PATIENT REGISTRATION

Should we thank any individual for referring you to Dr Dana?		Date	
Full Name	DOB	Age	☐ Male ☐ Female
Address		City State	Zip
Home Telephone ☐ Primary Contact	Work Telephone ☐ Primary Contact	Mobile ☐ Primary Contact	
Social Security Number	Email Address		
Emergency Contact Name	Relationship	Emergency Contact Number	

INSURANCE INFORMATION

Primary Insurance Carrier	Group Number	ID Number
Primary Insured	Employer Name	
Business Address		
Employee Social Security Number	Employee Date of Birth	

CREDIT CARD PAYMENT AUTHORIZATION

I _____, hereby authorize Dana Lyn Walters-Adelstein, DC and/or the staff at 2874 Merrick Road, Bellmore, NY 11710 to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify Dana Lyn Walters Chiropractic, PC of any changes regarding this credit card authorization.

Name on Card	Signature/Date	
Credit Card Type ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express	Credit Card Number:	
Expiration Date	Security Code	Billing Zip Code

I attest, to the best of my knowledge, the above information is accurate and true.

Signature: _____ *Date:* _____

AUTHORIZATIONS & ACKNOWLEDGEMENTS

While it is never our intention to bring anything potentially negative into a health and healing relationship, we, along with other health care providers and hospitals, are obliged by the state of New York to ask that you read and sign the following:

TREATMENT AUTHORIZATION: I (print name) _____ authorize Chiropractic Care, including spinal adjustment, of myself or my minor child by the Doctors and staff at Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom.

INFORMED CONSENT: Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

PRIOR CHIROPRACTIC TREATMENT INFORMATION

Name of Chiropractor:_____ Location (city): _____

When was your last treatment?_____ Have you had x-rays taken? _____

MEDICAL DOCTOR: Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom believes your medical doctor is a vital part of your healthcare team. As such, upon your request, we will send evaluations and progress reports to the physician ilsted below.

NAME: _____ SPECIALTY: _____

ADDRESS:_____

CITY: _____

CITY _____STATE:_____ ZIP CODE: _____

TELEPHONE: _____ FAX: _____

REFERRAL AUTHORIZATION: Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier requires an authorization for service, no service will be rendered until the authorization is obtained.

CANCELLATION AND/OR NO-SHOW POLICY: Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom urges you to keep every appointment, as consistent treatment provides optimal benefit. In the event you need to cancel an appointment, we require at least 24 hours notice, excluding Sunday.

ASSIGNMENT OF BENEFITS: I authorize payment of my Medicare and/or Insurance benefits to be made directly to Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom on my behalf for services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom within five (5) days of receipt of such payment.

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL DANA LYN WALTERS CHIROPRACTIC, PC D/B/A CHIROMOM SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom to take action to secure payment of an outstanding balance owed.

FURTHER NOTICES AS TO POLICIES REGARDING MEDICARE: Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom is a participating provider of Medicare, as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider's office you are responsible to pay your deductible to Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom. After your deductible is satisfied Medicare will reimburse us 80% of their standard fee for Chiropractic Adjustments Only. Therefore your payment responsibility is 20% of the standard Medicare fee for Chiropractic Adjustments, along with any additional products or services you have consented to and received.

I understand that, in certain circumstances, Medicare may find that chiropractic treatments are not "reasonable and/or medically necessary" for the illness, injury or condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my doctor and their standards for that diagnosis. I understand, in this case, I will be responsible for any and all charged incurred.

NO GUARANTEES: I recognize that the practice of chiropractic is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any treatment and/or therapy rendered at Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my doctor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including my Individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the chiropractic treatments offered or recommended to me by my Doctor. I intend this consent to apply to all my present and future Chiropractic care.

Patient's Signature	Date
Witness	Date

Acknowledgment of Receipt

NOTICE OF PRIVACY PRACTICES

By signing and dating this form, I acknowledge that I have received a copy of Dana Lyn Walters, Chiropractic, PC d/b/a/ ChiroMom Notice of Privacy Practices.

Patient's Name *(Please print)*	Last four digits of your Social Security #
Patient's Signature	Date

If executed by a patient's personal representative, please complete the information in the space below:

Personal Representative's Name *(Please print)*	Relationship
Personal Representative's Signature	Date

If executed by a patient's legal guardian, please complete the information in the space below:

Legal Guardian's Name *(Please print)*	Relationship
Legal Guardian's Signature	Date

HIPAA NOTIFICATION
ELECTRONIC MAIL (EMAIL) COMMUNICATIONS

The goal of Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom is to make communication between you and our office as easy for you as possible. As such, you have the right to request that we communicate with you via electronic mail (email). However, prior to consenting to such communication, please take a moment to realize any and all privacy risks associated with this form of communication.

Email communications are two-way communication. However, responses and replies to emails sent to or received by either you or Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom may be hours or days apart. As such, acute conditions should never be addressed using email communications.

Although Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom, will make every effort to maintain privacy, email messages, on any device, have inherent privacy risks, as there is no way to ensure an email is completely tamper-resistant. That being said, you should not use email to discuss anything you wish to remain entirely confidential.

In order to forward and/or process and/or respond to your email, individuals at Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom, other than the intended recipient, may have access to or read your email message. Please remember, email communication is not a means of private communication.

This document, along with any and all email communications, may become part of your Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom, medical record.

PATIENT REQUEST FOR EMAIL COMMUNICATION

Please complete the information below if you wish to communicate Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom, via email, knowing there are inherent privacy risks.

Patient Name: _____ Date of Birth: _____

Email Address: _____

Please initial each line and sign below: ☐ **Patient does not consent to email communication**

_____ The email address contained herein is accurate, and I accept full responsibility for messages sent to or from this address.

_____ I have read, reviewed, and received a copy of this HIPAA Notification: Electronic Mail Communications.

_____ I understand and acknowledge that there are inherent privacy risks when communication is over the Internet.

_____ I agree to hold *Dana Lyn Walters Chiropractic, PC d/b/a ChiroMom* and its agents and representatives harmless from any and all claims and liabilities arising from or related to this Request for Email Communication.

Patient Signature: _____ Date: _____