HAPEMAN RODRIGUEZ CHIROPRACTIC
"ADJUSTING YOU TO A BETTER QUALITY OF LIFE"

AUTOMOBILE / NO FAULT QUESTIONAIRE

NAME _____ TODAY'S DATE ____/____/____

ADDRESS _____

PHONE_____ DATE OF BIRTH _____/____/____

GENDER: M / F HEIGHT_____ WEIGHT_____ DATE OF ACCIDENT _____/____/____

INSURANCE INFORMATION

INSURANCE COMPANY _____

CLAIMS ADDRESS _____

POLICY#_____ CLAIM#_____

ADJUSTER'S NAME _____ PHONE#_____

WERE YOU: DRIVER / PASSENGER / PEDESTRIAN **SEATING POSITION**: FRONT / BACK

YOUR VEHICLE _____ **OTHER VEHICLE** _____

WERE YOU WEARING A SEATBELT? YES / NO **DID AIRBAG DEPLOY?** YES /NO

WAS THE VEHICLE HIT FROM: FRONT / REAR / DRIVER'S (LEFT) / PASSENGER (RIGHT)

PLEASE EXPLAIN IN DETAIL HOW THE ACCIDENT / INJURY OCCURRED: _____

_____

_____

AREAS OF INJURY: HEAD / NECK / BACK / LEGS / ARMS/ OTHER _____

ANY LACERATIONS (CUTS): NO / YES – DESCRIBE _____

DID YOU LOSE CONSCIOUSNESS: NO / YES – FOR HOW LONG _____

DID YOU GO TO AN EMERGENCY ROOM: NO / YES – DATE OF VISIT_____/_____/_____

NAME OF HOSPITAL: ARNOT / ST JOSEPH / GUTHRIE SAYRE / GUTHRIE CORNING

WERE YOU TAKEN BY AMBULANCE: YES / NO **XRAYS:** YES / NO

WHAT TYPE OF TREATMENT DID YOU RECEIVE? _____

_____

DUE TO THE ACCIDENT, WHAT ARE YOUR CURRENT SYMPTOMS:

NONE / NAUSEA / VOMITING / DIZZINESS / FAINTING / NERVOUSNESS

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HAVE YOU EVER BEEN IN ANOTHER / SIMILAR ACCIDENT? YES / NO

DO YOU HAVE PAIN? NO / YES – HEAD / NECK / BACK / CHEST / ABDOMEN / RIGHT SHOULDER / LEFT SHOULDER / RIGHT ARM / LEFT ARM / RIGHT HAND / LEFT HAND / RIGHT LEG / LEFT LEG / RIGHT KNEE / LEFT KNEE / RIGHT FOOT / LEFT FOOT

DO YOU HAVE DIFFICULTY: WALKING / BENDING / SLEEPING / BLURRED VISION / DOUBLE VISION

DO YOU HAVE DIFFICULTY MOVING: RIGHT ARM / LEFT ARM / RIGHT LEG / LEFT LEG

ARE YOU RECEIVING ANY OTHER TREATMENT FOR THIS INJURY? NO / YES – IF YES,

PAIN MANAGEMENT – DOCTOR / FACILITY _____

TYPE OF MEDICATION / DOSAGE _____

_____

PHYSICAL THERAPY - THERAPIST / FACILITY _____

STARTING DATE ____/____/____ HOW OFTEN _____

ORTHOPEDIC / NEUROLOGY – DOCTOR / FACILITY _____

WHEN WAS YOUR FIRST VISIT? ____/____/____ LAST VISIT ____/____/____

EMPLOYMENT – MUST BE FILLED OUT

WHEN ACCIDENT / INJURY OCCURRED, DID YOU HAVE A JOB? NO / YES / RETIRED

IF YES, OCCUPATION _____ FULL-TIME / PART-TIME HOURS PER WEEK _____

JOB DUTIES: LIFTING CARRYING_____LBS SITTING _____ HOURS PER WEEK

STANDING _____ HOURS PER WEEK WALKING _____ HOURS PER WEEK

DID YOU MISS TIME FROM WORK? NO / YES, IF SO HOW MUCH _____

HAVE YOU RETURNED TO WORK? NO / YES, WHEN _____

ARE YOU ACTIVELY WORKING NOW? NO / YES **SAME JOB?** NO / YES

NEW JOB? NO / YES **RETURNED WITH LIMITED DUTIES?** NO /YES

_____

SIGNATURE OF INJURED PARTY DATE SIGNED

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my individual identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or heath care provider; the release information may no longer be protected by federal privacy regulations. I understand that my health care will not be affected if I do not sign this form. Persons / organizations receiving the information:

Dr. Donna H Rodriguez, DC
Hapeman Rodriguez Chiropractic
460 E Church Street
Elmira, NY 14901-2832

Phone: (607) 733-3235
Fax: (607) 733-4036

Date: _____/_____/_____

Specific Description of Information Requested:

- ☐ Entire Emergency Record
- ☐ Operative Notes
- ☐ Labs
- ☐ Other
- ☐ Radiological Records

Additional Information _____
_____
_____
_____

☐ X-Ray ☐ CT Scan ☐ MRI ☐ Bone Scan ☐ Ultrasound ☐ Other -	☐ Head / Brain ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacral / Coccyx ☐ Other -
☐ Upper Extremity ☐ Shoulder - Left Right Bilateral ☐ Elbow - Left Right Bilateral ☐ Wrist - Left Right Bilateral ☐ Hand - Left Right Bilateral ☐ Other -	☐ Lower Extremity ☐ Hips - Left Right Bilateral ☐ Knee - Left Right Bilateral ☐ Ankle - Left Right Bilateral ☐ Foot - Left Right Bilateral ☐ Other -

Patient Name: _____

Birthdate: _____

Signature: _____

Hapeman Rodriguez Chiropractic

"Adjusting You to a Better Quality of Life"

HIPPA Privacy Authorization Form

Authorization for use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 & 164)

I hereby understand that as part of my healthcare, this practice originated and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information to applying my diagnosis and surgical information (if necessary) to my bill
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to object to the use of my health information for directory purposes. I also have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

- ☐ Mental Health Records
- ☐ Communicable Diseases (including HIV or AIDS)
- ☐ Alcohol / Drug Abuse Treatment
- ☐ Other (please specify):_____

I fully understand and __accept or __decline the terms of this contract.

Print Name_____ Today's Date _____

Signature _____

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

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assingor") hereby assign to *Hapeman Rodriguez Chiropractic*, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
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
(Print accident date)
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 the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A 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, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS 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, THE DEPARTMENT 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____	_____
(Print name of Patient)	**(Signature of Patient)**
_____	_____
	(Date of signature)
_____	
(Address of Patient)	
_____	Donna H Rodriguez D.C.
(Print name of Provider)	**(Signature of Provider)**
Dr. Donna H. Rodriguez, D.C.	_____
460 E. Church Street	(Date of signature)
Elmira, NY 14901	
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)