NEW YORK CHIROPRACTIC COLLEGE NEW PATIENT REGISTRATION

Seneca Falls Health Center – Rochester Health Center- Levittown Health Center- Depew Health Center- Campus Health Center

Welcome to our Health Center! Your Health History is important to us.
Please fill out this form COMPLETELY.

Today's Date:					
Patient Title: ☐Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev.					
Last Name					
First Name		Middle Initial			
Address					
City		State		Zip	
Primary Phone ( )		Mobile Phone ( )			
Email:					
Date of Birth: / /	Age	Sex: ☐ Male ☐Female ☐Other			
Marital Status: (Check One) ☐ Single ☐ Married ☐ Other					
Emergency Contact:		Phone: ( )			
Primary Care Provider:		Phone: ( )			
Primary Care Provider Address:					
☐ Please do not share the results of this visit with this provider					
Race: Please Check One					
☐ White	☐ Black/African American	☐ American Indian/Alaskan Native		☐ Asian	
☐ Native Hawaiian/other Pacific Island		☐ Other		☐ Choose not to Specify	
Ethnicity: Please Check One					
☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Choose not to Specify.			
Preferred Language: Please Check One					
☐ English	☐ Spanish	☐ Chinese	☐ French	☐ Tagalog	☐ American Sign Language
☐ Other				☐ Choose not to Specify	

Are you the patient, or are you completing this for the patient?
☐ I am the patient. ☐ I am completing this for the patient. Is the patient a minor? ☐ Yes ☐ No
If you are completing this form for the patient, please enter your name:

Employment Status: Please Check One					
☐ Employed Full Time	☐ Employed Part-time	☐ FT Student	☐ PT Student		
☐ Retired	☐ Self-Employed	☐ Other			
Employer Name		Address			
City		State		ZIP	
Employer Phone: ( )		Position/Occupation			

Please Continue on the Reverse

Patient Name:	
Insurance Information	
Subscriber's Name	Date of Birth
Subscriber's Address	
Relationship to Patient (If not Patient)	
Insurance Company	
Policy Number	
Is Patient covered by additional insurance? ☐ Yes ☐ No	
If Yes, Subscriber's Name:	Date of Birth
Subscriber's Address	
Relationship to Patient (If not Patient)	
Insurance Company	
Policy Number	

Please tell us how you heard about us:
☐ Physician Referral (Please indicate Name)
☐ Personal Referral (Please indicate Name)
☐Phone Book ☐ Internet Search ☐ Other (Please Specify)

Please review the following statements and sign on the last line indicating your agreement:

Payment Verification: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive

General Verification: To the best of my ability, the information I have supplied today is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

Patient Signature:	**Date:**

Please Continue to the Next Page

New Patient Information	Date:
Patient Name:	
CURRENT MEDICATIONS: Please list all prescriptions, over-the-counter medicines and supplements) including frequency and dosage (if known). If there are NO current medications, check here ☐	
1.	2.
3.	4.
5.	6.
7.	8.
Please list any ALLERGIES you have to medications. If NO known allergies, check here ☐	
1.	2.
3.	4.
Do you use tobacco of any type? ☐ Yes ☐ No ☐ Former Tobacco User ☐ Never Used Tobacco	
If Yes, how often do you use tobacco? ☐ Current every day user ☐ Current sometimes user	
If you are a tobacco user, what is your interest in quitting on a scale where 0 is "No Interest" and 10 is "Very Interested"?	

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Do you presently have a diagnosis of Hypertension?	☐ Yes ☐ No
Do you presently have a diagnosis of Diabetes? ☐	☐ Yes ☐ No
If "Yes" to Diabetes, what kind?	☐ Type I ☐ Type II
If "Yes" to Diabetes, do you know your A1C level?	☐ Yes ☐ No ☐ Not Sure
Comments regarding your Diabetes diagnosis:	
YOUR SYMPTOMS TODAY	
Please describe your symptoms:	
When did your symptoms start? Month Day Year	
How did your symptoms begin?	
Please indicate the location and severity of your symptoms on the Pain Diagram given to you today	
How often do you experience your symptoms?	
Do your symptoms affect other areas of your body? To what extent does the pain radiate, shoot or travel?	
What makes your pain better or worse? (Certain movements, activities, positions, etc.) Better:	
Worse:	
What time of day do you experience your symptoms? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night	
Prior Interventions: What have you done to relieve the symptoms? Please Check all that apply	

