Dr. Raymond A. Semente

CHIROPRACTOR
265 LAKE AVENUE – ST JAMES, NEW YORK 11780
TEL: 631 584-7722
FAX: 631 584-6198

Patient Data **Date:** _____

First Name:_____ **Middle Initial:** ____ **Last Name:**_____

Address Line 1

_____

Address Line 2

_____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Cell Phone (____) _____-_____ **Email** _____

Date of Birth ____/____/_____ **Sex:** Male Female Height: _____

Weight: _____

Social Security Number: _____

Marital Status: Single Married Widowed

Employment Status: Employed Unemployed Retired Disabled

Employer: _____ Employer Phone#: _____

Address: _____

_____

Emergency Contact: _____

Contact Name _____ **Relationship to Patient:** _____

Emergency Contact Phone #:_____

Are you pregnant? Yes No N/A

Primary Care Physician Name and Phone #:_____

_____

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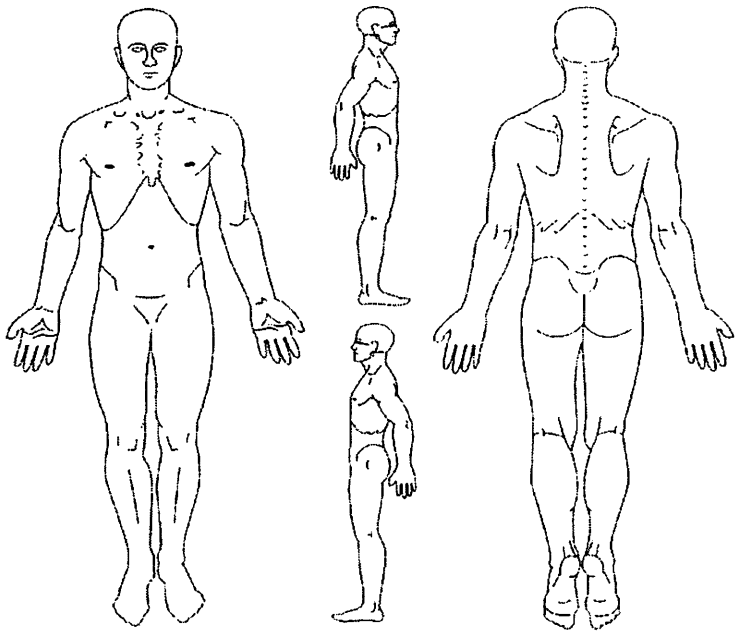
Indicate on the body diagram where you are experiencing pain/discomfort:



Date your symptoms began: _____

Are your symptoms a result of:

Motor Vehicle Accident Work Related Accident Other

How did your symptoms begin/ Accident description?

_____
_____
_____
_____

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Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp

Auto Insurance Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____

Insurance ID #:_____ **OR** Claim #: _____

Policy Holder's Name: _____

Group # _____

Policy Holder's Date of Birth _____ / _____ / _____

Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____

Time: _____am / pm

To the best of my knowledge all the above information is accurate and correct.

I hereby acknowledge and understand I am responsible for my bills for professional services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Dr. Raymond A. Semente will prepare any forms and reports and that he may releases any information concerning my casein preparation to be paid directly. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if for any reason the insurance company refuses to pay any part of my bill that I am directly responsible for payment. I further understand that if I suspend or terminate my care any fees for professional services rendered will immediately become due and payable

Patient Signature_____ Signature Date _____

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Assignment of Benefits and Conditions/Consent for Treatment

CONSENT TO MEDICAL AND SURGICAL PROCEDURE AND PHOTOGRAPHS

The undersigned (hereinafter "patient" which shall also include parents or legal guardians if the patient is a minor or lacks legal capacity and representative of the patient), consents to the procedures and services that may be performed by Dr. Raymond A. Semente. I consent to the taking of pictures of my medical or surgical condition or treatment, and the use of the pictures and medical history and/or medical records for purposes of my diagnosis or treatment or for education or training programs conducted by the above provider. I understand that I have the right to request the cessation of recording or filming. This office will gown female and male patients during initial examination and x-ray procedures. All patients should leave their underclothing on as any examination or x-ray procedure will not be compromised. All patients will be shielded. On subsequent office visits, all pants, shoes, socks, or shorts should be left on. Gowns on all patients open to the back and all undergarments do not need to be removed. This notice is provided to inform you of your evaluation procedures prior to examination. Some patients may not wish to be gowned upon subsequent examinations. Please notify our office if this applies to you.

PERSONAL BELONGINGS

It is understood and agreed that the provider shall not be liable for the loss or damage to any money, jewelry, documents, furs, or other articles of any value.

