Dr. Beth Cohen, Chiropractor

740 Veterans Hwy, Ste 210 • Hauppauge, NY 11788 • *Phone* (631)360-7999 • *Fax* (631)366-4473

Thanks for choosing Advanced Medical Associates, P.C.! To better serve you, please complete sections 1, and section 3 4, or 5 as the front desk person indicates depending on your particular case. Thank you, and welcome!

Section 1 INITIAL EVALUATION • PATIENT INFORMATION

Patient Name:_____ DOB_____ Age _____
Sex ( )M ( )F SS#_____-_____-_____ Marital Status _____
Address_____ City_____ State____ Zip_____
Home Phone _____ Cell _____
In Case of Emergency Please Contact _____
Phone # _____ Relationship _____
Employer Name_____ Occupation _____ Phone _____
Employer Address _____ City _____ State _____ Zip _____
Referring Doctor _____ Phone _____ Fax _____

Section 2 MEDICAL HISTORY • CHIEF COMPLAINTS

Have you ever had any of the following? (Please circle all that applies and fill in the blanks)

Allergies: _____ Prev. Surgeries: _____
Medication: _____
Agencies: Home Health Agency Ben._____ Home Services _____ Services through Home _____
Blood Disease: N/A Aids/HIV Blood clotting Hemophilia Hepatitis A B C _____
Cancer: N/A Specify _____ Surgery (Type) _____ Chemo/Radiation_____
Diet: N/A Are you Diabetic ( )yes ( )no Insulin( )yes ( )no Pills_____ Diet_____
Heart: N/A Angina Artificial Heart Valves Arrhythmias Heart Attacks (when)_____
Vascular Disease: N/A Hypertension / Hypotension (Last BP)____/____ Thromophlebitis_____
Lungs: N/A Asthma Emphysema Shortness of Breath Nervous: N/A Epileptic Seizure Stroke (TIA) When
Kidneys: Have you ever had kidneys problems? ( )yes ( )no Others: _____

SUBJECTIVE:

Pain level (0=no pain, 10=worse pain), Area, and Nature of symptoms: _____

What makes it better:_____
What makes it worse:_____
Cause of conditions _____
Patients' Goals:_____
Chief Complaints & Functional Limitations:_____

Pass Treatment for this condition: None Yes _____

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ASSIGNMENT OF BENEFITS

I authorize direct payment to Beth J. Cohen, DC (hereafter refer as Provider) of any sum I now or hereafter owe to Provider by any insurance company that is obligated to reimburse me for the charges for Provider's services. In the event of any insurance company obligated by contractual agreement to make payment to me or the Provider refuses to make such payments upon demand by Provider, I hereby assign and transfer to Provider the cause of action that exists in my favor against any such company and authorize Provider to prosecute said action either in my name or Provider's name as they see fit and further authorize Provider to compromise, settle or otherwise resolve said claim as they see fit.

I understand that I am ultimately responsible financially for any charges incurred at this office, including co-pays, deductibles, and charges denied or not covered by my insurance company. This office will notify me if a service is not covered by my insurance company

HIPPA PRIVACY CONFIDENTIALITY AGREEMENT & ACKNOWLEDGEMENT OF RECEIPT FOR Beth J. Cohen DC NOTICE OF PATIENT PRIVACY

I have been advised that this medical practice is committed to properly safe guard and other wise protect health information from unauthorized and /or unintended uses and disclosures as defined by HIPAA.

I understand that when I am physically present in the office, I will not view nor attempt to utilize in any way patient's health information maintained on the premises.

I further understand that any patient health information that is incidentally viewed or overheard by me while I am lawfully within the office facility will remain confidential and will not under any circumstance be used or disclosed by me.

I hereby acknowledge receipt of this Notice of Privacy Practices, and acknowledge the practice will use and disclose my health information for purposes mentioned above. I have been advised of my right to obtain access to and control my Protected Health Information.

This agreement will remain in effect for the duration of my relationship with the Provider.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

I understand that my personal health information is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize the full release of medical records or other personal information necessary to my insurance company, attorney, adjuster, and other medical providers to process claims or maintaining communication between health care professionals. I may revoke this authorization at any time in writing, but this will not affect disclosures already made due to my prior authorization. I also understand that when I authorize the release of medical records from this office, I am authorizing the release of records of all the disciplines, which included: Physical Therapy, Physiatry, Chiropractic, and Acupuncture.

By my signature below, I fully agree to all above terms, and acknowledge that I have been advised of my rights to obtain access to and control my Protected Health Information.

Print Name	Patient Signature	Date