☐ Prescription Medicine	☐ Acupuncture	☐ Over the Counter Medication	☐ Ice
☐ Homeopathic Remedies	☐ Chiropractic	☐ Physical Therapy	☐ Heat
☐ Massage	☐ Other		

Please Continue on the Reverse

New Patient Information	Date:
Patient Name:	

Is your condition due to an accident? ☐ Yes ☐ No Date of Accident or Injury:

Have you reported this accident to:

☐ Auto Insurance ☐ Employer ☐ Workers' Comp. ☐ Other ☐ Not Reported

Is there anything else we should know about your condition?

Please check the boxes if you HAVE or HAD any of the listed conditions

	Musculoskeletal		Cardiovascular		Endocrine		Respiratory
☐	No Issues	☐	No Issues	☐	No Issues	☐	No Issues
☐	Osteoporosis	☐	High Blood Pressure	☐	Thyroid Issues	☐	Asthma
☐	Arthritis	☐	Low Blood Pressure	☐	Immune Disorders	☐	Apnea
☐	Scoliosis	☐	High Cholesterol	☐	Hypoglycemia	☐	Emphysema
☐	Neck Pain	☐	Poor Circulation	☐	Frequent Infection	☐	Hay Fever
☐	Back Problems	☐	Angina	☐	Swollen Glands	☐	Shortness of Breath
☐	Hip Disorders	☐	Excessive Bruising	☐	Low Energy	☐	Pneumonia
☐	Knee Injuries	☐	Other	☐	Other	☐	Other
☐	Elbow/Wrist Pain						
☐	TMJ Issues		**Digestive**		**Genitourinary**		**Integumentary**
☐	Foot/ankle Pain	☐	No Issues	☐	No Issues	☐	No Issues
☐	Poor Posture	☐	Anorexia/Bulimia	☐	Kidney Stones	☐	Skin Cancer
☐	Shoulder Problems	☐	Ulcer	☐	Infertility	☐	Psoriasis
☐	Other	☐	Food sensitivities	☐	Bedwetting	☐	Eczema
	Neurological	☐	Heartburn	☐	Prostate Issues	☐	Acne
☐	No Issues	☐	Constipation	☐	Erectile Dysfunction	☐	Swollen Glands
☐	Anxiety	☐	Diarrhea	☐	PMS Symptoms	☐	Rash
☐	Depression	☐	Other	☐	Other	☐	Other
☐	Headache		**Sensory**		**Constitutional**		
☐	Dizziness	☐	No Issues	☐	No Issues		
☐	Pins and Needles	☐	Blurred Vision	☐	Fainting		
☐	Numbness	☐	Ringing in Ears	☐	Low Libido		
☐	Other	☐	Hearing Loss	☐	Poor Appetite		
		☐	Loss of Smell	☐	Fatigue		
		☐	Loss of taste	☐	Erectile Dysfunction		
		☐	Chronic Ear Infection	☐	Weakness		
		☐	Other	☐	Other		

Please explain any items you checked above:

ITEM	EXPLANATION

Please Continue to the Next Page

New Patient Information	Date:

Patient Name:

Are there any past or current medical conditions you have not told us about?

