient newsletter, notification of in-office event or other office needs. Please list below any restrictions you have.
By my signature below, I authorize Market Street Chiropractic to contact me as outlined above. I understand this authorization may be revoked at any time by simply submitting a written request for such.

_____	_____	___/___/____
Name of Patient	*Signature of Patient/Legal Representative*	*Date*