[ ] Hageman Chiropractic Health Center- Campus Clinic – 320 Porter Ave. Buffalo, NY 14201
[ ] D'Youville Chiropractic Clinic at ECMC – 462 Grider Street Buffalo, NY 14215

Patient Registration Form **Use black ink only** Today's Date: _____/_____/ 20____

Patient Information Patient File # _____

Current Condition Related To: [ ] Illness/Injury [ ] A Gradual Onset [ ] No Obvious Reason
[ ] Auto Accident [ ] Work Injury [ ] Personal / Liability Injury [ ] Other _____

If an Auto Accident, Work or Personal/Liability Injury, Please speak to the staff before completing this form.

Last Name: _____ First Name: _____ Middle Initial: _____

Nickname: _____ DOB: _____Age: _____Gender: M F Other_____ Marital Status: M S D W

Work Status: [ ] Employed [ ] Full Time Student [ ] Part Time Student [ ] Retired [ ] Self Employed [ ] Other

Are you a: [ ] DYC Faculty/Staff [ ] DYC Student [ ] College Student at _____.

Last four digits of your SS#: _____ How many children do you have? _____

Race: [ ] White [ ] Black/African American [ ] American Indian [ ] Asian [ ] Other [ ] Choose not to specify

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Choose not to specify

Multi Racial: [ ] Yes [ ] No [ ] Unknown Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Home email: _____ Work email: _____

Occupation: _____ Current Employer: _____ Work Phone#: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Please check what best describes your regular work description and movement:

[ ] drive or operate a vehicle [ ] mostly move or walk about [ ] mostly sit [ ] mostly stand
[ ] bending [ ] climbing [ ] stress [ ] running
[ ] perform light manual labor [ ] perform heavy manual labor [ ] work with hazardous substances
[ ] heavy lifting (occasional or repetitive) [ ] light repetitive lifting [ ] other _____

Primary Care Physician: _____ Your last visit / exam: _____

Office Phone: _____ Office Address: _____

Other than the condition for which you are presenting to this clinic for treatment, are you currently being treated for any other condition(s)? [ ] Yes [ ] No

If Yes, what condition(s), type of treatment and treated by whom?

Condition: _____

_____

_____

Patient Name: _____ Date: _____

Spouse Name: _____ DOB: _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

How did you learn about our clinic? [ ] Website [ ] Referral [ ] Other_____

Have you had prior Chiropractic Treatment? _____ If yes, date of last appointment? _____

CURRENT CONDITION

Started on _____ Time _____ [ ] Am [ ] PM
Reinjured on _____ Time _____ [ ] AM [ ] PM

Please explain the purpose of this appointment. Describe your symptom(s) and/or condition(s) and how they began?

_____

_____

_____

Other doctor(s) or hospital(s) consulted for this condition: [ ] Yes [ ] No If yes, who did you see? When? What treatment?

_____

_____

Diagnostic Testing Performed for this condition:

[ ] X-rays Body area: _____ Date _____ Facility _____

[ ] MRI Body area: _____ Date _____ Facility _____

[ ] CT Body area: _____ Date _____ Facility _____

[ ] Other Body area: _____ Date _____ Facility _____

_____

How do you plan to pay for care? [ ] Personal Health Insurance [ ] No Insurance, Private Pay

Person responsible for payment?

[ ] Self [ ] Spouse _____ [ ] Parent _____ [ ] Other _____

Insurance Information*: (Please present your insurance card(s) to the front desk)*

Primary Insurance	***Secondary Insurance***
Carrier: _____	Carrier: _____
ID#: _____	ID#: _____
Group#: _____	Group#: _____
Insured: _____	Insured: _____
Date of Birth: _____	Date of Birth: _____
Circle one that applies: **Self Spouse Parent Other**	**Self Spouse Parent Other**

Patient Name: _____ **Date:** _____

Authorization and Assignment of Benefits

I certify that I'm the patient or parent/legal guardian and I have read, completed and certify the information on this patient registration form to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to DYC Chiropractic Health Centers.