Please list date(s) and reason(s) for any hospitalizations:

Date	Reason	Date	Reason

Please list any surgical procedures you have had:

Date	Procedure	Date	Procedure

Please list any other injuries not described above:

Date	Injury	Date	Injury

Family History

Relative	Health Condition or Illness
Mother	
Father	
Brother(s)	
Sister(s)	
Son(s)	
Daughter(s)	
Other	

Stress Information

On a scale of 0 to 10, where 0 means you have NO stress and 10 means a LOT OF STRESS, please indicate your PHYSICAL stress level:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

On a scale of 0 to 10, where 0 means you have NO stress and 10 means a lot of stress, please indicate your EMOTIONAL stress level:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

What are the major stressors in your life:

Please Continue on the Reverse

New Patient Information	Date:
Patient Name:	
Consumption, Sleeping , and Exercise Information	
How much alcohol do you consume?	Frequency?
How many cups of coffee do you drink daily?	
How much soda pop do you consume daily?	
How much water do you drink daily?	
Do you use recreational drugs? ☐ Yes ☐ No	

Please rate your eating habits where 0 means your eating habits are UNHEALTHY and 10 means your eating habits are HEALTHY:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

What are your typical eating habits:

☐ Skip Breakfast	☐ 2 Meals per Day	☐ 3 Meals per Day	☐ Snacking Between Meals

On average, how many hours do you sleep at night?	
What is your preferred sleeping position?	
On a regular basis, how much do you exercise?	

What would be the most significant thing you could do to improve your health?

What additional health goals do you have?

Patient Signature:

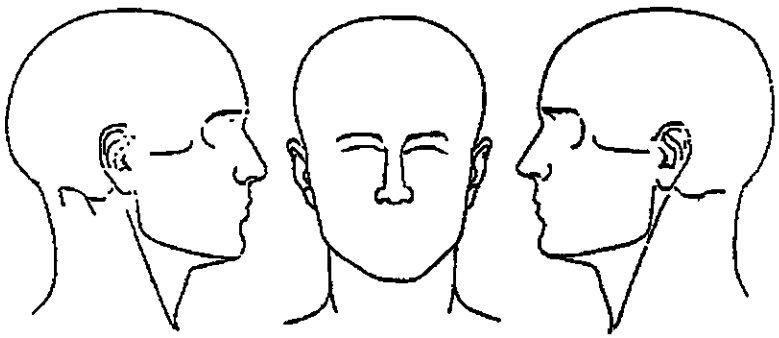
Pain Diagram

Patient's Name: _____

NEW YORK CHIROPRACTIC COLLEGE

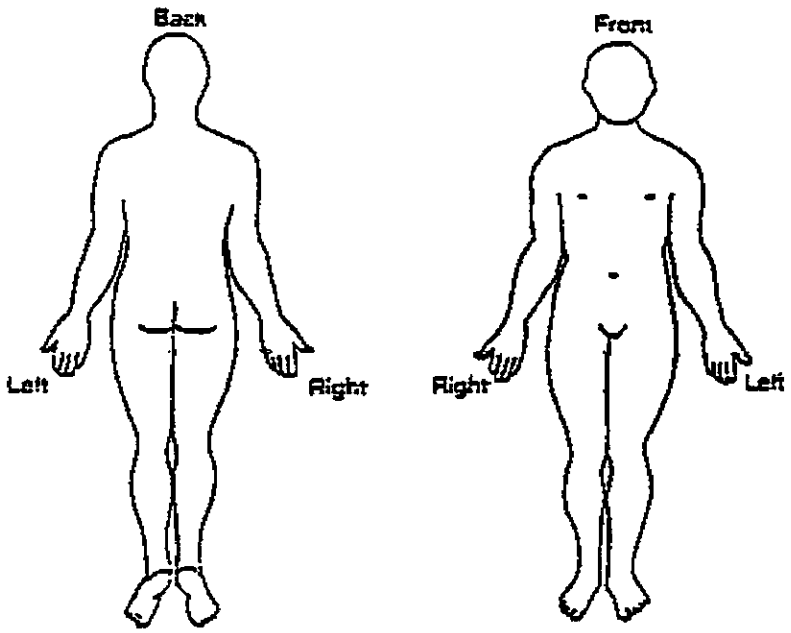
Draw the location of your pain on body outlines and mark how bad it is on pain line at bottom of page.
Indicate location and the type of pain using the following chart:

1 – Ache	2 – Burning	3 – Numbness
4 – Pins and Needles	5 – Stabbing	6 – Other



No Pain ——————————— Worst Pain Possible

Please make a slash through this line as to the level of your pain



No Pain ——————————— Worst Pain Possible

Please make a slash through this line as to the level of your pain

Patient's Signature	Date:

