CHIROPRACTIC ASSOCIATES of ROCHESTER

585-544-1540 *Fax:* 585-544-1580
chirorochester@gmail.com
190 Perrin Drive Rochester, NY 14622
www.chiroROC.com

Tina Shores, D.C. | Colby Shores, D.C., CCSP

New Patient Information

Name:_____ Date: _____
Address:_____,_____,_____
(Street) (City) (State) (Zip)

Patient Contact #: (Home / Cellular) (_____)_____-_____ Preferred (H | C)
Email Address:_____
Sex:__Male | Female | Other:_____) Date Of Birth: _____/_____/_____
Referred By: _____ **Relationship:**_____

Emergency Contact

Name:_____Relationship:_____
Phone #:__(_____)_____ Work #: _(____)_____

Medical History

Primary Care Physician:_____ Phone:_____
Office Name: _____
Are you being seen by other specialists?_____
Have you seen a Chiropractor in the past? (Y | N) Who?:_____
Date of last adjustment:_____ None_____

Date of Last:
Physical Exam:_____ Blood Test:_____ Urine Test:_____
MRI | CT Scan:_____ Prostate Exam:_____ DEXA:_____
Other:_____

Habits

____ Smoking Packs/ Day:_____
____ Alcohol Drinks / Week:_____
____ Caffeine Cups/ Day_____
____ High Stress Reason_____

Women Only

Are you pregnant? (Y | N)
# of Pregnancies:____ # of Deliveries:_____
Vaginal _____ C-Section _____
Birth Control? (Y | N)

Injuries / Surgeries you have had (Date or Year): _____
Motor Vehicle Accidents: _____
Broken Bones / Fractures: _____
Spinal Injuries (Neck, Back, Low Back, Pelvis): _____
Surgeries (Include all, i.e. Tonsillectomy): _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

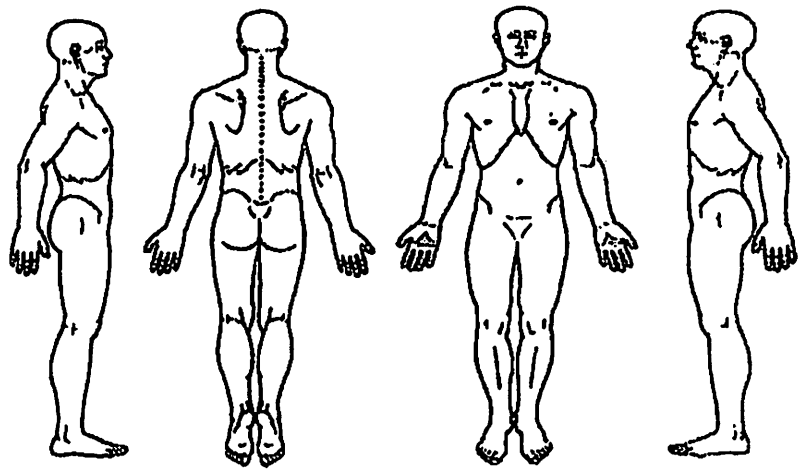
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

---

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: _____ ③ CT Scan date: _____
② MRI date: _____ ④ Other date: _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ①None ②Light ③Moderate ④Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Stroke			
O	O	Low Back Pain	O	O	Angina	O	O	Smoking/Use Tobacco Products
						O	O	Drug/Alcohol Dependence
O	O	Shoulder Pain	O	O	Kidney Stones			
O	O	Elbow/Upper Arm Pain	O	O	Kidney Disorders	O	O	Allergies
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Depression
O	O	Hand Pain	O	O	Painful Urination	O	O	Systemic Lupus
			O	O	Loss of Bladder Control	O	O	Epilepsy
O	O	Hip/Upper Leg Pain	O	O	Prostate Problems	O	O	Dermatitis/Eczema/Rash
O	O	Knee/Lower Leg Pain				O	O	HIV/AIDS
O	O	Ankle/Foot Pain	O	O	Abnormal Weight Gain/Loss			
			O	O	Loss of Appetite	***Females Only***		
O	O	Jaw Pain	O	O	Abdominal Pain	O	O	Birth Control Pills
			O	O	Ulcer	O	O	Hormonal Replacement
O	O	Joint Swelling/Stiffness	O	O	Hepatitis	O	O	Pregnancy
O	O	Arthritis	O	O	Liver/Gall Bladder Disorder	O	O	
O	O	Rheumatoid Arthritis						
			O	O	Cancer	***Other Health Problems/Issues***		
O	O	General Fatigue	O	O	Tumor	O	O	
O	O	Muscular Incoordination				O	O	
O	O	Visual Disturbances	O	O	Asthma	O	O	
O	O	Dizziness	O	O	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

