

FIRST NAME _____ M.I. _____ LAST NAME _____

PREFERRED TO BE CALLED _____ DATE OF BIRTH _____ SSN _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ WORK # _____ CELL # _____

YOUR OCCUPATION _____ REFERRED BY _____

YOUR EMPLOYER _____ NAME OF SPOUSE _____

IF YOU ARE NOT RETIRED, A HOMEMAKER, OR A STUDENT, WHAT IS YOUR CURRENT WORK STATUS? FULL-TIME SELF-EMPLOYED OFF WORK PART-TIME UNEMPLOYED OTHER

IS THIS A GENERAL CHECK-UP/WELL VISIT? YES NO
IS THIS YOUR FIRST CHIROPRACTIC VISIT? YES NO
WOMEN: ARE YOU PREGNANT? YES NO
LAST PHYSICAL EXAM _____
DUE DATE _____

1. WHAT IS YOUR MAJOR COMPLAINT? _____
2. WHEN DID YOUR SYMPTOMS START? _____ 3. DESCRIBE YOUR SYMPTOMS AND HOW THEY BEGAN: _____

4. HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS? 5. INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS ↓

- CONSTANTLY (76-100% OF THE DAY)
- FREQUENTLY (51-75% OF THE DAY)
- OCCASIONALLY (26-50% OF THE DAY)
- INTERMITTENTLY (0-25% OF THE DAY)

6. WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?

- SHARP SHOOTING
- DULL ACHE BURNING
- NUMB TINGLING

7. HOW ARE YOUR SYMPTOMS CHANGING?

- GETTING BETTER
- NOT CHANGING
- GETTING WORSE

8. HOW BAD ARE YOUR SYMPTOMS AT THEIR:

	NONE										UNBEARABLE		
A. WORST:	0	1	2	3	4	5	6	7	8	9	10		
B. BEST:	0	1	2	3	4	5	6	7	8	9	10		

9. HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? YES NO

- A. IF SO, WHO DID YOU SEE? THIS OFFICE MEDICAL DOCTOR OTHER
 OTHE CHIROPRACTOR PHYSICAL THERAPIST

10. WHAT ACTIVITIES MAKE YOUR SYMPTOMS WORSE? _____

11. WHAT ACTIVITIES MAKE YOUR SYMPTOMS BETTER? _____

12. WHO HAVE YOU SEEN FOR YOUR SYMPTOMS? _____

- NO ONE MEDICAL DOCTOR OTHER
- OTHER CHIROPRACTOR PHYSICAL THERAPIST

A. WHEN AND WHAT TREATMENT? _____

B. WHAT TESTS HAVE YOU HAD FOR YOUR SYMPTOMS AND WHEN WERE THEY PERFORMED?

- XRAYS DATE _____ CT SCAN DATE _____
- MRI DATE _____ OTHER _____ DATE _____

13. WHAT DO YOU HOPE TO GET FROM YOUR VISIT/TREATMENT? (SELECT ALL THAT APPLY)

- REDUCE SYMPTOMS EXPLANATION OF CONDITION/TREATMENT RESUME/INCREASE ACTIVITY
- HOW TO PREVENT THIS FROM OCCURRING AGAIN LEARN HOW TO TAKE CARE OF THIS ON MY OWN

PATIENT SIGNATURE _____ DATE _____
PARENT/GUARDIAN SIGNATURE _____ DATE _____

----- OFFICE USE ONLY -----

INS: CASH WC PI PRIVATE INS 1ST _____ 2ND _____

Adirondack Family Chiropractic, P.C.

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 and 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.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

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 a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. 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 of those findings, we will recommend that you seek the advice of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read
(print name)

and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

ADIRONDACK FAMILY CHIROPRACTIC, P.C.

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.

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. governmental regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Julie Shiflett, Office Manager is in charge of privacy matters at our office. You can contact her at (518)-561-6004 if you desire further information, or have any questions or concerns.

Use and disclosure of protected information.

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. We will disclose PHI to other physicians who may be treating you, your PHI may be provided to a physician to whom you have been referred to insure that the physician has the necessary information to diagnosis or treat you.

