

**Knight Chiropractic Center**  
**PATIENT REGISTRATION**

Today's Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone #(\_\_\_\_) \_\_\_\_\_ Work Phone #(\_\_\_\_) \_\_\_\_\_

Cell Phone #(\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

**INSURANCE INFORMATION**

To ensure all billing is submitted properly, please provide us with the following information. The front office will also need to make a copy of your insurance card for our records.

Insurance Company \_\_\_\_\_ Phone #(\_\_\_\_) \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Contract # \_\_\_\_\_

Employer of the Insured \_\_\_\_\_ Relation (patient/insured) \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your current condition related to Employment? NO  YES

Is your condition related to an Auto Accident? NO  YES

Other Accidents? NO  YES  Please describe \_\_\_\_\_

When did your present symptoms appear? \_\_\_\_\_

Have you ever had any complaints in the involved area before? NO  YES

If yes, please explain: \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_

Phone #(\_\_\_\_) \_\_\_\_\_ Relationship to patient \_\_\_\_\_

# Knight Chiropractic Center

Chiropractic health care stresses the treatment of the *WHOLE* person, not just your back and neck. To help us understand your health history, we ask that you fill out this questionnaire.

Please check any boxes that apply to you **NOW**...

***Symptoms***

***Symptoms***

<ul style="list-style-type: none"> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Neck Pain</li> <li><input type="checkbox"/> Back Pain</li> <li><input type="checkbox"/> Trouble sleeping</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Tension</li> <li><input type="checkbox"/> Irritability</li> <li><input type="checkbox"/> Chest Pain</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Shoulder/Arm/Neck Pain</li> <li><input type="checkbox"/> Pins &amp; Needles in Arms</li> <li><input type="checkbox"/> Pins &amp; Needle in Legs</li> <li><input type="checkbox"/> Numbness in Fingers</li> <li><input type="checkbox"/> Numbness in Toes</li> <li><input type="checkbox"/> High Blood Pressure</li> <li><input type="checkbox"/> Difficulty urinating</li> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Weakness in the Arms</li> <li><input type="checkbox"/> Weakness in the Legs</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Light Bothers Eyes</li> <li><input type="checkbox"/> Loss of Memory</li> <li><input type="checkbox"/> Ringing in the Ears</li> <li><input type="checkbox"/> Face Flushing</li> <li><input type="checkbox"/> Buzzing in the Ears</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of Balance</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Loss of Smell</li> <li><input type="checkbox"/> Loss of Taste</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Cold Hands</li> <li><input type="checkbox"/> Cold Feet</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Muscle Spasms</li> <li><input type="checkbox"/> Frequent Colds</li> <li><input type="checkbox"/> Upset Stomach</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Cold Sweats</li> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Sinus Problems</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Leg Cramps</li> <li><input type="checkbox"/> Colitis</li> <li><input type="checkbox"/> Gall Bladder</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Shoulder Pain</li> <li><input type="checkbox"/> Knee Pain</li> <li><input type="checkbox"/> Hay Fever</li> <li><input type="checkbox"/> Menstrual Problems</li> <li><input type="checkbox"/> Positive for HIV or AIDS</li> </ul>
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Have you ever had chiropractic care before?    Yes               No  

If so, when and with whom? \_\_\_\_\_

Do you have any Allergies?    Yes               No       If so, to what are you allergic? \_\_\_\_\_

Have you ever broken any bones?    Yes               No       If so, which ones and when? \_\_\_\_\_

Patient's Name: \_\_\_\_\_

# Knight Chiropractic Center

Have you dislocated any Joints? Yes  No

If so, which joints? \_\_\_\_\_

Please list any operations you have had:

1. Year \_\_\_\_\_ Operation \_\_\_\_\_
2. Year \_\_\_\_\_ Operation \_\_\_\_\_
3. Year \_\_\_\_\_ Operation \_\_\_\_\_
4. Year \_\_\_\_\_ Operation \_\_\_\_\_

Have you been treated by a physician for any other health conditions in the last year?

Yes  No  If so, for what condition? \_\_\_\_\_  
\_\_\_\_\_

Have you lost or gained weight in the last year? Yes  No

Are you currently taking any medications? Yes  No

If so, what medication? \_\_\_\_\_  
(Please list dosage) \_\_\_\_\_  
\_\_\_\_\_

Do you take vitamins or herbs? Yes  No

If so, what type and how much? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Where are they located? \_\_\_\_\_ Phone: \_\_\_\_\_

When was your last:

	<u>0-6 Months</u>	<u>6-12 Months</u>	<u>Over 12 Months</u>	<u>Never</u>
Physical Exam:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X-rays:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any of the following habits?

