Lendino Sports & Family Chiropractic
120 W. Old Country Road
Hicksville, NY 11801

No- Fault History

Dear Patient:

Welcome to our office. To help better evaluate your condition, please take the time to fill out this history in its entirety:

Name_____ Cell ( )_____
Address_____ City_____
State_____ Zip_____
Age_____ Birth Date_____ M/F SSN:_____
Home Phone: (____)_____ Work Phone: ( )_____
Employer's Name:_____
Employer's Address:_____
Your Employment Title: _____
Your NF Insurance Co.:_____
NF Insurance Address:_____ Phone:_____
NF Insurance Agent Handling Claim:_____
Policy Holder's name (Insured):_____Relation to you:_____
Policy Holder's Date of Birth:_____
Policy Holder's Address:_____
Policy #:_____ Claim #:_____
Date of Accident:_____ Time of Day: _____AM/PM
Were you Driving?_____Passenger? Front Seat?_____ Passenger Back Seat?_____
Pedestrian?_____Bicyclist?_____ Were you wearing your seat belt?_____
Did air bags deploy? If yes, which?_____
Year/Make/Model of your Vehicle:_____
Year/Make/Model of other Vehicle:_____
Was your vehicle stopped?_____ If yes, in traffic?___Stop sign?____ Light?____

Was your vehicle moving?_____ If yes, approx. speed of your vehicle_____
What direction were your heading?_____ What Road?_____
Location of accident (Town):_____
Was your veh. rear-ended____ Front____ T-boned____ Left side____ Right side____
Any other vehicles involved?_____ If yes, Year/Make/Model_____
Was your vehicle pushed into any objects?____ If yes, what?_____
Was you head turned at the time of impact? ____ If yes, which direction_____
Did your head strike the interior of the vehicle upon impact?_____
Did you lose consciousness?_____ If yes, how long?_____
Approximate speed of other vehicle:_____
Did you have immediate pain after impact?___ If yes, where_____
_____
Did police arrive on scene?____ Did an ambulance arrive on scene?____
Were you taken to a hospital?____ If yes, where?_____
At hospital, what was performed? X-rays of_____ CT scan of_____
Medications given_____ Neck brace_____
Prescriptions for medications_____
Were you released the same day?____ Did you stay in hospital?_____
What areas of your body were painful later that day?_____
_____Next day?_____
Did you see any other doctors before presenting to this office?____ If yes, who?
_____
What type of testing or treatment did you receive? _____
Did you have any similar complaints PRIOR to this accident?_____ If yes, where?
_____
Did you lose any time from work? If yes, how long?_____
Do you notice any daily activity restrictions as a result of this injury? _____
If yes, please describe in detail: _____
_____
_____
Previous Chiropractic care: _____
Past or present fractures: _____
Past or present surgeries: _____

Health problems: _____

_____

Medications you are presently taking: _____

_____

_____

Prior Accidents: _____

_____

Since the accident, are your symptoms: Improving☐ Same☐ Worse☐

Please circle the symptoms that you have noticed since the accident:

Headache	Irritability	Constipation
Fatigue	Tension	Loss of Balance
Neck Stiffness	Dizziness	Loss of Memory
Neck Pain	Fainting	Difficulty Concentrating
Mid Back Pain	Fever	Shortness of Breath
Lower Back Pain	Cold Sweats	Vomiting
Chest Pain	Head Feels Heavy	Jaw Pain or Clicking
Sleeping Problems	Loss of Smell/Taste	Shoulder Pain
Ringing in Ears	Upset Stomach	Knee Pain
Cold Hands/Feet	Diarrhea	Hand or Wrist Pain
Numbness/Tingling in Fingers or Toes		Numbness/Tingling in Arms or Feet

Other Symptoms: _____

_____

_____

_____

To: Attorney_____

_____

_____

Re: _____ File #/DACC: _____

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, progress, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Patient's Signature: _____
Street Address: _____
City/State/Zip: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor above.

Dated: _____ Attorney's Signature: _____

Attorney: Please date, sign and return one copy to the doctor's office.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Patient's Signature: _____
Date: _____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:
-Broken bones -Burns or frostbite (physical therapy) -No improvement of symptoms or pain
-Dislocations -Worsening/aggravation of spinal conditions -Infection (Acupuncture)
Sprains/strains - Increased symptoms and pain -Punctured lung (Acupuncture)

In rare cases, there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: _____
_____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by patient:	*To be completed by patient's representative*
_____	_____
Print name	*Print name of patient*
_____*Date:*_____	_____
Signature of patient	*Sign name of patient's representative and relationship*

To be completed by doctor or staff:

Witness to patient's signature: _____Sign:_____ Date:_____

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 Richard G. Lendino, D.C.

(Print patient's name)

(Assignee") 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 to the contrary.

(Print accident date)

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 FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAWENFORCEMENT AGENCT, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND WILL 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)

Richard G. Lendino, D.C _____

(Name of Provider) (Signature of Provider)

_____ _____

(Date of Signature)

_____

(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

Richard G. Lendino, D.C.
120 W. Old Country Road
Hicksville, NY 11801

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 carryout 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 protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are 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, your protected health information may be provided to a 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, employee review, training of medical students, licensing, fundraising, 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 your 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. 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 diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under 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 the 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

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply)

Under federal law, however, you may not inspect or copy the following records. Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality. 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 and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications*- You have the right to request confidential communication 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 have the right to request an amendment to 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*- You have the right to receive an accounting of all disclosures except for disclosures : pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.*

You have the right to obtain a paper copy of this *notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.*

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 Compliance Officer of your complaint. ***We will not retaliate against you for filing a complaint.***

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. We are also required to abide by the terms of this notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the "Acknowledgement of Receipt" shown below. You are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____