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. Most health plans require us to supply diagnosis and treatment codes and description of services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. We may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. required by law;
2. required for public health purposes;
3. required by law to report child abuse;
4. required by a health oversight agency for oversight activities authorized by law, such as Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. required by law in judicial or administrative proceedings;
6. required for law enforcement purposes by a law enforcement official;
7. required by a coroner or medical examiner;
8. permitted by law to a funeral director;
9. permitted by law for organ donation purposes;
10. permitted by law to avert a serious threat to health or safety;
11. permitted by law and required by military authorities if you are a member of the armed forces of the United States.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communication with you in a confidential manner. Space for this provided below.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have.

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the request amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payments or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR-164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Julie Shiflett, Office Manager, 1942 Military Turnpike, Plattsburgh, New York 12901, (518) 561-6004.

No retaliatory action can be taken against you for any complaint you make.

I have received a paper copy of this notice.

I do not wish to receive a paper copy of this notice at this time.

Signature: _____

Date: _____

Print Name: _____

I make the following special request for confidential communications:

Signature: _____

Date: _____

ADIRONDACK FAMILY CHIROPRACTIC

WORKERS COMPENSATION/NO-FAULT HISTORY

PATIENT NAME: _____ PHONE: (_____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DOB: _____ AGE: _____ SEX: M / F SSN: _____

EMPLOYER'S NAME: _____ PHONE: (_____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

1. YOUR OCCUPATION: _____ TYPE OF BUSINESS: _____

2. DATE OF INJURY/ACCIDENT: _____ TIME: _____: _____ AM / PM STATE: _____

3. ARE YOU STILL WORKING? () YES () NO (IF YES) () FULL DUTY OR () WITH RESTRICTIONS
(IF NO) DATE LAST WORKED: _____

4. IN YOUR OWN WORDS, PLEASE FULLY DESCRIBE THE INJURY/ACCIDENT: _____

5. HAS ANOTHER DOCTOR FOR THIS ACCIDENT (INCLUDING PHYSICAL THERAPIST) TREATED YOU? () YES () NO

(IF YES) PLEASE GIVE DOCTOR'S NAME: _____

6. IS THIS DOCTOR STILL TREATING YOU? () YES () NO ARE YOU: () IMPROVING () UNCHANGED () WORSE

7. ARE YOU TAKING ANY MEDICATIONS? () YES () NO DO THEY HELP? () YES () NO

8. PRIOR TO THIS ACCIDENT, HAVE YOU HAD ANY OF THE PHYSICAL COMPLAINTS SIMILAR TO WHAT YOU HAVE NOW? () YES () NO

(IF YES) DESCRIBE: _____

9. WERE THESE SIMILAR COMPLAINTS THE RESULTS OF A PREVIOUS ACCIDENT(S)? () YES () NO

(IF YES) PLEASE PROVIDE DETAILS OF PREVIOUS ACCIDENT(S): _____

10. HAVE YOU HAD ANY PROBLEMS WITH NERVES OR MENTAL ILLNESSES? () YES () NO

(IF YES) HAVE YOU HAD PSYCHIATRIC CARE? () YES () NO

11. HAVE YOU RECEIVED A MEDICAL DISCHARGE FROM THE ARMED FORCES? () YES () NO

MEDICAL COMPLAINTS PERTAINING TO INJURY/ACCIDENT ONLY

BACK PAIN

- | | | | | |
|--|--------|---------------|---------------------|----------------|
| 1. CURRENTLY, I HAVE PAIN IN MY: | () NA | () LOW BACK | () MID BACK | () UPPER BACK |
| 2. MY PAIN BEGAN: | () NA | () GRADUALLY | () SUDDENLY | |
| 3. I HAVE PAIN: | () NA | () SOMETIMES | () ALL OF THE TIME | |
| 4. MY PAIN GOES INTO MY: | () NA | () RIGHT LEG | () LEFT LEG | () BOTH |
| 5. I HAVE TINGLING AND/OR
NUMBNESS IN MY: | () NA | () RIGHT LEG | () LEFT LEG | () BOTH |
| 6. MY PAIN IS WORSE WHEN I : | | | | |
| COUGH OR SNEEZE | () NA | () YES | () NO | |
| SIT | () NA | () YES | () NO | |
| BEND | () NA | () YES | () NO | |
| WALK | () NA | () YES | () NO | |
| LIFT | () NA | () YES | () NO | |
| PUSH | () NA | () YES | () NO | |
| PULL | () NA | () YES | () NO | |
| 7. MY BACK IS WORSE WITH
SEXUAL ACTIVITY: | () NA | () YES | () NO | |