Alcohol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How Much? _____
Coffee/Tea	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How Much? _____
Tobacco	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How Much? _____
Exercise	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How Much? _____

Is there anything else about your health history that you think we should know? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

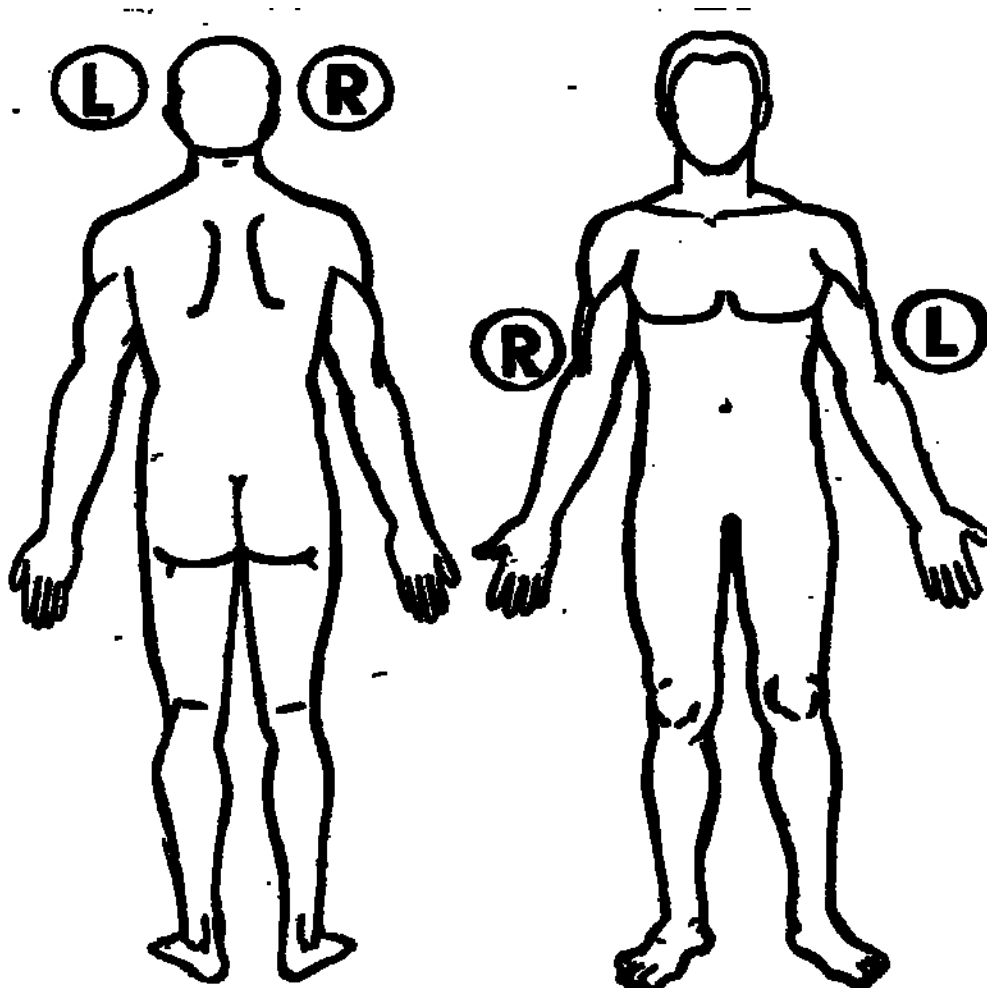
Mark all the areas of your body where you feel pain **NOW**.  
Use the symbols below to describe the type of pain in the area of pain.

ACHE #####  
BURNING xxxxx

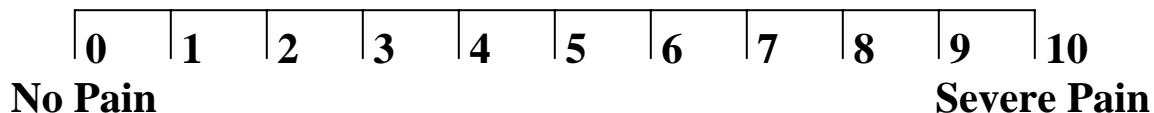
NUMBNESS =====  
STABBING ///

PINS & NEEDLES oooo  
OTHER ^^^^ (please describe)

***Draw At The Location Of Your Pain***



**Rate Your Pain For TODAY**



Knight Chiropractic Center

# FINANCIAL POLICY

**SCHEDULING**

- All appointments during regular hours must be scheduled so as to reduce waiting time for you and others.
- You are free to stop in at any time, but you will have to wait until all scheduled appointments are seen. You will be fit in as soon as possible
- Cancellations require 24 hour notice. **THERE IS A \$20.00 FEE OTHERWISE.**

**PAYMENT**

- Payment is expected in full at the time services are rendered. This includes all co-payments.
- For your convenience we accept Cash, Checks, MasterCard and Visa.
- Payments on your deductible will be made by paying our per visit charge until it is met.
- Should you discontinue care for any reason other than discharge by the doctor, any outstanding balances will become immediately due and payable in full by you.