CHIROPRACTIC ASSOCIATES of ROCHESTER

585-544-1540 *Fax*: 585-544-1580
chirorochester@gmail.com
190 Perrin Drive Rochester, NY 14622
www.chiroROC.com

Tina Shores, D.C. | Colby Shores, D.C., CCSP

Name:_____ Date: _____

Work Related Accident

DATE OF ACCIDENT:_____/_____/_____

On the date of injury what was your job title/description?:
_____

On the date of injury/illness what were your usual work activities?:
_____

Was your accident directly related to your work?
(YES | NO)

Briefly describe where and how did the injury happen:
_____
_____
_____

Address where accident occurred:
_____
_____

Did you report your accident to your employer?
(YES | NO)

What recommendations did your employer make just after your accident?:
_____
_____

Has this type of accident happened to you before?
(YES | NO)

Explain:_____
_____
_____

Motor Vehicle Accident

DATE OF ACCIDENT: _____/_____/_____

At the time of the accident, I was the (circle one):
DRIVER | FRONT PASSENGER | REAR PASSENGER

If a traffic violation was issued, to whom was it issued?
_____

Number of people in accident vehicle? _____
Did the police come to the accident site?.....(YES | NO)
Was a police report filed?.....(YES | NO)
Were you wearing your seat belt?.....(YES | NO)
Was this vehicle equipped with airbags?.....(YES | NO)
If yes, did the airbag inflate?.....(YES | NO)

In relation to the base of your skull, where was the headrest?

- **ABOVE**
- **BELOW**
- **AT BASE OF SKULL**

What did your vehicle impact?

- **ANOTHER VEHICLE**
- **OTHER:** _____

Did any part of your body strike anything in the vehicle?
(YES | NO)
If yes please explain: _____

In your words, please describe the accident:
_____
_____
_____
_____

Name:_____ Date: _____

After Injury Information

Have you gone to a hospital or another doctor?
(YES | NO) If yes., when did you go?
___Immediately ___Next Day ___ Two Days Plus After

How did you get there?:
_____PRIVATE TRANSPORT _____ AMBULANCE

Name of hospital:_____
Describe any treatment you received:
_____
_____

Were x-rays taken?..... **(YES | NO)**
Was medication prescribed?..... **(YES | NO)**
Have you been able to work since this injury? **(YES | NO)**
Have you lost time at work due to the accident?
..... **(YES | NO)**

- If yes, when was the first day you did not work?
  _____
- What day did you return to work?
  _____

Are you work activities restricted as a result of this injury?
..... **(YES | NO)**

Mark **(X)** the symptoms that are a result of this accident:

___Dizziness	___Difficulty sleeping	___Nausea
___Memory Loss	___Irritability	___Jaw Issues
___Headache(s)	___Fatigue	___Tension
___Blurred vision	___Back pain	___Low Back Pain
___Back Stiffness	___Neck Pain	___Upset Stomach
___Chest Pain	___Buzzing in Ear	
___Numb Hands/Fingers		___Numb Feet/Toes
___Arm/Shoulder Pain		

___Other:_____

Is your condition getting worse?
_____YES _____NO _____CONSTANT _____COMES & GOES
Indicate your degree of comfort while performing the following activities:

Employer Information

Name of Employer:_____
Address: _____
_____

Phone #: (_____)_____-_____
Contact Person: _____

Insurance Information

Name of Worker's Comp / Auto Insurance Company:
_____
Address of insurance company:
_____
_____

Phone #: (_____)_____-_____
Contact Person: _____

CLAIM #: _____

Recovery

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal work day? _____

Please circle your daily job duties and any activities which you are occasionally asked to perform:

Standing | Driving | Operating equipment
Sitting | Twisting | Walking | Crawling
Typing | Lifting | Bending | Stooping
Work w/ arms above head

