WELCOME

Suburban Chiropractic Associates

Patient Information

Today's Date: _____

Soc. Sec. #: _____

Patient Name: _____
Last

_____
First Middle Initial

Address: _____

City: _____

State: _____ Zip: _____

E-Mail: _____

Date of Birth: _____

() Male () Female Age: _____

() Married () Single () Widowed () Divorced () Separated

() Minor () Partnered for _____Years

Home Phone: ( ) _____

Cell Phone: ( ) _____

Employer: _____

Employer Phone: ( ) _____

Employer Address: _____

Occupation: _____

Spouse's Name: _____

Spouse's Date of Birth: _____

Insurance Information

Who is responsible for this account? _____

Relationship to Patient: _____

Ins. Co. _____

Policy Number: _____

Group #: _____

Subscriber (Policy Holder) Info if it is not You

Name: _____

D.O.B. _____ SS#: _____

Address: _____

Primary Care Physician (PCP): _____

PCP Address: _____

Is Patient Covered By Additional Insurance? () Yes () No

In Event Of Emergency

Who Should We Contact? _____

Relation: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Accident Information

Is Condition Due To An Accident? () Yes () NO Date: _____ Type of Accident: () Auto () Work () Home () Other

Did You Report Your Accident? () Yes () No If Yes, To Whom? () Auto Ins () Employer () Worker Comp () Other

Attorney Name (If Applicable): _____

Reason For Visit

Reason for your visit: _____

When did your symptoms appear? _____

Is this condition getting better or worse? () Yes () NO Is the pain constant or come and go? _____

Does the pain interfere with your () Work () Daily Routine () Recreation () Sleep

Type of Pain: () Sharp () Dull () Throb () Ache () Numb () Tingle () Shooting () Pinch () Pressure

Where is the pain? _____ Pain Level 0 (No Pain) to 10 (Worst Pain Ever) _____

Assignment And Release

I certify that I, and/or my dependent(s), have insurance coverage with (Ins Co)_____ and assign directly to Dr. Acquisto all 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 authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

Signature of Patient/Guardian _____ **Relationship to Patient** _____

Date _____ **Print name of Guardian** _____

HABITS: **Suburban Chiropractic Associates**

Did/Do you smoke? Y / N _____
Did/Do you drink alcohol? Y / N _____
Exercise Regularly? Y / N _____
Eye Problems? Y / N _____
High Stress Levels? Y / N _____
Have you been in any accidents/trauma? Y / N _____
Sports Injuries? Y / N _____
Do you sleep well, hours of sleep? Y / N _____

Name & address of doctors who have treated you: _____

What activities make condition feel better? _____
What activities make condition feel worse? _____

WORK ACTIVITY:

() Sitting () Standing () Light Labor () Heavy Labor

FEMALE ONLY:

Are You Pregnant? () Yes () No Due Date: _____

INJURIES/SURGERIES You Have Had	**Description**	**Date**
Falls	_____	_____
Broken Bones	_____	_____
Head Injuries	_____	_____
Surgeries	_____	_____

Please Mark Any Of The Following Conditions You Have Now Or Have Had In The Past:

AIDS/HIV	()	Cataracts	()	High Cholesterol	()	Headache	()
Alcoholism	()	Chicken Pox	()	Kidney Disease	()	Psychiatric Care	()
Allergy Shots	()	Diabetes	()	Liver Disease	()	Rheumatic Fever	()
Anemia	()	Emphysema	()	Measles	()	Stroke	()
Appendicitis	()	Fractures	()	Multiple Sclerosis	()	Tuberculosis	()
Arthritis	()	Glaucoma	()	Osteoporosis	()	Tumors/Growths	()
Asthma	()	Gout	()	Pacemaker	()	Ulcers	()
Bleeding Disorder	()	Heart Disease	()	Parkinson's	()	SexuallyTransmitted Infxn	()
Bowel/Bladder	()	Hepatitis	()	Polio	()	Thyroid	()
Bronchitis	()	Hernia	()	Prostate Problem	()	High Blood Pressure	()
Cancer	()	Herniated Disc	()	Prosthesis	()	Miscarriage	()
Epilepsy	()	Herpes	()	Eating Disorders	()		
Rheumatoid Arthritis	()	Pneumonia	()	Other:_____			

MEDICATIONS

_____ _____ _____ _____ _____

VITAMINS

_____ _____ _____ _____ _____

ALLERGIES:

_____ _____ _____ _____ _____

FAMILY HISTORY ___ Auto-immune Disorder ____Cancer ____Diabetes ____G.I. ____High Blood Pressure ___Heart Disease ___Kidney Disease ___Lung Disease ____Seizure Disorder ____Stroke ____Thyroid Disorder _____Other: _____