**INSURANCE**

- Our office will verify your insurance coverage in effort to help you determine exactly what chiropractic coverage is available under your policy.
- It is your responsibility to provide us with all the appropriate insurance forms, addresses, and information so that proper filing can be done.
- We are not obligated to accept your insurance payment on assignment although for your convenience, we may based on our experience with your insurance carrier.
- You are always responsible for the portion of your bill that the insurance may not cover and for your annual deductible.
- Remember that your insurance coverage is a contract between you, your employer and the insurance company. We do not bill any secondary insurance carriers.

**FEES**

- Our fees generally fall between what is considered reasonable and customary for this area.
- Many insurers pay a percentage of the reasonable and customary rate, called the Co-Pay.

**LASTLY**

- You are responsible for all charges incurred as a patient of this office.
- We will do all we can with your insurance claims, but ultimately, you are responsible for payment.
- Past due statements for unpaid balances will be mailed. Statements unpaid for more than 30 days may be subject to an interest charge. In the effort to avoid expensive collection agency fees we hold the right to automatically bill any unpaid and outstanding balances, including interest payments to any credit card account on file in our office.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regards to your health or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I, the undersigned, have read and agree to the guidelines of this financial/insurance policy. I also fully acknowledge that I have insurance coverage with \_\_\_\_\_ Insurance Company and assign directly to [ **Dr. Susan Knight / Dr. Nathan Corbin** ] (please **circle**) 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 whether manual or electronic.

**Patient's  
Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Knight Chiropractic Center

3313 Chili Avenue  
Rochester, NY 14624  
(585) 889-3280

## **PATIENT CONSENT** **FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

(Name) \_\_\_\_\_ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent.<sup>1</sup> The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request.<sup>2</sup> The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.<sup>3</sup>

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice. In accordance with applicable law.<sup>5</sup>

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:  
a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.<sup>6</sup>

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.<sup>7</sup>

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations.<sup>8</sup> However, the Practice is not required to agree to any restrictions that I have requested.<sup>9</sup> However, if the Practice agrees to a requested restriction, then the restriction is binding on the Practice.<sup>10</sup>

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation will not apply to the extent that the Practice has already taken action in reliance on this consent.<sup>11</sup>

I 7. understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.<sup>12</sup>

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.<sup>13</sup>

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
**Name of Individual (Printed)**

\_\_\_\_\_  
**Signature of Individual**

\_\_\_\_\_  
**Signature of Legal Representative  
(e.g., Attorney-in-Fact, Guardian, Parent if a minor):**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Date Signed // Witness:**

- Continuation -  
***PATIENT CONSENT***  
**FOR USE AND/OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION  
TO CARRY OUT TREATMENT, PAYMENT  
AND HEALTHCARE OPERATIONS**

**This is the signature page for the HIPPA Agreement:**

(If you wish to read the whole article please ask our office staff and they will gladly provide you the correct reading material)

- **New York Civil Practice Law and Rule, Article 45, Evidence**
  - **§ 4504. Physician, dentist, podiatrist, chiropractor, and nurse**
  - **Rule 4518. Business records**
  - **Rule 4532-a Admissibility of graphic, numerical, symbolic, or pictorial representation of medical or diagnostic tests in personal injury actions**
  - **§ 4548. Privileged communications; electronic communication thereof**

(C) is required to abide by the terms of this Privacy Notice. <sup>65</sup>

(D) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains. <sup>68</sup>

(E) Will distribute any revised Privacy Notice to you prior to implementation. <sup>67</sup>

(F) Will not retaliate against you for filing a complaint. <sup>68</sup>

**EFFECTIVE DATE**

This notice is in effect today : \_\_\_\_/\_\_\_\_/\_\_\_\_

By signing below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in a language that I understand.

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative  
(e.g., Attorney-in-Fact, Guardian, Parent if a minor):

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date Signed // Witness: