New York City CHIROPRACTIC™
www.NewYorkCityChiropractic.com

JAMIE BASSEL DC PC
425 Madison Avenue, 11th Floor
New York, NY 10017
Tel. (212) 227-7310 Fax (917) 591-4477

PATIENT INFORMATION

NAME ____ DATE OF BIRTH___/___/___ SEX: [M] [F]

HOME ADDRESS__________________________________CITY_______________STATE:_____ZIP:________

EMAIL ADDRESS_______________________________________SOCIAL SECURITY #______-____-________

WORK #______-______-________ CELL#______-______-________ HOME#_______-_______-________

WEREYOUREFERRED BY ANYONE ____

EMPLOYER INFORMATION

OCCUPATION____

NAME_____________________STREET__________________CITY______________STATE____ZIP______

(PLEASE CIRCLE) **MINOR / SINGLE / MARRIED / DIVORCED / SEPARATED / WIDOWED**

SPOUSES NAME____________________________________ CHILDREN [Y] [N] IF SO HOW MANY_____

INSURANCE INFORMATION

COMPANY________________ADDRESS______________CITY______________STATE________ZIP_____

MEMBER ID#________________________________GROUP#____

INSURED'S NAME IF NOT YOUR OWN____________________________RELATION_______________________________

DATE OF BIRTH_____/_____/_____ INSURED'S EMPLOYER_____________________________________

REASON FOR VISIT____

IS IT A RESULT OF (PLEASE CIRCLE) **WORK / SPORTS / AUTO / TRAUMA / CHRONIC**

PLEASE EXPLAIN WHAT HAPPENED____

____

____

EXPLAIN THE PAIN AND THE LOCATION____

____

____

WHEN DID THE CONDITION BEGIN___/___/___

IS IT GETTING WORSE (PLEASE CIRCLE ONE) **Y / N / CONSTANT / COMES AND GOES**

HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN FOR THIS CONDITION [Y] [N]

IF SO, WHERE____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR BEFORE [Y] [N]
IF SO, BY WHOM____
TELEPHONE #______-_______-_______________

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EMERGENCY CONTACT INFORMATION

NAME _____________________________ RELATION__________________ PHONE # ______-_____-_______
PRIMARY CARE PHYSICIAN__________________________________ PHONE # ______-_______-_________

Please circle yes or no, add/circle additional information as needed

Nerve Pills	Y	N	Anemia	Y	N
Pain Killers (including aspirin)	Y	N	Psychiatric Problems	Y	N
Muscle Relaxers	Y	N	Severe / Frequent Headaches	Y	N
Insulin	Y	N	Ulcers / Colitis	Y	N
Stimulants	Y	N	Heart Murmur	Y	N
Blood Thinners	Y	N	Sinus Problems	Y	N
Tranquilizers	Y	N	Diabetes	Y	N
Supplements or Vitamins	Y	N	Tuberculosis	Y	N
Birth Control	Y	N	Chemotherapy	Y	N
Are you pregnant	Y	N	Artificial Bones / Joints	Y	N
Nursing	Y	N	Heart Surgery / Pacemaker	Y	N
Do you smoke? How much____Years____	Y	N	Congenital Heart Defect	Y	N
Are you on a special diet Since:___/___/____	Y	N	Artificial Valves	Y	N
What is the age of your mattress? ______			Venereal Disease	Y	N
Is your mattress comfortable	Y	N	HIV+ / AIDS	Y	N
Are you wearing Heel Lifts	Y	N	Cancer	Y	N
Are you wearing Sole Lifts	Y	N	Emphysema / Glaucoma	Y	N
Are you wearing Inner Soles	Y	N	High / Low Blood Pressure	Y	N
Are you wearing Arch Supports	Y	N	Rheumatic Fever	Y	N
Heart Attack / Stroke	Y	N	Kidney Problems	Y	N
Mitral Valve Prolapse	Y	N	Fainting / Seizures / Epilepsy	Y	N
Alcohol / Drug Abuse	Y	N	Asthma	Y	N
Hepatitis	Y	N	Difficulty Breathing	Y	N
Shingles	Y	N	Lower Back Problems	Y	N
Frequent Neck Pain	Y	N	Arthritis	Y	N

PLEASE LIST ANY OTHER MEDICAL CONDITIONS

____

IS THERE ANYTHING YOU ARE ALLERGIC TO

____

PLEASE LIST PREVIOUS SURGERIES WITH DATES

____

PLEASE LIST PAST ACCIDENTS WITH DATES

____

PLEASE LIST YOUR FAMILY HEALTH HISTORY

____

____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

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CONSULT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-Rays by Dr. Jamie H. Bassel.

I have had the opportunity to discuss with the doctor or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that in the practice of medicine as well as in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgment in my best interest during the course of procedures.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about this consent and by signing below I agree to the chiropractic care provided to me by Dr. Jamie H. Bassel. I intend for this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name____

Signature:____

Date_______/_______/_______

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HIPPA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION: We are required by law to maintain the privacy of "Protected Health Information." "Protected Health Information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care that you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosure we will make of your protected health information.

We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time. We will provide you with any Revised Notice for Privacy Practices at the time of your next appointment.

PERMITTED USES AND DISCLOSURES: As provided by law, we can use or disclose your protected health information for purposes of treatment, payment and health care operations. If you refuse to consent, we do not have to provide you with non-emergency care.

Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals or health care from one health care provider to another. For example, your protected health information may be provided to a physician who referred you to our practice to ensure that the physician has all of your medically necessary information.

Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we many need to provide to your insurance company information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the insurance company for the services rendered to you, we can provide the insurance company with information regarding your care if necessary to obtain payment.

Health care operations means the support functions of our practice related to ***treatment*** and ***payment***, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff when caring for you. We may also combine medical information about patients to decide what other medical services are not needed, and whether certain new treatments are effective.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

When we determine, in our professional judgment, that it is in your best interest, we may disclose your protected health information to your family or friends when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment.

We will share your protected health information with third party "business associates" that perform various activities (e.g. Answering service) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by law: We may use or disclose your protected health information to the extent that law requires the use of disclosure. The use of disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information to the extent that law requires the use of disclosure. The use of disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Communicable Disease: We may disclose protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system government benefit programs, other government regulatory programs and civil right laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, products defects or problems, biologic product deviations, track products to enable product recalls, make repairs or replacements, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain condition in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met. These law enforcement purposes include: 1) legal processes and otherwise required by law, 2) limited information requests for identification and location purposes, 3) pertaining to victims of a crime, 4) suspicion that death has occurred as a result of a criminal conduct, 5) in the event that a crime occurs on the premises of the practice and 6) medical emergency (noton Practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we my use or disclose protected health information of individuals who are Armed Forces personnel: 1) for activities deemed necessary by the appropriate military command authorities, 2) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, 3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of the protective services to the President or others legally authorized.

Except for the general uses and disclosures described above, we will not use or disclose your protected health information for any other purpose unless you provide a written authorization. You have the right to revoke that authorization in reliance on your authorization.

YOUR RIGHTS:

1. You have the right to request restriction on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.
3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you.
4. You have the right to request and receive a paper copy of this notice from us.

COMPLAINTS:
If you believe that your privacy rights have been violated, you should immediately contact the office manager at our Practice. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

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ACKNOWLEDGEMENT AND CONSENT FOR TREATMENT

I, ________________________________, have been given an opportunity to read New York City Chiropractic's and Jamie H. Bassel DC PC HIPPA privacy notice. I have also been offered opportunity to ask questions about the office policy.

To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the treating physician at New York City Chiropractic of any changes to my medical status. I also authorize the health care staff to perform the necessary health care services I may need.

Patient Signature: ____
Date:___________________________

FINANCIAL AGREEMENT

I authorize the release of medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to the provider of New York City Chiropractic and Jamie H. Bassel DC PC. I permit a copy of this authorization to be used in place of an original. I accept full responsibility of the full amount due for services provided to me. I understand that all insurance forms that I may have signed may be sent to my insurance company(s) or employer on my behalf. Any payments that are received by me for services rendered by New York City Chiropractic and Jamie H. Bassel will be endorsed and presented immediately along with an explanation of benefits. I understand that any insurance deductible or co-insurance is my responsibility to pay to New York City Chiropractic and Jamie H. Bassel. I also understand that I am responsible to present any information pertinent to the processing of claims.

Patient Signature: ____
Date:___________________________

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PAYMENT FOR SERVICES

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager or doctor. If account is not paid within 90 days of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and other expenses incurred in collecting your account. We accept cash, credit and personal checks.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the provider and or managed care organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Print Name____

Signature:____

Date_______/_______/_______