GBAI

Greater Buffalo Accident and Injury Chiropractic
1275 Main Street, Suite 110
Buffalo, NY 14209
716-200-0651

REGISTRATION

Date: ____________________ Phone: ________________________

Patient: ____
Last Name First Name Initial

Street Address: ____

City/State/Zip Code: ____

Sex: M F Age: ____ Birthdate: ______ Single Married Widowed Separated Divorced

Social Security #: ____________________ Email: ______________________________

Insured's Name: ____
Last Name First Name Initial

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ______________________________
Name of Insurance Company

and assign directly to **{OFFICE NAME}** all medical 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 the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________________ ____________________
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Medical Implants: ____________________ **Medical alerts:** ____________________

Surgical Implants: ____________________ **Pregnancy:** **yes** ____ **no** ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Patient Name: ______________________________________ Date: ________________

Medications: *(please list all medications and supplements that you currently take)*

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

Allergies: *(please list all medications that cause allergic reaction)*

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

Smoking: ___ Yes ___ No If yes, ______ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week ________

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery ____ Date ____________________

____ ____________________

____ ____________________

____ ____________________

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: ____________________

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: ____________________ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: ____________________

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: ____________________

Patient Name: ____ Date: ______________

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type ______
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: ____________________

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: ____________________

Metabolic & Other Disorders

□ Diabetes x ________ years □ skin disorder _____________ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _________________

Cancer : any type -- please specify

____

Other medical problems NOT included above (explain)

____

____

Family History:

Please indicate with an “X” any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :________________________
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy
□ MS or Parkinson’s □ other neuro :__________________
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: ____________________
□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI :______________________
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Cancer : any type -- please specify

____

Other medical problems NOT included above (explain)

____

____

Patient Name: ____ Date: _______________

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

Medicare	Blue Shield	Auto Accident
Medicaid	Major Medical	Union Plan
Blue Cross	Worker's Compensation	Other

Insurance Identification Number: ____

Medicare/Medicaid Identification Number: ____

Major Medical or Auto Insurance:

Date of Accident: _______________
Insurance Company Name: ____
Adjuster: ____
Address/Phone: ____
Claim #: _________________ Policy #: ___________________ Effective Date: ____________

Primary Care Physician:
Name & Address:
____
____
Phone #: ____

LEGAL INFORMATION:

Attorney Name & Address:
____
____

Attorney Phone #: ____

*Person to contact in an emergency (Name and Phone #):
____

Patient Name: ____ Date: ____________

GBAI

Greater Buffalo Accident and Injury Chiropractic
1275 Main Street, Suite 110
Buffalo, NY 14209
716-228-3847

MOTOR VEHICLE COLLISION QUESTIONNAIRE
Please answer all questions completely:

1: Your name and address:

____

____

2: Phone Number: ____

3: Please describe the collision in your own words:

____

____

4: Where did the collision occur? City/Town: ____________________ State: ______

5: Date of collision: ____________________ Time: ________________ AM PM

6: Were you the: driver passenger pedestrian

7: If passenger, were you in the front seat right rear seat left rear seat

8: What type of vehicle were you in? ________________________________

9: What type was the other vehicle? ________________________________

10: Did your vehicle strike the other vehicle? yes no

11: Was your car struck by the other vehicle? yes no

12: What direction was your vehicle going? ____________________________

13: What direction was the other vehicle going? __________________________

14: Was the impact from: the front the rear the left side the right side

15: What was the approximate speed at the time of the impact?

16: Your vehicle _________ mph Other vehicle __________ mph

17: What was the weather at the time of the collision? dry wet icy

18: Was your vehicle in: park neutral in gear moving stopped

19: Were your brakes being applied? yes no

20: Was your vehicle shoved: forward backward sideways

21: Were you shoved: forward whipped backward

GBAI
Greater Buffalo Accident and Injury Chiropractic
1275 Main Street, Suite 110
Buffalo, NY 14209
716-228-3847

22: Did your seat have a head restraint (headrest?) yes no

Patient Name: ____ Date: ______________

23: If yes, what was the position low mid-position high

24: Did your head ride over the headrest? yes no

25: Did your hat/glasses end up in the back seat or rear window? yes no

26: Did any other part of your body hit the interior of the vehicle? yes no

27: If yes, please specify: seatbelt restraints steering wheel dashboard
windshield side door side window other ____________________

28: Which part of your body? chest head chin face R L knee
R L shoulder R L hand other ______________________________

29: Were you holding on to the steering wheel? yes no

30: Did you brace your arms against the dash? yes no

31: Did you brace your legs against the floorboard? yes no

32: Was your ankle turned? yes no

33: Did the vehicle go into a spin or roll as a result of the impact? yes no
If yes, explain: ____

34: How much damage was there to the outside of the vehicle? none some a lot

35: How much damage was there to the inside of the vehicle? none some a lot

36: At the point of impact, where did you experience pain? Be specific:

____

37: Immediately after the accident were you: conscious dazed unconscious

38: If you lost consciousness, how long? __________________________________

39: Were you wearing a seat belt? yes no

40: Did the belt have a shoulder harness? yes no
If yes, did it contribute to the pain you are experiencing? yes no

41: At the time of impact were you: looking straight ahead looking to the right
looking to the left looking down looking up

42: Did the seat break as a result of the impact? yes no

GBAI

Greater Buffalo Accident and Injury Chiropractic
1275 Main Street, Suite 110
Buffalo, NY 14209
716-228-3847

