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: _____

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1275 Main Street, Suite 110
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716-228-3847

WORKER'S COMPENSATION QUESTIONNAIRE

Date of Injury: Time: AM/PM

Location (City and state where injury occurred):

Did you go to the hospital? □ Yes □ No Via: □ Ambulance □ Other (Indicate):

Did you suffer any cuts or contusions? □ Yes □ No (Describe)

Are you working at the present time? □ Yes □ No Date last worked:

Have you missed any time from work? □ Yes □ No Dates:

At work you are required to (in hours): Stand: Drive: Walk: Lift: Sit: Type:

Other (Describe):

What where you doing when the injury occurred:

Employers Name:

Employers Address:

Employers Phone Number: Type of Business:

Did you NOTIFY your employer of the injury (Circle) YES NO

What body part did you tell them was injured:

Workers' Compensation Insurance Carrier:

What is your CLAIM NUMBER:

Have you received treatment by any other providers: YES NO

If YES by whom:

Have you had a Workers' Compensation claim BEFORE: YES NO

Patient Name (Print): Date:

Patient Signature:

Doctor Reviewed (Initial) Date:

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1275 Main Street
Suite 110
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(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: _____

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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

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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

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:_____