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:**_____

Major Medical Insurance Information

Insurance Company:_____

ID#:_____

Name of Insured:_____

Insureds date of birth:_____

Description of your Injury/Pain that brings you in today:

_____

_____

_____

List ALL medication you are currently taking: _____

_____

_____

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)*
- TMJ Disorder

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.
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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:_____

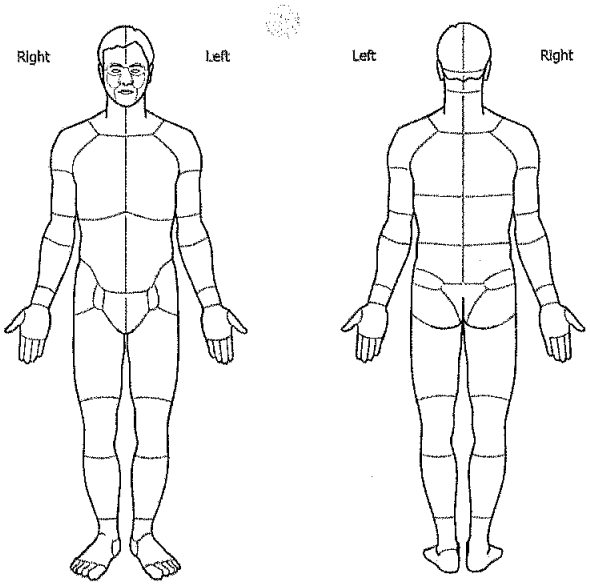
Long Island Integrated Medical
2805 Veterans Memorial Highway, Suite #8
Ronkonkoma, NY 11779
p 631.738.8300
f 631.738.8500
masterintegratedhealth.medicfusion.com

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										

I certify that I am the patient or legal guardian listed above. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

The Emergency Medical Services and surprise Bills law requires physicians, ambulatory practices and hospitals to notify patients about the health plans in which they participate and share the names and contact information for all of the providers who will be involved in the patients' scheduled care, including those who are out-of-network. Out-of-network providers must provide patients with a cost estimate upon request, prior to delivering non-emergency care. In emergencies, regardless of whether the provider participates in the patient's health plan, patients will be required to pay only the amount due as if the services were in-network. This medical office may be a non-participating (out of network) provider with your insurance. Providers include Bruce Berns, D.C., Lawrence Howard, LAc.,, Ashley Trinidad, LMT, Daniele Schwarz LMT, Linda Chavez LMT, Community Medical Wellness, Robert Antoniou MD, Aman Deep MD each of whom can be reached at 631-738-8300.

I hereby acknowledge and have read the above disclosure.

Patient's Signature_____ Date:_____