Buffalo Chiropractic, Acupuncture & Physical Therapy, PLLC
Telephone: 716.892.8811
Fax: 716.892.3888

Patient Registration Information

Name_____ SS#: _____

Street Address _____

City _____State _____Zip _____

Home Phone ( ) _____ Work Phone ( )_____

Date of Birth _____ Age _____ Gender ❑ Male ❑ Female ❑ Other: _____

Height _____ Weight _____ Primary Care Doctor: _____

Employer/Name of School _____ Occupation _____

Insurance Carrier _____

General Information

1. Is this injury related to? ☐Work Injury ☐ Auto Injury ☐ Other Liability ☐Not Applicable
2. Do you have a Primary Care Physician / Family Doctor? ☐No ☐Yes
   If yes, have you had an appointment with him / her in the last 12 months? ☐No ☐Yes

Please Mark One Box For Each Item	No	Yes Under a year	Yes Over a year	No Answer /Invalid	Please Mark One Box For Each Item	No	Yes Under a year	Yes Over a year	No Answer /Invalid
Smoking	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Bladder / bowel problems	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐	Groin numbness	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Psychological condition	☐	☐	☐	☐
Kidney condition	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Blood clot / DVT	☐	☐	☐	☐	Dizziness / faintness	☐	☐	☐	☐
Metal implants / pacemaker	☐	☐	☐	☐	Ringing in ears	☐	☐	☐	☐
Breathing difficulties / asthma	☐	☐	☐	☐	Allergy to latex (gloves)	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Other allergy	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	Head Injury	☐	☐	☐	☐
Circulation/vascular problems	☐	☐	☐	☐	Obesity	☐	☐	☐	☐
Peripheral neuropathy	☐	☐	☐	☐	Chronic pain/fibro/headaches	☐	☐	☐	☐

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Unexplained weight loss	☐	☐	☐	☐	Fractures	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	Infection	☐	☐	☐	☐
Night sweats / night pain	☐	☐	☐	☐	Fever / nausea	☐	☐	☐	☐
					Are you pregnant?	☐	☐	☐	☐

	No	Yes	If yes, please specify the condition
Infection Disease	☐	☐	
Neurologic Condition (MS/Parkinson's)	☐	☐	
Prior Auto Injury	☐	☐	
Prior Work Injury	☐	☐	
Other Injuries (Sports, Slip & Fall, Etc)	☐	☐	
Unlisted Condition or Illness	☐	☐	

Patient Medication List:

Please list ALL medications (including prescription, over the counter vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis OR provide a list with this intake form.

_____

_____

_____

Patient Surgeries:

_____

_____

Comments/Additional Information:

_____

_____

Patient's or Authorized Person's Signature:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. Additionally, I authorize payment of medical benefits to the undersigned physician or supplier of services described below.

Name _____ Date _____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

_____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

ADVIERTA QUE USTED PUEDE LLEGAR A SER RESPONSABLE POR LOS COSTOS MÉDICOS EN CASO DE ABANDONO DEL PROCESO, O SI SE RECHAZA LA SOLICITUD DE INDEMNIZACIÓN, O SI SE APRUEBA UN ACUERDO EN VIRTUD DE LA LEY DE INDEMNIZACIÓN LABORAL WCL §32

Nº DE CASO WCB (si se conoce)	Nº. DE CASO DE LA ASEGURADORA (si se conoce)	FECHA DE LA LESIÓN	NATURALEZA DE LA LESIÓN O ENFERMEDAD	Nº SEG. SOC. DE PERSONAS LESIONADAS

RECLAMANTE	NOMBRE	DIRECCIÓN	APT. NO.
EMPLEADOR			
COMPAÑÍA DE SEGUROS			

Usted puede llegar a ser responsable por hacer el pago de los costos médicos del tratamiento de su enfermedad o condición al proveedor que se indica a continuación si (1) abandona el proceso de compensación laboral (2) si la institución Workers' Compensation Board (Junta de Compensación Laboral) determina que la enfermedad o condición que requería tratamiento no ocurrió por un accidente de trabajo indemnizable o enfermedad ocupacional o (3) si el acuerdo fue tramitado por usted y aprobado conforme a la Ley de Indemnización de Trabajadores WCL §32 ; en virtud de esta ley, usted renuncia a sus derechos de obtener los beneficios médicos de la compañía aseguradora de indemnizaciones laborales o del empleador auto asegurado para cubrir los tratamientos y servicios realizados después de la fecha en que se aprobó el acuerdo. Si ocurriera cualquiera de los hechos mencionados con anterioridad, el proveedor podrá cobrarle directamente el costo por los servicios recibidos en lugar de hacerlo al empleador o a la compañía aseguradora, y usted será responsable por hacer los pagos correspondientes.

Por medio de la presente reconozco que he leído el párrafo anterior y que entiendo las circunstancias bajo las cuales me hago responsable del pago.

Firma del reclamante _____ Fecha_____

Nombre y dirección del proveedor_____

AL RECLAMANTE

La Regulación 325-1.23 de la institución Workers' Compensation Board (Junta de Compensación Laboral) permite que su doctor o terapeuta le solicite que firme esta notificación A-9. Al firmar esta notificación, usted reconoce la obligación de pagar los honorarios al proveedor por los servicios que recibe en el supuesto caso que la ley no requiera que su empleador o aseguradora de indemnización laboral pague tales honorarios y si tales honorarios no están cubiertos por otro seguro. Es posible que el empleador o aseguradora no deba pagar los honorarios médicos si, por ejemplo, usted no presenta una solicitud de indemnización laboral, o si no notifica su lesión o enfermedad a su empleador, o si no asiste a la audiencia de la institución Workers' Compensation Board si su empleador desafía sus derechos a los beneficios. Aun cuando hubiese realizado todos los trámites necesarios para procesar su solicitud, la institución Workers' Compensation Board puede decidir que usted no tiene derecho a los beneficios. En tal caso, esta notificación le aconseja a su proveedor de servicios de salud que usted reconozca su responsabilidad personal por el pago de sus cuentas.

