DRS. ABRAMS, PIAZZA & JULEWICZ

THE FIRST CHOICE IN CHIROPRACTIC CARE

PLEASE FILL OUT FORMS COMPLETELY, THANK YOU

Patient Data **Date _____**

First Name _____ Middle Initial ___ Last Name_____

Address_____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email _____

Date of Birth _____/_____/_____ Marital Status: Single Married Divorced Other

Social Security Number: _____-_____-_____ Sex: Male Female

Emergency Contact: Contact Name _____

Relationship to Patient _____Contact Phone (_____) _____-_____

Employer Data_____

Employer_____

Your Occupation _____Your Job Description _____

Address _____

City _____State _____Zip Code _____

***** If unemployed, disabled or retired please notate above. Thank you *****

3077 Hylan Boulevard, Staten Island, New York 10306 Phone: 718.987.2408 Fax: 718.987.9240

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How did you hear about our office?

_____

***Medical Conditions*:** (Circle all that apply to you)

Arthritis Cancer Diabetes Heart Disease
Hypertension Psychiatric Illness Skin Disorder Stroke
Other

_____

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedures	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia

Other _____

Family History: (List any pertinent family history ie. Cancer, Diabetes, High Blood Pressure)

1._____
2._____
3._____

Please list any other doctor you are currently treating with and what for:

1)_____
2)_____
3)_____

Are you pregnant? Yes _____ No _____ N/A _____

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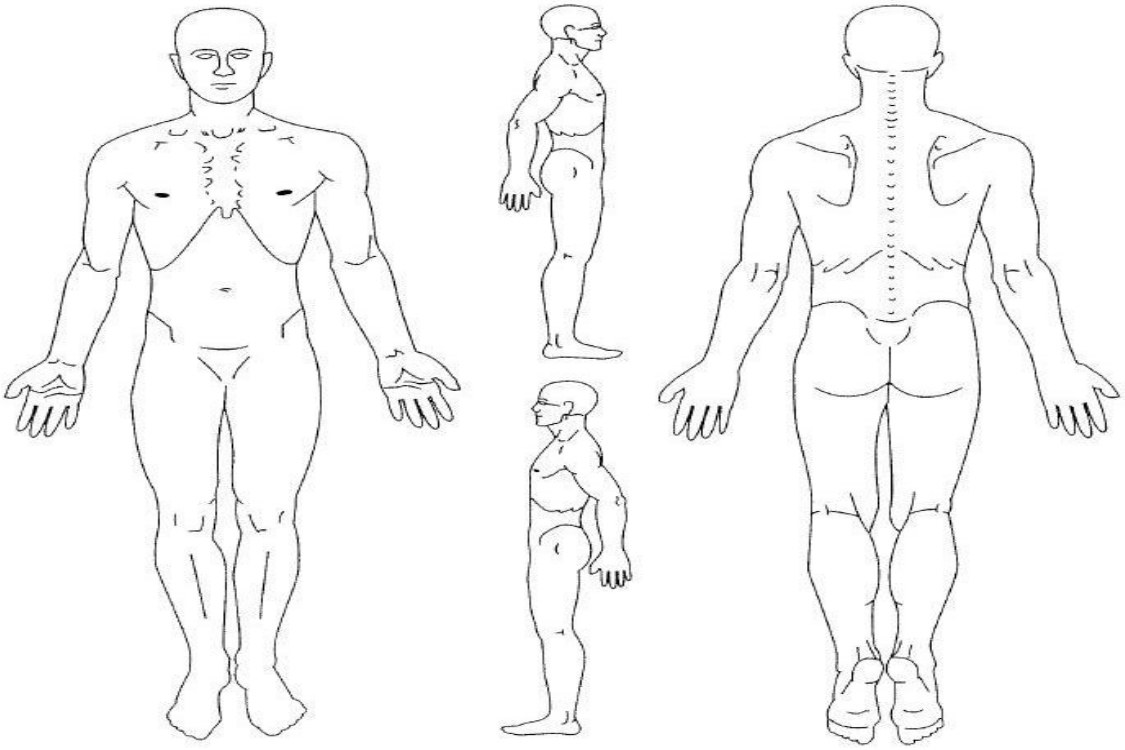
By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity:

_____

_____

When did your symptoms begin? Month_____ Day_____ Year _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident
Other _____ Slip & Fall Accident

How did your symptoms begin?