TURN PAGE OVER →

NECK PAIN

- 1. MY NECK PAIN BEGAN: NA GRADUALLY SUDDENLY
- 2. I HAVE PAIN: NA SOMETIMES ALL OF THE TIME
- 3. MY PAIN GOES INTO MY: NA RIGHT ARM LEFT ARM BOTH
- 4. I HAVE TINGLING AND/OR
 NUMBNESS IN MY: NA RIGHT ARM LEFT ARM BOTH
- 5. MY PAIN IS WORSE WHEN I:
 - COUGH OR SNEEZE NA YES NO
 - BEND FORWARD NA YES NO
 - LIFT NA YES NO
 - PUSH NA YES NO
 - PULL NA YES NO
 - TURN MY HEAD NA YES NO
- 6. I HAVE NECK STIFFNESS: NA YES NO
- 7. I HAVE HEADACHES: NA YES NO
- 8. IF I DO GET HEADACHES, THEY OCCUR: SOMETIMES ALL OF THE TIME
- 9. DOES YOUR PAIN WAKE YOU DURING THE NIGHT? YES NO

JOB DESCRIPTION

1. IN A TYPICAL 8-HOUR WORKDAY, I: (CIRCLE NUMBER OF HOURS FOR EACH ACTIVITY)

SIT:	1	2	3	4	5	6	7	8	HOURS
STAND:	1	2	3	4	5	6	7	8	HOURS
WALK:	1	2	3	4	5	6	7	8	HOURS

<i>IN TERMS OF AN 8-HOUR WORKDAY</i>	<i>"OCCASIONALLY"</i>	<i>MEANS</i>	<i>33%</i>	<i>OF THE DAY</i>
	<i>"FREQUENTLY"</i>	<i>MEANS</i>	<i>34% TO 66%</i>	<i>OF THE DAY</i>
	<i>"CONTINUOUSLY"</i>	<i>MEANS</i>	<i>67% TO 100%</i>	<i>OF THE DAY</i>

2. ON THE JOB, I PERFORM THE FOLLOWING ACTIVITIES:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
BEND/STOOP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SQUAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CRAWL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLIMB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REACH ABOVE SHOULDER LEVEL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CROUCH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KNEEL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BALANCING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PUSHING/PULLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. ON THE JOB, I LIFT:

UP TO 10 POUNDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 TO 24 POUNDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 TO 34 POUNDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 TO 50 POUNDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 TO 74 POUNDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 TO 100 POUNDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 4. DO YOU HAVE TO BEND OVER WHILE DOING ANY LIFTING? YES NO
- 5. ARE YOUR FEET USED FOR REPETITIVE MOVENTS, SUCH AS IN OPERATING FOOT CONTROLS? YES NO
- 6. DO YOU USE YOUR HANDS FOR REPETITIVE ACTIONS, SUCH AS:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATION
RIGHT HAND	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
LEFT HAND	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

7. ARE YOU REQUIRED TO WORK ON UNPROTECTED HEIGHTS? YES NO

DESCRIBE: _____

8. ARE YOU REQUIRED TO BE AROUND MOVING MACHINERY? YES NO

DESCRIBE: _____

9. ARE YOU EXPOSED TO MARKED CHANGES IN TEMPERATURE AND HUMIDITY? () YES () NO

DESCRIBE: _____

10. ARE YOU REQUIRED TO DRIVE AUTOMOTIVE EQUIPMENT? () YES () NO

DESCRIBE: _____

11. ARE YOU EXPOSED TO DUST, FUMES AND/OR GASES? () YES () NO

DESCRIBE: _____

PLEASE LIST ANY ADDITIONAL COMMENTS RELATED TO YOUR CONDITION: _____

IF YOU RECEIVE ANY INFORMATION PERTAINING TO YOUR WORKERS COMPENSATION/NO-FAULT ACCIDENT (FOR EXAMPLE: LETTERS, PHONE CALLS, E-MAILS, ETC.) YOU WILL NEED TO BRING IT TO THE ATTENTION OF THIS OFFICE!!!

