Brian Yodice D.C., P.C.
1230 Mamaroneck Ave., Suite 200A
White Plains, NY 10605
P: 914-600-3222

Patient Information

Name: _____ **Date:** _____

Address: _____

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

Cell: _____ **Home:**_____ **Email:**_____

Birth Date: _____ **Sex:** _____ **Status:** Single Married Other _____

Social Security Number (For Workers' Comp Only): _____

Referred by: _____

Employment Information

Status: Employed Retired Student

Occupation: _____ **Employer:** _____

Address: _____

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

Primary Insurance Information

Subscriber's Name:_____ **Subscriber's Date of Birth:** _____

Relationship to Insured: _____

Insurance Company: _____

Insured ID#: _____

Phone Number: _____

Secondary Insurance Information

Subscriber's Name:_____ **Subscriber's Date of Birth:** _____

Relationship to Insured: _____

Insurance Company: _____

Insured ID#: _____

Phone Number: _____

Brian Yodice D.C., P.C.
1230 Mamaroneck Ave., Suite 200A
White Plains, NY 10605
P: 914-600-3222

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT & OFFICE POLICY

We ask that you please keep your appointments and be on time. Your improvement is dependent on how well you maintain your treatment.

Missed Appointment Policy: Our doctors and staff want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen**. As of January 1, 2019, there may be a fee of $25.00 assessed if we do not receive a call to cancel an appointment within 24 hours of the scheduled time.**

Financial Agreement: The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Brian Yodice D.C., P.C. if I belong to a plan that is not on their list of contacts. I agree that in return for the services provided to the patient by Brian Yodice D.C., P.C., I will pay my account at the time the service is rendered or will make financial arrangements satisfactory to Brian Yodice D.C., P.C. for this payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that is my account is delinquent, I may be charged interest at any legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Brian Yodice D.C., P.C. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Brian Yodice D.C., P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Non-Covered Services: I understand that Brian Yodice D.C., P.C. contracts with health care service plans (i.e., HMO's, PPO's) related only to items and services which are "covered" by the health care service plan. Accordingly, the undersigned accepts full financial responsibility for all items and services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Brian Yodice D.C., P.C. to obtain necessary health care service plan authorizations.

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:
Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the follow circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- If you are a member of DMPO (Discount Medical Plan Organization) we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients.
- If you are eligible & choose a pre-payment pan, auto-debit plan or "prompt payment" option.
- Patients who meet state and, or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of January 1, 2019 our office will be unable to extend any type of discounts other than those listed above.

Acknowledged By: _____ **Date:** _____

Brian Yodice D.C., P.C.
1230 Mamaroneck Ave., Suite 200A
White Plains, NY 10605
P: 914-600-3222

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name (Parent/Guardian) _____ Signature: _____ Date:_____

Witness Name: _____ Signature: _____Date:_____

Brian Yodice D.C., P.C.
1230 Mamaroneck Ave., Suite 200A
White Plains, NY 10605
P: 914-600-3222

Current Condition:

Reason for your visit:

_____

_____

_____

_____

When did your symptoms appear? _____

Is the condition getting worse? _____ Getting better? _____ Staying the same? _____

Rate the severity of your pain on a scale of 1 (least pain) to 10 (most severe pain): _____

Type of pain:

( ) Sharp ( ) Dull ( ) Throbbing ( ) Numbness ( ) Aching ( ) Shooting

( ) Burning ( ) Tingling ( ) Cramps ( ) Stiffness ( ) Swelling ( ) Other

How often do you have this pain?

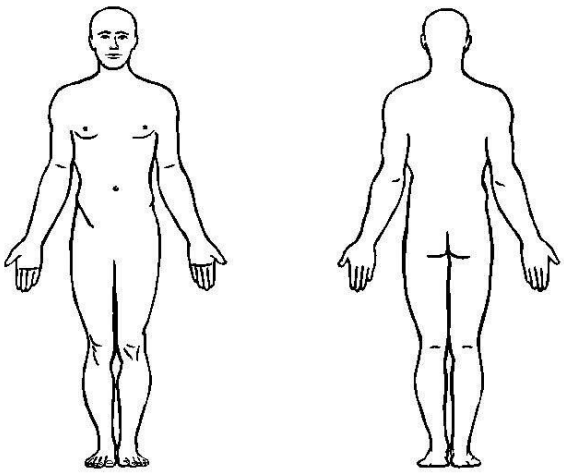
( ) Constantly, 76-100% of the time ( ) Frequently, 51-75% of the time

( ) Occasionally, 26-50% of the time ( ) Intermittently, 0-25% of the time

Does it interfere with your ( ) work ( ) Sleep ( ) Recreation ( ) Exercise ( ) Daily Routine