What positions can you work in with minimum physical effort and for how long?:_____

- Prior to the injury were you capable of working on an equal basis with others your age?..... **(YES | NO)**
- Do you work with others who can help you with any heavy lifting? ..... **(YES | NO)**
- While in recovery, is there and light duty work you could request? ..... **(YES | NO)**

NOTICE THAT YOU MAYBE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (IfKnown)	CLAIM ADMIN CLAIM NUMBER (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	CLAIMANT'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the health care provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation insurer/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your health care provider to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or insurer may not be required to pay the provider's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of their bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with their employer or its insurance carrier settling their case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or insurer of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of their bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that they may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the insurer of liability for medical treatment is approved.

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

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

I, _____ , ("Assignor") hereby assign to , Chiropractic Associates of Rochester
(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

_____ _____
Address of Patient Date of Signature

Name of Provider: _____
Address: 190 Perrin Dr., Rochester, NY 14622

Date: _____

NYS FORM NF – AOB (Rev 1/2004)

CHIROPRACTIC ASSOCIATES of ROCHESTER

585-544-1540 *Fax:* 585-544-1580
chirorochester@gmail.com
190 Perrin Drive Rochester, NY 14622
www.chiroROC.com

Tina Shores, D.C. | Colby Shores, D.C., CCSP

NO FAULT APPOINTMENT POLICY

Dear Patient:

In accordance with New York State No-Fault regulations, it is your responsibility as the patient to notify this office 24 hours in advance if you cannot keep your scheduled appointment.

If you fail to give prior notice, you will be charged the usual and customary fees of $50. If you have any questions, please direct them to the office manager.

Thank you for your time and consideration in this matter.

NO FAULT CLAIM DENIAL POLICY

I,_____, understand in the event that my No-Fault carrier denies any or all of my claim, I am responsible and obligated to pay the usual and customary fees for all services rendered.

I have read and understand the above explanations concerning my scheduled appointments and carrier denial.

_____ _____

Signature of Patient Date

CHIROPRACTIC ASSOCIATES of ROCHESTER

585-544-1540 *Fax:* 585-544-1580
chirorochester@gmail.com
190 Perrin Drive Rochester, NY 14622
www.chiroROC.com

Tina Shores, D.C. | Colby Shores, D.C., CCSP

HIPPA Policy

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices before signing this consent. I understand that this practice has the right to change the Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand the practice is not required to agree to my requested restrictions, but if the practice does agree, then it is bound to abide by such restrictions.

This notice is in effect as of the date signed below. By signing below, I certify that I have received this notice and all of my questions have been answered to my satisfaction with language that I can understand.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement and consent on this Notice of Privacy Practices Acknowledgement/Consent Form, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

CHIROPRACTIC ASSOCIATES OF ROCHESTER

585-544-1540 *Fax:* 585-544-1580
chirorochester@gmail.com
190 Perrin Drive Rochester, NY 14622
www.chiroROC.com

Tina Shores, D.C. | Colby Shores, D.C., CCSP

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care, including spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years. These studies have demonstrated that chiropractic care is a highly effective treatment for spinal pain, headaches, and other symptoms. Maintaining spinal alignment through chiropractic care contributes to overall well-being. The risk of injury or complications from chiropractic treatment is substantially lower than that associated with many medical treatments, medications, and procedures used for similar conditions.

I acknowledge that I have received information regarding my condition and the proposed chiropractic treatment, as well as alternative options for care, including the benefits, risks, and potential side effects of treatment, and the consequences of not receiving the proposed treatment.

I understand and am informed that, as with all health care, chiropractic treatment carries some risks, including but not limited to: muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I trust the doctor to exercise judgment during the course of treatment based on the information available at the time and in my best interest.

My doctor has responded to all 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. I intend for this consent to apply to all my present and future chiropractic care in this office.

Patient Signature_____Date_____

Witness_____Date_____

Insurance Financial Agreement 2026

Insurance Company:_____

Policy Holder Name:_____ **D.O.B.:**_____/_____/_____

Policy Number:_____ **Group # (If Applicable):**_____

Relationship to Policy Holder: Self | Spouse | Child

INDIVIDUAL POLICY

Insurance policies are individualized per each patients benefit. Please read and initial next to your benefit plan.