43: Were you braced for the impact? yes no

44: Were you surprised by the impact? yes no

45: Did you go to the hospital? yes no

46: If yes, when? right after the accident next day other ________________

47: If yes, how did you get there? ambulance other: ________________________

Patient Name: ____ Date: ________________

48: If by ambulance, did the ambulance attendants place you in a: neck brace

back brace other ____

49: Any medication or medical supplies given? __________________________________

50: Did you have x-rays taken at the hospital? yes no

51: If you went to the hospital, please answer the following:

Name of hospital ____

Treatment Received ____

52: Have you had any similar problems before? yes no

If yes, explain: ____

53: Are you diabetic? yes no

54: Do you have high blood pressure? yes no

55: Do you have low blood pressure? yes no

56: Do you have arthritis or degenerative joint disease? yes no

57: What type of work do you do? ____

58: What are your job requirements? ____

59: Have you lost any days of work from this injury? yes no

If yes, give dates: ____

Patient Name: ____ Date: ________________

_____ Doctor Reviewed with Patient

Doctor Signature: ______________________________________ Date:___________

GBAI

Greater Buffalo Accident and Injury Chiropractic

1275 Main Street
Suite 110
Buffalo, NY 14209
(P) 716-200-0651
(F) 716-939-3867

Informed Consent for Examination and Treatment

I (we) herby consent to the performance of examination and treatment on me or on _____________________, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists that may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period __________________________.

____
Patient's Name (Print)

_______________________________________ _____________________
Patient's Signature **Date**

____
State relationship to patient if signing for patient

GBAI

Greater Buffalo Accident and Injury Chiropractic

1275 Main Street
Suite 110
Buffalo, NY 14209
(P) 716-200-0651
(F) 716-939-3867

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs. We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name. We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree with your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:

You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions. You have the right to inspect and obtain copies of your medical information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager. You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised policy as stated in this notice.

Signature of Patient or Legal Guardian: ______________________________ Date: ________

Print Name of Patient or Legal Guardian: ______________________________ Date: ________

GBAI

Greater Buffalo Accident and Injury Chiropractic

1275 Main Street
Suite 110
Buffalo, NY 14209
(P) 716-200-0651
(F) 716-939-3867

OFFICE POLICY & PROCEDURE – EFFECTIVE – 03/2018

1. I am aware that my insurance overage may not fully cover all treatment that is recommended.

2. **Copay Policy** - Co-pays are due PRIOR to being seen by our doctors. If your co-pay is not paid at the time of your visit and/or your account has a co-pay balance you will be required to pay your balance in full prior to seeing the doctor(s). Should you maintain a balance, you will be required to reschedule your office visit.

3. **Imaging Study Policy** - The office requires 5 business days' notice to pick up films/reports; this includes CDs of imaging studies and any associated treatment notes and/or reports.

4. **Fax Policy** – be advised that due to circumstances out of our control our office will no longer fax working restrictions or disability notices to insurance carriers, attorneys or other third parties for our patients. They will be provided to you.

5. **Forms Policy** - Insurance forms, disability notices and working restriction forms and/or reports will be available 5 business days after they are received by our office. Please be advised that these items will only be provided to patients under Active Care. Active care is defined as an appointment within the last 5 business days.

6. **Scheduling Policy I** – our office reserves the right to discharge you from care due to non-compliance after 3 missed scheduled appointments.

7. **Scheduling Policy II** – should you arrive at the office without a scheduled appointment our office will promptly reschedule you for the next available time slot.

8. **Scheduling Policy** III - $10.00 No Call No Show Fee Per Appointment Missed **MUST** be paid **PRIOR** to seeing the Dr.

____
(Print) Patient name

____
Patient signature   Date

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

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

Claim Number:

I, ______________________________, ("Assignor") hereby assign to ______________________________, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights 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
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY 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 DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

____
(Print name of Patient)

____
(Signature of Patient)

____

____
(Date of signature)

____
(Address of Patient)

____
(Print name of Provider)

____
(Signature of Provider)

____

____
(Date of signature)

____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

DISCLOSURE OF DOCTOR OWNERSHIP
NOTICE TO PATIENTS

Due to concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, New York State passed a law prohibiting the physician, with certain exceptions, from referring you for clinical laboratory, pharmacy or imaging services to a facility in which the physician or the physician's immediate family members have a financial interest. If any of the exceptions in the law apply, or if the physician is referring you for other than clinical laboratory, pharmacy, or imaging services, the physician can make the referral under one condition. The condition is that the physician disclose this financial interest and tell you about alternative places to obtain these services. This disclosure is intended to help you make a fully informed decision about your health care. *Public health law, §238 a (10).*

For more information about alternative facilities, please ask your physician, or the physician's staff. They will provide you with names and addresses of places best suited to your individual needs that are nearest to your home or place of work. You will not be treated differently by your physician if you choose to obtain health care services at another facility.

***Dr. William Owens* is the owner of and/or has an interest in the following:**
Greater Buffalo Accident & Injury Chiropractic P.C.
Greater Rochester Spine & Injury P.C.
Queen City Physical Therapy and Chiropractic PLLC

By signing this Disclosure of Physician Ownership, you acknowledge (i) that you have read and understand the foregoing notice and (ii) that you understand that if you were provided services by Dr. Owens or his staff, your chiropractor has an interest in the companies listed above.

________________________ Signature of Patient

________________________ Print Name of Patient

Date:__________________