LI Integrated Chiropractic, Physical Therapy & Acupuncture

James H. Lambert, DC ***Bruce R. Berns, DC***

2805 Veterans Memorial Highway, Suite 8, Ronkonkoma, NY 11779
Phone (631) 738-9539 Fax (631) 738-8500

Personal Information

Name: _____
First *M.I.* *Last*

Address: _____
Street Address

_____
City *State* *Zip*

Cell Phone: _____ **Home Phone:** _____

Date Of Birth: _____/_____/_____ **Gender:** ___**Male** ___**Female**

Marital Status: ___**Single** ___**Married** ___**Widowed** ___**Divorced**

Email Address: _____

Referral Source:

___**Internet**

___**Friend/Relative** (name so we can thank them)_____

___**Other:**_____

No Fault Insurance Information

Insurance Company:_____

Claim#:_____

Date of Accident: _____/_____/_____

Adjuster's Name: _____ Phone:_____

Attorney:_____ Phone:_____

Description of the accident/Injury:

_____

_____

_____

Did you go to the hospital? Y___ N___

Did you have any other treatment? Y___ N___ List_____

Are you currently working? Y___ N___

Have you had past work/car accidents? Y___ N ____ When_____

Were you the driver ____ passenger ____ pedestrian ____ ?

Are you taking any medications? _____

_____

List **ALL** activities you cannot currently perform:_____

_____

Please list **ALL** of the areas that have been injured: _____

_____

_____

_____

REVIEW OF SYSTEMS

Patient Name: _____ Today's Date:_____ /_____/_____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
- **None**
- Chills
- Daytime Drowsiness
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

Eyes/Vision:
- **None**
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching *(around the eyes)*
- Photophobia
- Tearing
- Wears Glasses or Contacts

Ears, Nose and Throat:
- **None**
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection*(s)*
- Ear Pain
- Fainting
- Headaches
- Head Injury *(history of)*
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Rhinorrhea *(runny nose)*
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus *(ringing in the ears)*

Cardiovascular:
- **None**
- Angina *(chest pain or discomfort)*
- Chest Pain
- Claudication *(leg pain or achiness)*
- Heart Murmur
- Heart Problems
- Orthopnea *(difficulty breathing while lying)*
- Palpitations *(irregular or forceful heart beat)*
- Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
- Shortness of Breath
- Swelling of Leg*(s)*
- Ulcers
- Varicose Veins

Gastrointestinal:
- **None**
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice *(yellowing of the skin)*
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber *(quality)*
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

Respiration:
- **None**
- Asthma
- Coughing up blood
- Shortness of Breath
- Sputum Production
- Wheezing

Endocrine:
- **None**
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

Skin:
- **None**
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness, prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

Nervous System:
- **None**
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

Allergy:
- **None**
- Anaphylaxis *(history of)*
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

Hematology/Lymphatic:
- **None**
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion*(s)*
- Bruises easily
- Fatigue
- Lymph Node Swelling

Psychological:
- **None**
- Anhedonia *(inability to experience joy or enjoy life)*
- Anxiety
- Appetite Changes
- Behavioral Change*(s)*
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change*(s)*

Musculoskeletal:
- **None**
- Joint Pain
- Joint Stiffness or Swelling
- Weakness of muscles/joint
- Muscle Pain or Cramps
- Back Pain
- Cold Extremities
- Difficulty Walking

Height _____ Weight _____

L _____ Handed R _____ Handed

Patient Signature: _____

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: _____ _____

Doctor Signature Date

Authorization for Treatment, Release of Information, Assignment of Benefits & Acknowledgement of Receipt of Notice of Privacy, Financial Policy and/or Medicare Financial Responsibility/Disclosure, Release of Information & Consent for Treatment

Release of Information & Consent for Treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment from **LI INTEGRATED CHIROPRACTIC PHYSICAL THERAPY & ACUPUNCTURE, PLLC** permit its employees and all other persons caring for me to treatment ways they judge are beneficial to me. I consent to Chiropractic services and I understand, acknowledge and affirm that Chiropractic services may involve bodily contact, and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment No guarantees have been made to me about the outcome of this care.
.

I give permission to **LI INTEGRATED CHIROPRACTIC PHYSICAL THERAPY & ACUPUNCTURE PLLC** to release Information, verbal and written, contained in my medical record, and other released information, to my insurance company, rehab curse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries, and all other relented person's as it relates to my treatment and/or payment for services provided. I authorize **LI INTEGRATED CHIROPRACTIC PHYSICAL THERAPY & ACUPUNCTURE PLLC** to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment the signature below certifies that I have read and understand the above information,

Initial. _____

Assignment of Benefits

I authorize payment directly to **LI INTEGRATED CHIROPRACTIC PHYSICAL THERAPY & ACUPUNCTURE PLLC** for services and to bill and release payment directly to **LI INTEGRATED CHIROPRACTIC PHYSICAL THERAPY & ACUPUNCTURE PLLC** for any Chiropractic services provided, this is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial. _____

Notice of Privacy Practices (HIPAA Acknowledgment/Consent)