_____ **Excellus BC/BS, Aetna and United:** Deductibles: Referral may be needed. Until your annual deductible is met, the insurance fee schedule will be procedure-dependent. Once the deductible is met, you will be responsible for the co-insurance policy dependent. Your co-pay is due at the time of service and will range from $0-$70, depending upon your contract. Insurance covers acute care and not maintenance care. Supplements are not covered and are the patient's responsibility.

_____ **Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United:** Authorization may be required. Some insurances set a number of visits allowed. Some costs are out of pocket per Medicare. Please refer to the ABN agreement. Your insurance covers acute care, not maintenance care.

_____ **Medicare:** No referral needed. Until your annual deductible of $283.00 is met, the insurance fee schedule is $50-$100.00. You will be responsible for any usual and customary fee (ABN). Your insurance covers acute care and no maintenance care.

_____ **MVP/Cigna/Other:** The doctors in this office are out of network providers. Payment follows the Usual and Customary Fee shown below.

_____ **Usual & Customary Fees:** First visit for consultation, history and examination is $100.00. Subsequent visits thereafter are $50.00.

_____ **Maintenance Care:** Elective healthcare defined as patient has achieved and maintained pre-complaint status, plateaued in improvement, and/or chronic symptoms show no progression in reduction or remain stable. This is a service not covered as per your insurance company policy, and you will be responsible for the office fee of $50. If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan until that condition has achieved pre-complaint status or plateaued in improvement.

I understand that I am financially responsible for all charges, whether paid by insurance or self-pay.

_____

Responsible Party Signature Date

_____

Printed Name

CHIROPRACTIC ASSOCIATES OF ROCHESTER

Tina Shores, D.C. | Colby Shores, D.C., CCSP

585-544-1540 *Fax:* 585-544-1580
chirorochester@gmail.com
190 Perrin Drive Rochester, NY 14622
www.chiroROC.com

Office Financial Agreement 2026

Workers Compensation (WC) | Motor Vehicle Accident (MVA) | Personal Injury (PI)

INDIVIDUAL POLICY

____ **Worker's Compensation:** If you require treatment for an injury that occurred while performing your normal employment, you may be eligible for 100% coverage by your employer's worker's compensation insurance. In such cases, to ensure your coverage, it is your responsibility to report your injury to your employer in writing and fill out the appropriate reports. Failure to do so will jeopardize your coverage. Should your case be denied you would become liable for services rendered.

____ **Auto Accidents/No Fault Insurance:** If you are seeking treatment because of an auto accident, you may be eligible for 100% coverage by your No-Fault Insurance. Some companies have a deductible that must be met first. It is your responsibility to contact your insurance company and fill out the appropriate reports. Should your insurance decline to pay for your case, you would become liable for all services rendered.

____ **Personal Injury Fees:** First visit for consultation, history and examination is $100.00. Subsequent visits thereafter are $50.00. Payment is accepted with each visit. Receipts are available upon request.

OFFICE POLICY

____ **Should your insurance decline to pay for your case, you would become liable for all services rendered.**

____ **I understand that I am financially responsible for all charges whether paid by insurance. Record requests are available.**

____ **A financial fee will be assessed by case for all medical records. A signed Medical Release Form will be required to all inquired parties.**

I understand that I am financially responsible for all charges, whether paid by insurance or self-pay.

Responsible Party Signature Date

Printed Name

CHIROPRACTIC ASSOCIATES OF ROCHESTER

Tina Shores, D.C.
Colby Shores, D.C., CCSP

190 Perrin Drive
Rochester, New York 14622
Phone (585) 544-1540
Fax (585) 544-1580
doctors@chiroroc.com

www.chiroROC.com

AUTHORIZATION FOR RELEASE OF INFORMATION:

OFFICE USE ONLY

TO: _____

_____

_____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____ Medical Records regarding _____

_____X-Rays and / or report of findings, CT scans, MRI's

_____ Consult reports from specialists

_____ Test Results

_____Billing Records

_____ Other _____

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials _____

I understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials _____

I understand that this authorization will expire one (1) year from the date of the original signature indicated below.

Initials _____

Patient Name: _____Date of Birth: _____

Signature of Patient _____Date: _____

If under age 18 Signature of Guardian: _____Date: _____

Relationship to Patient: _____