

**Dr. Patrick Szurek
195 Church Street
Saratoga Springs, NY 12866**

PATIENT INFORMATION

First: _____ **M.I.** _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Social Security#: _____ - _____ - _____ **Date-of-Birth** ___/___/___ **Gender:** ___

Marital Status _____ **Home Phone:** (____) ____ - _____ **Alt Phone:** (____) ____ - _____

Spouses Name: _____ **Social Security#:** _____ - _____ - _____

Date-of-Birth: ___/___/___

E-mail Address: _____

Occupation: _____ **Employer:** _____

Employer Address: _____

City: _____ **State:** _____ **Zip:** _____

Employer Phone: (____) ____ - _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Name of Insured: _____ **Relationship:** _____

Insurance Comp: _____

Policy #: _____ **Group #:** _____

Do you have additional Insurance? ___ Yes ___ No

Insurance Comp: _____

Policy #: _____ **Group #:** _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Dr. Patrick Szurek** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Date

MEDICAL HEALTH HISTORY

Date of last Physical Exam: _____

Name of Primary Care Physician: _____

What is your reason for this visit? _____

Please place an "x" next to any symptoms you currently have or have had in the past year

General

- ___ Chills
- ___ Depression/Nervousness
- ___ Fever
- ___ Forgetfulness
- ___ Headache
- ___ Loss of Sleep
- ___ Loss of Weight
- ___ Numbness
- ___ Sweats

Gastrointestinal

- ___ Appetite Poor
- ___ Bloating
- ___ Bowel Changes
- ___ Constipation
- ___ Diarrhea
- ___ Excessive Thirst
- ___ Gas
- ___ Hemorrhoids
- ___ Indigestion
- ___ Nausea
- ___ Rectal Bleeding
- ___ Stomach Pain
- ___ Vomiting
- ___ Vomiting Blood

Eye, Ear, Nose, Throat

- ___ Bleeding Gums
- ___ Blurred Vision
- ___ Crossed Eyes
- ___ Difficulty Swallowing
- ___ Double Vision
- ___ Earache/Ear Discharge
- ___ Hay Fever
- ___ Hoarseness
- ___ Loss of Hearing
- ___ Nosebleeds
- ___ Persistent Cough
- ___ Ringing in Ears
- ___ Sinus Problems
- ___ Vision - Flashed/Halos

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ___ Arms ___ Hips
- ___ Back ___ Legs
- ___ Feet ___ Neck
- ___ Hands ___ Shoulders

Please place an "x" next to any conditions you have or have had in the past.

- | | | | |
|-------------------------|----------------------|------------------------|----------------------|
| ___ AIDS | ___ Chicken Pox | ___ HIV Positive | ___ Polio |
| ___ Appendicitis | ___ Diabetes | ___ Kidney Disease | ___ Prostate Problem |
| ___ Arthritis | ___ Emphysema | ___ Liver Disease | ___ Rheumatic Fever |
| ___ Asthma | ___ Epilepsy | ___ Measles | ___ Scarlet Fever |
| ___ Bleeding Disorders | ___ Glaucoma | ___ Migraine Headaches | ___ Stroke |
| ___ Breast Cancer | ___ Heart Disease | ___ Multiple Sclerosis | ___ Thyroid Problems |
| ___ Cancer | ___ Hepatitis | ___ Mumps | ___ Tuberculosis |
| ___ Cataracts | ___ Herpes | ___ Pacemaker | ___ Ulcers |
| ___ Chemical Dependency | ___ High Cholesterol | ___ Pneumonia | ___ Venereal Disease |

Medications and Allergies

List any Medications that you are currently taking _____

List any allergies to Medications or Substances: _____

Signatures

I certify that above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____

**Dr. Patrick Szurek
195 Church Street
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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other 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 Dr. Patrick Szurek and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Patrick Szurek, including those working at the office listed above or any other office or clinic.

I have had an opportunity to discuss with Dr. Patrick Szurek and/or with other office or office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and 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, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, 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.

I have read or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name: _____

Signature of Patient: _____

Signature of Parent or Guardian: _____

Date Signed: _____

HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully

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 permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that releases to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protect Health Information:

Uses and Disclosures of Protected Health Information

Your protected health information may be used by your physician, our office staff and others outside of our office that our involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity, Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

*Dr. Patrick J. Szurek
195 Church Street
Saratoga Springs, NY 12866
Phone 518-581-9100
Fax 518-581-1707*

MEDICAL AUTHORIZATION

I, _____, do hereby authorize any physician or nurse who has attended, examined or treated me, or any hospital at which I have been confined, or at which I have been examined or treated, to furnish Dr. Patrick Szurek or an authorized representative with any and all information which may be requested regarding my past or present physical condition and treatment rendered, therefore, and to allow them to examine any x-ray pictures taken of me or records which you may have regarding my condition or treatment.

Sign: _____

Date: _____