Artículo 32 de la Ley de Indemnización Laboral (WCL 32)

La notificación A-9 también cubre las instancias en las que un reclamante por un caso de compensación laboral válido existente llega a un acuerdo con su empleador/a o su compañía aseguradora tras resolver su caso según el artículo 32 de la ley WCL. Un acuerdo según el Artículo 32 puede incluir una cláusula que libere al empleador/a o aseguradora de la responsabilidad de pagar en el futuro cuentas médicas asociadas con el caso. Su proveedor de servicios médicos puede solicitar que usted firme esta notificación A-9 para garantizar que reconoce su responsabilidad personal por el pago de sus cuentas si renunció al derecho de recibir beneficios médicos futuros mediante un acuerdo conforme al artículo 32.

Si tiene alguna pregunta, comuníquese con su abogado o representante autorizado para la audiencia, de tener uno. También puede comunicarse con la institución Workers' Compensation Board (Junta de Compensación Laboral) en la oficina de su distrito.

AL PROVEEDOR DE SERVICIOS DE SALUD

Esta notificación tiene el fin de avisar al reclamante de indemnización laboral que puede ser responsable del pago. Si el reclamante no firma este formulario, no libera con este acto al proveedor de su obligación de tratar al reclamante, ni tampoco anula la responsabilidad de pago por parte del reclamante.

Mantenga el original de este formulario en sus propios registros y entregue una copia al reclamante. **No lo presente en la institución Workers Compensation Board** (Junta de Compensación Laboral)**.** Usted recibirá notificaciones de las decisiones en las que se incluirá si la solicitud es indemnizable, la autorización del tratamiento o el pago de cuentas médicas. También se le notificará si el reclamante presenta un acuerdo conforme al Artículo 32 para que lo apruebe la institución Workers' Compensation Board. No cobre al reclamante a menos que y hasta que usted reciba una decisión de la institución Workers Compensation Board que indique: 1) que el reclamante no procesará la solicitud, o 2) que la solicitud fue rechazada, o 3) que el tratamiento no tiene relación causal con las lesiones laborales, o 4) que se aprobó un acuerdo conforme al Artículo 32 liberando a la aseguradora de la responsabilidad por el tratamiento médico.

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1) I, _____, Hereby authorize Buffalo Chiropractic & Acupuncture, PLLC to use, receive and /or disclose the following specific protected health information: Medical information, which relates to my past, present, or future physical or mental health history. E.g., diagnostic testing, specialist reports.

2) I understand that this authorization is valid until ___/___/____ or until I am discharged as a patient.

3) I understand that the purpose or use of the disclosure I am granting is to obtain or release private health Information to/from, other health care facilities and

   _____

4) I expressly acknowledge that this authorization is voluntary.

5) The following is/are the criteria or limitations I make regarding this authorization:

   _____

   _____

6) I understand that the office /practice will receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7) I understand this authorization may be revoked by me as the authorizer, at any time, provided the revocation is in writing. I understand that the revocation of this particular authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

8) I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

9) I understand that I may refuse to sign this form and my health care and payment for my healthcare will not be affected if I do not sign this form.

10) I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

11) This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

12) This authorization is valid as of the date I have signed below.

_____ Date of Birth

_____ Signature of Patient

_____ Signature of Legal Representative (e.g.,Parent)

_____ Relationship to Patient

_____ Date Sign

_____ Witness

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Informed Consent for Examination and Treatment

I (we) herby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, and/or licensed physical therapists that may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor physical therapy treatment is an exact science and that my care may involve judgments to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care I am about to receive.

Buffalo Chiropractic, Acupuncture & Physical Therapy, PLLC may photograph, film, videotape or otherwise make video and/or audio recordings of the patient only for purposes of diagnosing and treating the patient's condition. No photograph or videotape will be used for any other purpose other than treatment without the patient's written consent.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____

Patient's Name (Print)

_____ _____

Signature of Patient or Legal Guardian | Legal Guardian Relationship/Name

_____

Date

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Preferred Method of Contact

I, _____ herby authorize Buffalo Chiropractic & Acupuncture, PLLC (BCA) to contact me by the preferred method listed below.

☐ I agree to receiving phone calls from the above referenced heath care facility.

☐ I agree to having any test results or other medical information left on my voicemail or answering machine.

☐ I agree to receiving text message appointment reminders and agree to text message communication with BCA. No personal health information will be sent via text message.
Mobile Phone Provider & Number: _____
(Required to receive text messages)

☐ I authorize the following person and phone number to be contacted in case of an emergency, or in the event that the number I have provided is no longer in service.
Name: _____ Phone Number: (_____)_____
Relationship: _____

_____
Patient's Name (Print)

_____ _____
Signature of Patient or Legal Guardian Legal Guardian Name & Relationship

_____
Date

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Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
Patient Name or Legal Guardian (print) Date

_____
Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

BUFFALO CHIROPRACTIC, ACUPUNCTURE & PHYSICAL THERAPY, PLLC
HIPAA Omnibus Notice of Privacy Practices - Revised 2013

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to or from whom you have been referred, and other healthcare providers that are involved in your care, insurers, workers' comp adjusters and nurse case managers, etc. to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is approval for DME equipment, prosthetics or orthotics, a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to your health plan to obtain approval for the item or service.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we

are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

HIPAA COMPLIANCE OFFICER:
Lawrence Adymy 716.892.8811

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign below. Please note that by signing this form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.