NEW YORK CHIROPRACTIC COLLEGE

New York Chiropractic College Health Centers Financial Policy

- It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.
- All patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed $150 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require.
- This office offers prompt payment discounts of 15% when payment is made at the time of service. For your convenience, this office accepts cash, checks, and the following credit cards: Visa, MasterCard, American Express, Discover. This office does not turn away any patient due to their ability to pay. If you feel you might qualify for our financial hardship policy, notify the office immediately so we can begin your qualification process.
- Should payment be refused by your bank for any check written, this office will charge a fee of $25 to offset the charges we will incur as a result of the returned check.
- As a courtesy to our patients, this office will bill third party payers, accept assignment, and wait to be paid for some portion of our patients' financial responsibility.
- The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a "cash" patient and payment is expected at the time of service. As a courtesy to you, our office will pre-qualify your insurance coverage, in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage.
- No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.
- If your insurance has not paid on an assigned bill within 90 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 120 days, the balance becomes due and payable immediately and your assignment is revoked.
- All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous payment options to allow you to continue maintenance, wellness or supportive care.
- Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

Patient Name: (Print) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

New York Chiropractic College Health Centers
2360 State Rte. 89 Seneca Falls, New York 13148
(800) 234-6922

Notice of Privacy Practices

Your Rights & Our Responsibilities

EFFECTIVE: May 1, 2021

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical health condition and related health care services. **Please review it carefully.**

Your Rights

This section explains your rights and how we are required to acknowledge them.

Request a copy of your paper or electronic medical record

- Upon request, we will supply you with a ***Request to Inspect or Copy Patient Information*** form (also referred as a ***Patient Records Request*** form). The form contains the contact information of our compliance officer, and any related fees for copying your records. NOTE: Portions of an Electronic Health Record (if applicable) may be available via an on-line portal or other healthcare exchange. This will be noted in the request form.
- We will provide a copy or a summary of your health information, usually within 15 days of your request. We may charge a reasonable fee for cost of labor, postage, and supplies associated with your request (in compliance with state and federal laws regarding medical records request). We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

Receive a paper copy of this Notice of Privacy Practices

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Request correction of your medical record

- Upon request, we will supply you with the ***Request to Amend Patient Record*** form.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request; our response will be in writing within 60 days.

Request confidential or alternative communication

- Request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by email.
- Request alternative communications; you must make your request in writing to our privacy office, a ***Request for Alternative Communications*** form will be provided upon request.

Ask us to limit or restrict the information we share

- List individuals who are involved in your care and as a result PHI can be disclosed; a ***PHI Use and Disclosure Authorization*** form will be provided, upon request.
- Restrict payer access. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You must make your request in writing to our privacy office; a ***Request to Restrict Disclosure to Health Plan*** form will be provided upon request.

Receive a list of those with whom we've shared your information

- You have the right to request an accounting of disclosures of your health information made by us. We are not required to list certain disclosures, including: disclosures made for treatment, payment, and health care operations purposes (TPO).
- You must submit your request in writing. A ***Request for Accounting of Disclosure*** form will be provided upon request. In turn you will receive a ***Response to Request for Disclosure*** form. The first accounting of disclosure request within a 12 month period will be at no cost. Additional request within that time period, will result in a charge based on the reasonable costs for providing accounting of disclosures.

Right to Receive Notice of a Breach

- We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than 30 days following the discovery of the breach.

File a complaint if you believe your privacy rights have been violated

- If you believe your privacy rights have been violated, you may file a complaint with our privacy officer also referred to as compliance officer; we will supply you with a ***Complaint*** form upon request (form contains the name of our privacy official and his/her contact information).
- All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, call-ing 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices

This section addresses your choices regarding health information we may share.

You have the choice to tell us to:

- Share information with your family and friends about your condition.
- Disclose your health information when disaster relief organizations seek your health information to coordinate your care. Note: If you are unable to communicate your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.