THIS SECTION IS FOR WORKERS COMPENSATION ONLY!!!
AFTER COMPLETING THIS SECTION PLEASE SIGN AND DATE THE BOTTOM OF THIS PAGE.

NAME OF COMPENSATION CARRIER: _____ PHONE: (____) _____

ADDRESS OF CARRIER: _____ CITY: _____ STATE: _____ ZIP: _____

1. ACCIDENT REPORTED TO EMPLOYER? () YES () NO NAME OF PERSON REPORTED ACCIDENT TO: _____

2. INJURED AT: _____ CITY: _____ STATE: _____ ZIP: _____

3. LENGTH OF TIME WORKED PRIOR TO ACCIDENT: _____

4. PREVIOUS WORKERS COMPENSATION INJURY? () YES () NO

*****ATTENTION ALL WORKERS' COMPENSATION PATIENTS!*****

IF ANY CORRESPONDENCE CONCERNING YOUR WORKERS' COMPENSATION CONDITION IS NEEDED FOR ANY OF THE FOLLOWING REASONS:

- COURT HEARINGS
- INDEPENDENT MEDICAL EXAMS
- TRAVEL DATES (\$6.00 CHARGE)
- ATTORNEY REQUEST FOR RECORDS
- DISABILITY FORMS (\$10.00 CHARGE)
- SPECIAL LETTERS (\$5.00-\$10.00 CHARGE)

THIS OFFICE REQUESTS AT LEAST FIVE BUSINESS DAYS NOTIFICATION TO MEET YOUR REQUESTS.

SIGNATURE: _____ DATE: _____

THIS SECTION IS FOR NO-FAULT ONLY!!!
AFTER COMPLETING THIS SECTION PLEASE SIGN AND DATE THE BOTTOM OF THIS PAGE.

VEHICLE INFORMATION: 1. MAKE & MODEL OF VEHICLE: _____

2. WHOS NAME IS VEHICLE INSURED TO? _____

3. INSURANCE AGENT'S NAME: _____ PHONE (____) _____

*****ATTENTION ALL NO-FAULT PATIENTS!*****

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY THE APPROPRIATE INSURANCE COMPANY IMMEDIATELY FOLLOWING AN ACCIDENT. AFTER WE HAVE VERIFIED THE NO-FAULT BENEFITS WE WILL BE HAPPY TO SUBMIT ON THE PATIENT'S BEHALF. HOWEVER, AT ALL TIMES, THE PATIENT REMAINS RESPONSIBLE FC THE ACCOUNT BALANCE.

*****PLEASE NOTE THAT NEW YORK STATE IS A NO-FAULT STATE*****

ALL MEDICAL BENEFITS ARE PAID THROUGH THE INSURANCE POLICY OF THE OWNER OF THE VEHICLE YOU ARE RIDING IN AT TIME OF ACCIDENT.

TURN PAGE OVER →

ADIRONDACK FAMILY CHIROPRACTIC

WORKERS' COMPENSATION AND NO-FAULT PATIENTS PLEASE READ THEN SIGN AND DATE

ASSIGNMENT OF RELEASE OF INFORMATION STATEMENTS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION BY ADIRONDACK FAMILY CHIROPRACTIC.

I HEREBY AUTHORIZE AND DIRECT THE ABOVE NAMED, HAVING TREATED ME, TO RELEASE TO GOVERNMENT AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY CHIROPRACTIC CARE, ALL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT FOR SUCH CARE AND TO PERMIT REPRESENTATIVE THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATING TO SUCH CARE AND TREATMENT.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

ASSIGNMENT TO ADDIRONDACK FAMILY CHIROPRACTIC.

I HEREBY ASSIGN, TRANSFER, AND SET OVER TO THE ABOVE NAMED SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY CHIROPRACTIC CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OF MY DEPENDENT IN SAID OFFICE.