Patient Name: _____ ***Signature:*** _____ ***Date:*** _____

Authorization to Call, Text, E-mail

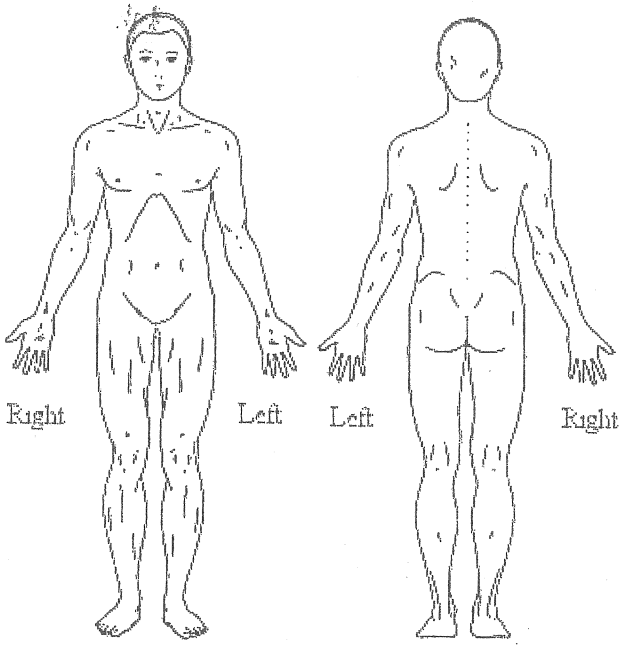
I authorize the office and the doctors of Suburban Chiropractic Associates to contact all phone numbers, including text messages and email addresses listed on file. In addition, I am requesting appointment reminder calls or other non-personal matters to be sent via text/email to the following:

PRINTED PATIENT NAME: _____
TEXT: Cell Phone: ( )_____ Cell Phone Carrier: _____
E-mail Address: _____

_____ I choose not to be contacted by _____Email, _____ TEXT, or _____email/text. I may withdraw this authorization at anytime by submitting in a request in writing to this office.

Patient Name _____

Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
Using the symbols below, mark on the pictures where you feel pain.



Numbness N

Dull Ache A

Burning B

Sharp/Stabbing S

Pins, Needles P

Other _____ O

Please circle the appropriate number that corresponds to the pain level that you are **CURRENTLY** experiencing.

1. My pain when it is at its worst is:

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

2. My pain when it is at its least is:

   No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

3. My average pain level is:

   No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient
Signature_____Date_____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

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

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

I, _____, ("Assignor") hereby assign to, Christopher J. Acquisto, D.C., ("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 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 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)

Christopher J. Acquisto, D.C. _____
(Print Name of Provider) (Signature of Provider)

2577 Sheridan Dr.
Tonawanda, NY 14150 _____
(Address of Provider) (Date or Signature)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

(This form is NOT for verification of hospital treatment)

Name and Address of Insurer or Self-Insurer	Name, Address & Phone Number of Insurer's Claims Representative

Date	Policyholder	Policy No.	Date of Accident	Claim Number

Provider's Name and Address

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. Patient's Name and Address

2. Date of Birth	3. Sex	4. Occupation (if known)

5. Diagnosis and Concurrent Conditions:

6. When did symptoms first appear?
Date:_____

7. When did patient first consult you for this condition? Date _____:

8. Has patient ever had same or similar condition? ☐ Yes ☐ No IF "YES", state when and describe:

9. Is condition solely a result of this automobile accident? ☐ Yes ☐ No IF "NO", explain:

10. Is condition due to injury arising out of patient's employment? ☐ Yes ☐ No

11. Will injury result in significant disfigurement or permanent disability?
☐ Yes ☐ No ☐ Not determinable at this time
If "Yes", describe:

12. Patient was disabled (unable to work)
From _____ Through _____

13. If still disabled the patient should be able to return to work on : _____
(DATE)

14. Will the patient require rehabilitation and/or occupational therapy as a result of the injuries sustained in this accident? ☐ Yes ☐ No
If "Yes", describe your recommendation below:

CONTINUED ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

(Page 2)

15. REPORT OF SERVICES RENDERED - ATTACH ADDITIONAL SHEETS IF NECESSARY

Date of Service	Place of Service Including Zip Code	Description of Treatment or Health Service Rendered	Fee Schedule Treatment Code	Charges
			TOTAL CHARGES TO DATE $	

16. If treating provider is different than billing provider complete the following:

Treating Provider's Name	Title	License or Certification No.	Business Relationship Check Applicable Box		
			Employee	Independent Contractor	Other (Specify)

17. If the provider of service is a professional service corporation or doing business under an assumed name (DBA), list the owner and professional licensing credentials of all owners (Provide an additional attachment if necessary).

18. Is patient still under your care for this condition? ☐ Yes ☐ No

19. Estimated duration of future treatment

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____**(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN ITEM #21)**

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME_____ SIGNED_____

PATIENT PATIENT DATE

PATIENT: Your health provider may agree to have you assign you right to no-fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in #21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____**(IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)**

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE 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, NOTWITHSTANDING ANY OTHER AGREEMENT 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.

PRINT NAME :_____ SIGNED:_____

PATIENT (ASSIGNOR) PATIENT DATE

PRINT NAME:_____ SIGNED:_____

PROVIDER OF HEALTH CARE SERVICE (ASSIGNEE) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

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.

Date	Provider's Signature	IRS/TIN Identification No.	WCB Rating Code If None, Specialty

Suburban Chiropractic Associates
2577 Sheridan Drive
Tonawanda, NY 14150
Ph: 716-874-2040 Fax: 716-832-0124

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: _____

Date of Birth: _____

Patient Address: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form to Dr. Acquisto and/or Suburban Chiropractic Associates:

[ ] Re-evaluation Reports: _____

[ ] Imaging Reports: _____

[ ] Test Results: _____

[ ] Medical Records From: _____ To: _____

[ ] Other: _____

AUTHORIZATION TO DISCUSS HEALTH INFORMATION:

* By initialing here, _____, I authorize Dr. Acquisto and/or Suburban Chiropractic Associates
Initials
To discuss my health information with the following checked individuals:

[ ] Primary Doctor: _____

[ ] Family Members: _____

[ ] Attorney: _____

[ ] Specialists: _____

[ ] Other: _____

_____ _____
Signature of patient or representative authorized by law. *Date*