We will never share your information in these cases without permission:

- Marketing purposes. We are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.
- Sale of your information. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

Our Uses and Disclosures

This section lists ways in which we may use your information and disclose it.

Healthcare Treatment

- Plan your care and treatment, including preauthorization and pre-certification.
- Communicate with other providers such as referring physicians.
- Billing and coordination of payment for services with health plan administrator.
- Quality and outcome assessments for improvement of care we render.
- Contracted third-party business associates for services, such as answering services, transcriptionists, record keeping, consultants, and legal counsel.
- Communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Public Health and Safety Issues

- Product recalls
- Reporting suspected abuse, neglect or domestic violence ; reporting disease or other required data in compliance with state and federal laws.
- Communicating with healthcare exchanges and networks according to federal and state laws with regards to Right of Access and interoperability regulations.

Compliance with the law

- Department of Health and Human Services investigations for complying with federal privacy laws.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions such as a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law.
  If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative. To include communication with medical examiner and or funeral director (if applicable).

Other

Text & Email Reminders; Health Tips; Product Offers

References apply to all of NYCC Health Centers
Depew Health Center 4974 Transit Road
Seneca Falls Health Center 2360 State Route 89
Levittown Health Center 70 Division Ave.
https://www.nycc.edu/join-the-movement/health-centers

Our Responsibilities

- If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information.
  We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than 30 days following the discovery of the breach.
- To provide you with notice, such as this Notice of Privacy Practices and abide by the terms of our most current Notice of Privacy Practices.
- Notify you if we are unable to agree to a requested restriction.

Changes to the Terms of this Notice

- We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain. Should our information practices change; a revised Notice of Privacy Practices will be available upon request. We will not use or disclose your health information without your authorization, except as described in our most current Notice of Privacy Practices. If you have limited proficiency in English, you may request a Notice of Privacy Practices in Spanish.

New York Chiropractic College Health Centers

NYCC Health Centers
2360 State Rte. 89 Seneca Falls, New York 13148 Ph: (800) 234-6922

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of NYCC Health Centers'* *Notice of Privacy Practices (NPP).* I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices.*

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____
(Print) **Date**

Signature of Personal Representative: _____

Relationship to Patient: _____**Driver's License Number:** _____**State**____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

*All references to NYCC Health Centers apply to all centers including Depew Health Center 4974 Transit Road; Seneca Falls Health Center 2360 State Route 89; Levittown Health Center 70 Division Ave.

OFFICE USE ONLY
We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:
Attempt 1 Date _____ Staff_____
- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ Other (Specify:)_____

Attempt 2 Date _____ Staff _____
- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ Other (Specify:)_____

NYCC Health Centers
2360 State Rte. 89 Seneca Falls, New York 13148 Ph: (800) 234-6922
PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. We have permission to (please check all that apply):

- ☐ Leave messages on home phone or with household members about appointments, and test results.
- ☐ Leave messages on work phone about appointments, and test results.
- ☐ Leave messages on cell phone about appointments, and test results.
- ☐ Email appointment reminders
- ☐ Confirm appointments by phone or text

This authorization is effective through (check one):

- ☐ ____/____/____

- ☐ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative.

I hereby authorize NYCC Health Centers'* disclosure of my individually identifiable health information to the individuals listed below:

1. Name _____ Relationship to Patient _____

Authorization to:

- ☐ Disclose treatment plans and test results.
- ☐ Billing information including statement balances.
- ☐ Past and future Appointments.
- ☐ Receive phone messages and/or email regarding appointments or test results.
- ☐ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ☐ Disclose treatment plans and test results.
- ☐ Billing information including statement balances.
- ☐ Past and Future Appointments.
- ☐ Receive Phone Messages or email regarding appointments or test results.
- ☐ Other _____

I understand that I may revoke this authorization to disclose information at any time by notifying NYCC Health Centers* in writing (*Termination of Disclosure Form* provided upon request). If I choose to do so, I am aware that my revocation will not affect any actions taken by NYCC Health Centers* until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative **Date**

Relationship to Patient: _____ **Driver's License Number:** _____ **State**____

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