I hereby authorize the DYC Chiropractic Health Centers to release all information necessary to any insurance company, attorney or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of this signed statement of authorization with my signature for required insurance submissions. I authorize my insurance carrier to make direct payment to DYC Chiropractic Health Centers for the amount of any and all processed claims for my treatment.

I also understand that if I am responsible for payment for all services provided, unless I have insurance coverage then I am responsible for payment of any deductible, co-insurance, copay, and/or non-covered services, whichever applies to my insurance benefits. I understand that my payment is due on the day of the visit. If I have insurance coverage, after all services are billed and processed and there is a balance due, I am responsible for payment of this balance due upon receipt of a statement from DYC Chiropractic Health Centers. If needed, payment arrangements may be established.

Records Release

To the DYC Chiropractic Health Centers, I hereby authorize you to release to all insurance carrier(s) and/or attorney(s) information from this day forward, including the diagnosis and medical records of treatment or examination(s) rendered.

Consent for Professional Services by DYC Chiropractic Interns

I understand that the clinic I am attending is a teaching clinic. I agree to allow chiropractic interns to participate and to perform the examination, periodic re-examination, treatment and other diagnostic procedures that I may undergo. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I may agree, at my choosing, to allow the observation of my visits that I may undergo by students in the D'Youville Doctor of Chiropractic Program or other D'Youville College health processions programs.

In order to establish a treatment plan, Chiropractic Clinicians and/or Interns must perform an examination and may request other clinical services to determine the exact cause of your complaint(s). I hereby authorize Chiropractic Clinicians and/or Interns to administer a physical examination, radiographic studies, laboratory procedures or any other clinical service deemed necessary to reach a clinical decision/diagnosis needed to develop an appropriate treatment plan. I also understand that Chiropractic Clinicians and/or Interns may perform some procedures or maneuvers that are intended to reproduce my symptoms and could cause a temporary aggravation of my symptoms.

_____ Date: _____
Signature of Patient or Parent/Legal Guardian

_____ Relationship: _____
Printed Name of Parent/Legal Guardian

_____ Date: _____
Witness-Printed Staff Name and Signature

Patient Name: _____ Date: _____

Notice of Privacy Practices- Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Privacy Notice explains how DYC Chiropractic Health Centers may use and disclose health information about you. If you have any questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officers is located in the clinic's Notice of Privacy Practices. I was offered a copy of the notice, a copy is located in the waiting area of each clinic and is also available on the DYC Chiropractic Health Center's website.

I acknowledge that I have read and understand the Notice of Privacy Practices for the clinics of DYC Chiropractic Health Centers, which went into effect April 14, 2003, with the latest revision September 23, 2013.

I, _____, hereby consent and state my preference to have all staff at DYC Chiropractic Health Centers communicate with me by voicemail and / or email. In addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that voicemail and email are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that voicemail and email messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave messages for <u>both appointment reminders</u> and <u>my private health information</u> at the following (please fill-in the ones you agree to):

Home phone # _____ Cell phone # _____

Home email _____ Work email _____

I give my permission to contact me, relative to <u>appointment reminders only</u>, by the following methods:

Phone messages at the following number _____

Email messages at the following email address _____

Appointment reminders and private health information will be communicated to me only in the manner in which I have agreed to and have given specific written authorization to. I have the option to opt out of any of methods at any time by notifying the health centers.

Patient or Parent/Legal Guardian Signature _____ Date_____

Printed Name of Parent / Legal Guardian _____Relationship_____

<u>DYC Office Staff Use Only</u>:

Patient was unable to acknowledge receipt of the Notice of Privacy Practices for DYC Chiropractic Health Centers:

[ ] Individual unwilling to sign [ ] Communications barrier prohibited prevented the clinic from obtaining acknowledgement

[ ] An emergency prevented the clinic from obtaining acknowledgment [ ] Other_____

DYC Staff Printed name and Signature _____Date_____