_____

_____

How often do you experience your symptoms?

Constantly	Frequently	Occasionally	Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

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Assignment of Benefits – Drs. Abrams, Piazza & Julewicz,
DAVID ABRAMS, D.C, JOHN P. PIAZZA, D.C., DENNY JULEWICZ, D.C., ANTHONY VERRILLI, D.C.

Assignment of Insurance Benefits: I, the undersigned patient, or guarantor of the patient, hereby authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Drs. Abrams, Piazza & Julewicz, for all covered medical services and supplies provided to me (or, to the patent if I am the guarantor of the patient) during all courses of treatment and care provided by Drs. Abrams, Piazza & Julewicz, and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by Drs. Abrams, Piazza & Julewicz and will constitute a continuing authorization, maintained on file with Drs. Abrams, Piazza & Julewicz which will authorize and allow for direct payment to Drs. Abrams, Piazza & Julewicz of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Drs. Abrams, Piazza & Julewicz.

Authorization to Submit Insurance Claims: I hereby authorize Drs. Abrams, Piazza & Julewicz to submit claims, on my behalf to my Insurance Company(s), which is/are the insurance company(s) ["my Insurance Company(s)"] listed on the copy of the current insurance card(s) I have provided Drs. Abrams, Piazza & Julewicz which I represent I have provided to Drs. Abrams, Piazza & Julewicz "in good faith" and which I represent provide current medical coverage for the contemplated Medical Services. I fully agree and understand that the submission of a claim does not absolve me (or the patient, if aim the guarantor) of my responsibility to ensure the claim is paid in full.

Limited Attorney-in Fact to Obtain Payment: I hereby irrevocably designate, authorize and appoint Drs. Abrams, Piazza & Julewicz as my true and lawful personal representative and attorney-in-fact for the limited purpose of obtaining payment from my Insurance Company(s) with the regard to the Medical Services; including the power to receive any and all payments from the Medical Services from my Insurance Company(s) or other third parties, submit any and all requests for benefits information to my Insurance Company(s), receive and review any and all applicable plan documents from my Insurance Company(s) and to pursue all remedies as to claims as to the Medical Services with or against my Insurance Company(s), including but not limited to formal complaints, appeals, administrative reviews or litigation to any State or Federal agency, insurance board or insurance company that has jurisdiction over benefits that are or may be available to pay for all or part of the Medical Services. *This is power of attorney shall automatically terminate. Without formation action being taken, as soon as Drs. Abrams, Piazza & Julewicz has received payment in full and all remedies available there to under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.*

ERISA Authorization: For good and valuable consideration I do hereby designate, authorize and convey to Drs. Abrams, Piazza & Julewicz and the above named to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: a) the right and ability to act on my behalf in connection with any claim, right or chose in action that I may have under such insurance policy and/or any employee health care benefit plan; and b) the right and ability to act on my behalf to pursue such claim, right or chose in action with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of Employment Retirement Income Security Act of 1974 as provided in 29 CFR §2560.503-1(b)(4)) with respect to any medical or health care expense incurred as a result of the services I received from the above-named doctor and, to the extent permissible under the law, to claim on my behalf, such medical or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

Direct Payment Authorization: I hereby instruct and direct Insurance Company(s) to pay Drs. Abrams, Piazza & Julewicz and its associates directly. I understand the ERISA that I have the right and authority to direct where payment for services rendered is sent. If my current insurance policies with my Insurance Company(s) prohibit direct payment to the provider of services, I (under my rights per state and federal ERISA regulations) hereby instruct and direct my Insurance Company(s) to provide SPD documentation evidencing the existence of such non-assign ability clause to myself and Drs. Abrams, Piazza & Julewicz and its associates. Upon receipt by Drs. Abrams, Piazza & Julewicz of nonassignability documentation, I instruct that the Insurance Company(s) to make out the check to me (or the patient, if I am the guarantor) and I will mail it directly to Drs. Abrams, Piazza & Julewicz, 3077 Hylan Blvd, Staten Island, NY 10306 for the professional or medical expense benefits and otherwise payable to me (or the patient, if I am the guarantor) under my current insurance policy as payment