PATIENT PERSONAL HEALTH INFORMATION

The patient agrees and provides consent to the provider to discuss and disclose his/her personal health and medical information (PHI) with any of its staff, its representatives and third parties for purposes of the treatment, payment of services, or operations.

AUTHORIZATION TO FILE CLAIMS AND APPEALS

The patient agrees and proves consent for the provider, its staff, and/or their preferred legal group to do the following on my behalf: (1) file patient medical claims with my health plan; (2) file any necessary appeals of denied or partially paid patient medical claims with my plan or regulatory authorities on my behalf; (3) file any necessary external appeals with regulatory authorities; (4) file litigation if necessary

AUTHORIZATION FOR ASSIGNMENT TO RECEIVE INSURANCE CHECK PAYMENTS

The patient agrees to authorize payment of medical benefits and claims to Dr. Raymond A. Semente D.C, P.C. at 265 Lake Avenue St. James, NY 11780 for services billed to the carrier. The patient authorizes the release of any medical or other information necessary to process claims. I also request payment of government benefits to Dr. Raymond A. Semente D.C, P.C. at 265 Lake Avenue St. James, NY 11780 to accept assignment.

CHARITY CARE POLICY

The patient acknowledges that he/she is aware of the Provider's Charity Care Policy. If a patient believes that they qualifies for a partial or total reduction of patient responsibility, coinsurance, or deductible under such policy, the patient must notify the provider in writing and provide a copy of his/her Federal Income Tax Return for the tax year prior to the year services were rendered.

_____ _____

Signature of Patient Date Acknowledged

Dr. Raymond A. Semente

CHIROPRACTOR
265 LAKE AVENUE – ST JAMES, NEW YORK 11780
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PATIENT ACKNOWLEDGMENT

I _____ (print name), hereby acknowledge that at the beginning of my treatment or services rendered by the provider, I have been furnished with the HIIPA policy and I voluntarily sign this acknowledgment that I consent and agree to this conditions of treatment for services to be rendered by the provider.

I _____ (print name), hereby acknowledge that I am consenting to treatment and all services that the Doctor feels are medically necessary.

CONSENT TO TREAT A MINOR (IF APPLICABLE)

Minor's Name Printed: _____

Parent/Guardian Signature Authorizing Care: _____

_____ _____
Signature of Patient Date Acknowledged

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AGREEMENT FOR TREATMENT FOR ALL WORKERS' COMPENSATION PATIENTS

Please read the following carefully, since the following is your responsibility under workers' compensation

1. As part of signing this document, I have filed an accident report form for the injuries to my spine sustained from my work-related injury of _____, or will do so within the thirty day period from my DOI
2. I understand that if the injury to my spine was not reported and/or if I did not submit the necessary documentation for my spine injury, I am financially responsible for treatment, diagnostics, and/or DME provided by the office
3. I understand that by signing this document I confirm that I have sustained an injury to my neck, midback, and/or low back compensable under the NYS workers' compensation law
4. I understand it is my (the patient's) responsibility to enrure that alli the documents are reported and submitted to my employer and failure to do so will result in my (the patient's) responsibility
5. The insurance carrier can, at any time, decide that are not going to pay your workers' compensation care for any reason. Whether you had a new accident or an exacerbation of an old one. The carrier will file a document called a C8.1, which argues your need for care. Some carriers routinely do this
6. Should this document be filed, you and the office will get a form sent from the NYS Workers' Compensation Board which REQUIRES you to fill out a statement simply stating that your neck and/or back hurt due to your workers' compensation injury and you needed the care that was given to you. It must be signed in 30 days for a judge to review
7. The Workers' Compensation Board may just award your care when they receive your C8.1 response or require a hearing that you must attend
8. If a hearing is scheduled and you do not attend, benefits for treatment rendered to you will not be paid and there is no excuse under the NYS workers' compensation system for not attending your hearing

To avoid balance billing from our office, this signed document indicates that the patient is aware of the responsibilities under workers' compensation and will sign and send any necessary documentation and attend a scheduled hearing relevant to his/her injuries.

_____
Print Name

_____ _____
Sign Name Date

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COMPLIANCE WITH 97110

The below patient was demonstrated and/or given exercises to be performed at a minimum of eight minutes as part of their treatment program at each visit.

Print Name: _____

Sign Name: _____

WORKERS' COMPENSATION INFORMATION

Name: _____

Date of Birth: _____

Date of Accident: _____

WC Insurance Carrier: _____

WCB # (starts with G): _____

Carrier Case #: _____

Established Body Part (circle all that apply): Neck Mid back Low back

Attorney (name and number): _____

_____

Claims Adjuster (name and number): _____

_____

Employer (name, number, and address: _____

_____

_____

Job Description: _____

_____

_____

Work Status (circle one): Working Retired Disabled from injury

Dates of Disability from Injury _____ to _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date**

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date**

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.