SIGNATURE OF INSURED OR AUTHORIZED REPRESENTATIVE

DATE

ADIRONDACK FAMILY CHIROPRACTIC

NO-FAULT PATIENTS READ THEN SIGN AND DATE

CHIROPRACTIC REPORTS AND DOCTOR'S LIEN

I DO HEREBY AUTHORIZE THE DOCTOR NAMED BELOW TO FURNISH YOU, MY ATTORNEY, WITH A FULL REPORT OF EXAMINATION, CARE, ETC., I RECEIVED IN REGARD TO ACCIDENT IN THAT 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/HER FOR CHIROPRACTIC SERVICE RENDERED ME BOTH BY REASON OF THIS ACCIDENT AND BY REASON OF ANY OTHER BILLS THAT ARE DUE HIS/HER OFFICE, EXCEPT TO THE ENTENT LIMITED BY LAW, AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT, OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID DOCTOR.

AND I HEREBY FURTHER GIVE A LIEN ON MY CASE TO YOU, MY ATTORNEY, OR MYSELF AS THE RESULT OF THE UNJURIES FOR WHICH I HAVE RECEIVED CARE OF INJURIES IN CONNECTION THEREWITH.

I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO SAID DOCTOR FOR ALL CHIROPRACTIC BILLS SUBMITTED BY SAID DOCTOR FOR SERVICE RENDERED ME AND THAT THIS AGREEMENT IS MADE SOLEY FOR SAID DOCTOR'S ADDITIONAL PROTECTION AND IN CONSIDERATION OF THE DOCTOR'S AWAITING PAYMENT.

I UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGEMENT, OR VERDICT BY WHICH I MAY EVENTUALLY RECOVER SAID FEE.

PLEASE ACKNOWLEDGE THIS LETTER BY SIGNING BELOW AND RETURNING TO THE DOCTOR'S OFFICE. I HAVE BEEN ADVISED THAT IF YOU, MY ATTORNEY, DO NOT WISH TO COOPERATE IN PROTECTING THE DOCTOR'S INTEREST, THE DOCTOR AGREES TO WAIT FOR PAYMENT BUT WILL REQUIRE ME TO PAY ON MY ACCOUNT AND KEEP IT ON A CURRENT BASIS.

THE UNDERSIGNED, BEING ATTORNEY OF RECORD FOR THE BELOW PATIENT, DOES HEREBY AGREE TO OBSERVE ALL THE TERMS OF ABOVE AND AGREES TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT THE DOCTOR NAMED BELOW.

_____	_____
PATIENT'S NAME	ATTORNEY'S NAME
_____	_____
PATIENT'S SIGNATURE	ATTORNEY'S SIGNATURE
_____	_____
DATE	DATE

PLEASE SIGN, DATE, AND RETURN ONE COPY TO THE OFFICE OF THE DOCTOR NAMED BELOW. KEEP ONE COPY FOR YOUR RECORDS. A PHOTOCOPY OF THIS FORM SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

JOSEPH J. CLAUSS, D.C.

CAROLYN F. CLAUSS, D.C.

ADIRONDACK FAMILY CHIROPRACTIC, P.C.
1942 MILITARY TURNPIKE
P.O. BOX 3046
PLATTSBURGH, NY 12901
(518) 561-6004

**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, Adirondack Family Chiropractic, P.C., ("Assignee")
(Print patient's name) (Print hospital or health care provider name)

All rights privileges and remedies to which I am entitled under article 51 (the No-Fault Provisions) 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 service provided to said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any prior written agreement to the contrary.
(Print accident date)

This agreement shall become null and void if at any time it is determined that benefits are not payable due to the following circumstances: lack of coverage, violation of a policy condition, or determination that the treatments/services rendered are not related to said motor vehicle accident.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATIONS.

(Print Name of Patient)

(Signature of Patient)

(Date of Signature)

(Address)

Adirondack Family Chiropractic, P.C.
1942 Military Turnpike
P.O. Box 3046
Plattsburgh, NY 12901
(518) 561-6004

(Signature of Provider)

(Date of Signature)