I hereby acknowledge that I have been given the opportunity to receive and/or review the office Notice of Privacy Practices. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations,

Initial. _____

I agree to pay **LI INTEGRATED CHIROPRACTIC PHYSICAL THERAPY & ACUPUNCTURE PLLC**. for the services provided to me or the party named above, if any law, such as Workers' Compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of Information necessary to allow for speedy collection from my third-party payer, Where the law or an Insurance contract does not prohibit payment by me, I acknowledge responsibility for all account balances. The Intake Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it Is not a guarantee of coverage. If the Information provided by my Insurance company is not accurate or the insurance company changes its coverage, I will be responsibility for payment of services, I understand that my good faith payment may not be inclusive of all payments for which I am responsible, and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of **LI INTEGRATED CHIROPRACTIC PHYSICAL THERAPY & ACUPUNCTURE PLLC.**

Initial. _____

Financial Policy and/or Medicare Financial Responsibility Disclosure (Acknowledgement)

I hereby acknowledge that I have received a copy of the Financial Policy and/or Medicare Financial Responsibility.

Initial. _____

PATIENT OR GUARDIAN SIGNATURE:_____ DATE:_____

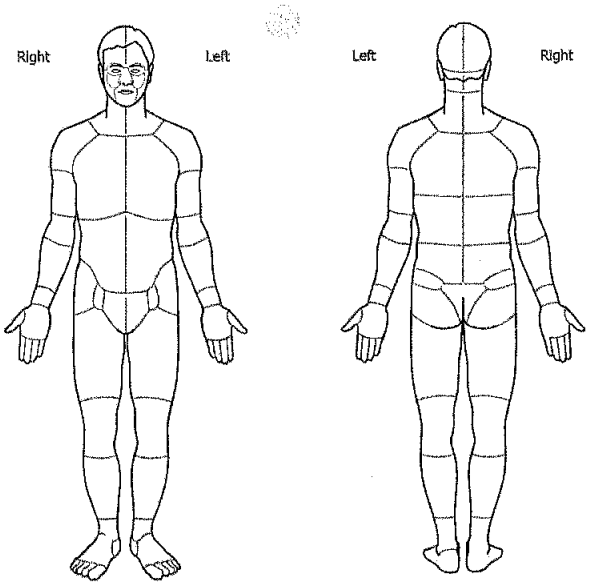
Long Island Integrated Medical
2805 Veterans Memorial Highway, Suite #8
Ronkonkoma, NY 11779
p 631.738.8300
f 631.738.8500
masterintegratedhealth.medicfusion.com

Patient: _____

Patient Symptom Illustrator

Patient Symptom Illustrator

Front **Back**



Instructions:

Identify your areas of discomfort by marking the affected body parts in the illustration.

Indicate the area name along with your specific symptoms associated with each selected area.

Rate your discomfort associated with each selected area.

		Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	0 = No Discomfort 10 = Severe Discomfort
Ex.	L (R) Lower Back			X			X			X	X
1.	L R										
2.	L R										
3.	L R										
4.	L R										

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS-FORM

(FOR ACCIDENTS OCCURRING AFTER 3/1/02)

I, _____ ("Assignor") hereby assign to **LI Integrated Chiropractic Physical Therapy & Acupuncture, PLLC** ("Assignee") all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _____**,** not withstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to actions or conduct of the assignor.

LI Integrated Chiropractic Physical Therapy & Acupuncture, PLLC is utilized to dynamically assess musculoskeletal structures by capturing articular motion through stress views of the spine. This diagnostic tool enables motion analysis to quantify spinal abnormalities and above all **LI Integrated Chiropractic Physical Therapy & Acupuncture, PLLC**. I hereby give my consent to have my treating doctor refer my x-ray films for this stress study.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERICAL INSURANCE OR STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWING MAKES OR KNOWING ASSISTS, ABETS SOLICITES OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THEDEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____ _____

(Patient's Name) (Signature of Patient) (Date)

_____

(Patient's Address)

_____

LI Integrated Chiropractic Physical Therapy & Acupuncture, PLLC
(Name of Provider)
2805 Veterans Highway #8
Ronkonkoma NY 11779

_____ _____

(Signature of Provider) (Date)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS-FORM
(FOR ACCIDENTS OCCURRING AFTER 3/1/02)

I, _____ ("Assignor") hereby assign to **Ligament Laxity Analysis** ("Assignee") all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _____**,** not withstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to actions or conduct of the assignor.

Ligament Laxity Analysis is utilized to dynamically assess musculoskeletal structures by capturing articular motion through stress views of the spine. This diagnostic tool enables motion analysis to quantify spinal abnormalities and above all Ligament Laxity. I hereby give my consent to have my treating doctor refer my x-ray films for this stress study.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERICAL INSURANCE OR STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWING MAKES OR KNOWING ASSISTS, ABETS SOLICITES OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THEDEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____ _____ _____
(Patient's Name) (Signature of Patient) (Date)

_____

_____
(Patient's Address)

Ligament Laxity Analysis
(Name of Provider)

_____ _____
(Signature of Provider) (Date)

2805 Veterans Highway #8
Ronkonkoma NY 11779