towards the total charges for the Medical Services rendered. I agree and understand that any funds I receive from my Insurance Company(s) due me (or due the patient, if I am the guarantor) for services rendered by Drs. Abrams, Piazza & Julewicz will be immediately signed over by me and sent directly to Drs. Abrams, Piazza & Julewicz.

Check Deposit Authority: Whenever, with or without authority, my Insurance Company(s) might send a check directly to me for Medical Services provided by Drs. Abrams, Piazza & Julewicz and its associates. If I deposit such a check into an account other than Drs. Abrams, Piazza, I agree to send Drs. Abrams, Piazza & Julewicz a payment for the equivalent amount. If I receive from an insurance company, Medicare or Medicaid, an Explanation of Benefits (EOB), I agree to send a copy of the EOB, by U.S. Mail or fax directly to: Drs. Abrams, Piazza & Julewicz (718)987-9240. This is a direct assignment of my rights and benefits under my Insurance Policy(s). Upon receipt by Drs. Abrams, Piazza & Julewicz of any and all checks made payable to me or patient, I authorize Drs. Abrams, Piazza & Julewicz and its associates to receive and such check, endorse it for deposit only, and to deposit it and to apply all the proceeds toward payment on my account for Medical Services.

Submission of Insurance Claims Courtesy/Financial Arrangements: Unless Drs. Abrams, Piazza & Julewicz has agreed as a courtesy to submit my claim to my Insurance Company(s) for Medical Services, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Drs. Abrams, Piazza & Julewicz for payment. If my account with Dr. Abrams, Piazza & Julewicz is referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. I understand and agree that if my account is delinquent, I may be charged a service fee.

Confession of Judgment: In addition to Drs. Abrams, Piazza & Julewicz other remedies at law, I, the undersigned authorize any attorney to appear in a court of record and confess judgment, without process, against me, in favor of Drs. Abrams, Piazza & Julewicz and its associates, for any sum unpaid and due thereto, together with collection costs including attorneys' fee at 25% of the principle balance due, which percentage is stipulated and deemed reasonable.

Today's Standards: I authorize Drs. Abrams, Piazza & Julewicz and its associates to provide medical care and or medical supplies to me/patient reasonable by today's standards.

Release of Medical Records to Obtain Coverage: I authorize the release of any medical or other information reasonably necessary to determine benefits available or benefits payable by my Insurance Company(s) or for the purposes of satisfying
charges billed by Drs. Abrams, Piazza & Julewicz and its associates for Medical Services to the Health Care Financing Administration, my Insurance Company(s) or other medical entity. A copy of this assignment will be sent to the Health Care Financing Administration, my Insurance Company(s) or other entity, if requested. I hereby release and forever discharge Drs. Abrams, Piazza & Julewicz and its respective employees, directors, officers, shareholders, agents, assigns and legal representatives (collectively, "Drs. Abrams, Piazza & Julewicz Parties") from any and all obligations, claims, liabilities, damages, debt, liens, and deficiencies arising out of or in connection with Drs. Abrams, Piazza & Julewicz use or disclosure of my health information in accordance with this Financial Responsibility and Assignment of Benefits ("Assignment") A photocopy of this Assignment shall be considered as effective and valid as the original

_____ _____

Signature of Patient/Guarantor Date

_____

Print Name of Patient/ Guarantor

_____

Witness

DRS. ABRAMS, PIAZZA & JULEWICZ

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INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by any of the licensed doctors of chiropractic at Drs. Abrams, Piazza and Julewicz DC, PLLC.

I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this office. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.” It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with like cases.

My doctor has responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to chiropractic treatment.

Print patient’s name	Signature of Patient	Date
Print parent/guardian’s name	Signature of parent/guardian	Date

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