Activities/movements that are painful to perform ( ) Sitting( ) Standing ( )Walking ( ) Bending ( ) Lying Down

Please use an "x" to mark areas where you have pain, numbness or tingling:



Brian Yodice D.C., P.C.
1230 Mamaroneck Ave., Suite 200A
White Plains, NY 10605
P: 914-600-3222

Health History:

What treatment have you already received for your condition? ( ) Medical Doctor ( ) Medications ( ) Physical Therapy
( ) Acupuncture ( ) Massage Therapy ( ) Chiropractic ( ) None ( ) Other _____

Date of last: Physical Exam: _____ Spinal Exam: _____

Spinal X-ray: _____ Chest X-ray: _____ Dental X-ray: _____

Blood test: _____ Urine Test: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	( )Yes	( )No	Diabetes	( )Yes	( )No	Liver Disease	( )Yes	( )No	Rheumatoid Arthritis	( )Yes ( )No
Alcoholism	( )Yes	( )No	Emphysema	( )Yes	( )No	Measles	( )Yes	( )No	Rheumatic Fever	( )Yes ( )No
Allergy Shots	( )Yes	( )No	Epilepsy	( )Yes	( )No	Migraine Headaches	( )Yes	( )No	Scarlet Fever	( )Yes ( )No
Anemia	( )Yes	( )No	Fractures	( )Yes	( )No	Miscarriage	( )Yes	( )No	STD's	( )Yes ( )No
Anorexia	( )Yes	( )No	Glaucoma	( )Yes	( )No	Mononucleosis	( )Yes	( )No	Stroke	( )Yes ( )No
Appendicitis	( )Yes	( )No	Goiter	( )Yes	( )No	Multiple Sclerosis	( )Yes	( )No	Suicide Attempt	( )Yes ( )No
Arthritis	( )Yes	( )No	Gonorrhea	( )Yes	( )No	Mumps	( )Yes	( )No	Thyroid Problems	( )Yes ( )No
Asthma	( )Yes	( )No	Gout	( )Yes	( )No	Osteoporosis	( )Yes	( )No	Tonsillitis	( )Yes ( )No
Bleeding Disorder	( )Yes	( )No	Heart Disease	( )Yes	( )No	Pacemaker	( )Yes	( )No	Tuberculosis	( )Yes ( )No
Breast Lump	( )Yes	( )No	Hepatitis	( )Yes	( )No	Parkinson's Disease	( )Yes	( )No	Tumors, Growths	( )Yes ( )No
Bronchitis	( )Yes	( )No	Hernia	( )Yes	( )No	Pinched Nerve	( )Yes	( )No	Typhoid Fever	( )Yes ( )No
Bulimia	( )Yes	( )No	Herniated Disc	( )Yes	( )No	Pneumonia	( )Yes	( )No	Ulcers	( )Yes ( )No
Cancer	( )Yes	( )No	Herpes	( )Yes	( )No	Polio	( )Yes	( )No	Vaginal Infections	( )Yes ( )No
Cataracts	( )Yes	( )No	High Blood Pressure	( )Yes	( )No	Prostate Problem	( )Yes	( )No	Whooping Cough	( )Yes ( )No

Brian Yodice D.C., P.C.
1230 Mamaroneck Ave., Suite 200A
White Plains, NY 10605
P: 914-600-3222

Chemical Dependency	( )Yes	( )No	High Cholesterol	( )Yes	( )No	Prosthesis	( )Yes	( )No	Other: _____ _____
Chicken Pox	( )Yes	( )No	Kidney Disease	( )Yes	( )No	Psychiatric Care	( )Yes	( )No	_____

Exercise:	**Work Activity:**	**Habits:**	
( ) None	( ) Sitting	( ) Smoking	Pack/Day: _____
( ) Moderate	( ) Standing	( ) Alcohol	Drinks/Week: _____
( ) Heavy	( ) Light Labor	( ) Coffee/Caffeine	Cups/Day: _____
( ) Frequency	( ) Heavy Labor	( ) High Stress Level	Reason: _____

Have you been pregnant or are you pregnant? ( ) Yes ( )No

Due Date: _____

How many times? _____

Injuries and/or surgeries:	Description	Date
Falls:	_____	_____
Head Injuries:	_____	_____
Broken Bones:	_____	_____
Dislocations:	_____	_____
Surgeries:	_____	_____

Medications: Please list all medications that you are currently taking.

_____

_____

_____

Allergies: Please list any and all allergies you have.

_____

_____

Supplements: Please list any and all Vitamins, Herbs, Minerals or other supplements you are currently taking.

_____

_____