



Welcome

TO THE SIMPLY ALIGNED FAMILY.
THANK YOU FOR TRUSTING US
WITH YOUR CARE.

Patient Info

FIRST NAME:

LAST NAME:

DATE OF BIRTH:

SEX: MALE FEMALE

PHONE NUMBER:

ADDRESS:

OCCUPATION:

- SINGLE MARRIED
 DIVORCED SEPARATED
 PARTNER WIDOWED

Coverage

TYPE:

- INSURANCE SELF-PAY/CASH
 NO-FAULT WORKER'S COMP.

ASSIGNMENT AND RELEASE:

I authorize Simply Aligned Chiropractic to release any medical or billing information necessary to process insurance claims, obtain payment, coordinate benefits, or support the administration of my care. I authorize payment of medical benefits, when applicable, to be made directly to Dr. Scott Przybyla/Simply Aligned Chiropractic for services provided. I understand that I am financially responsible for any charges not covered or paid by insurance, including but not limited to deductibles, copayments, coinsurance, non-covered services, denied claims, or balances remaining after insurance processing. I also understand that if I do not have insurance coverage, or choose not to use insurance, I am responsible for payment according to the office's self-pay policies.

PATIENT/GUARDIAN NAME:

PATIENT/GUARDIAN SIGNATURE:

Emergency Contact

NAME:

RELATIONSHIP:

PHONE:

Accidents

CONDITION BECAUSE OF AN ACCIDENT:

- YES NO

IF YES, TYPE OF ACCIDENT:

- HOME AUTO WORK SPORT

DATE OF ACCIDENT:

Patient Condition

INJURY MECHANISM/VISIT REASON:

WHEN SYMPTOMS APPEARED:

PAIN IS:

- CONSTANT FREQUENT
 OCCASSIONAL INTERMITTENT

CIRCLE YOUR TYPE(S) OF PAIN:

- | | | |
|------------|---------|-----------|
| Discomfort | Diffuse | Shooting |
| Aching | Dull | Stabbing |
| Annoying | Heavy | Stiffness |
| Burning | Numb | Throbbing |
| Cramping | Pulling | Tight |
| Deep | Sharp | Tingly |

DOES PAIN RADIATE? YES NO

IF YES, WHERE: _____

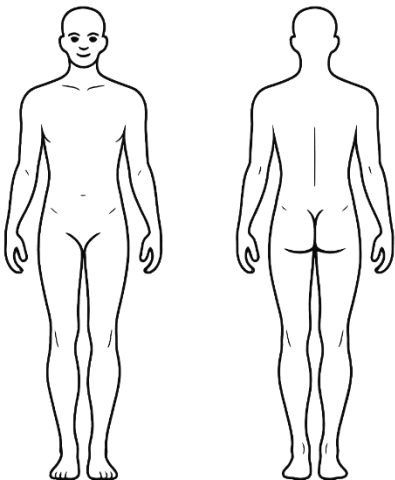
CONDITION WORSENING? YES NO

RATE PAIN 1-10 (10 WORST): _____

WHAT AGGRAVATES SYMPTOMS:

PAST TREATMENTS FOR CONDITION:

MARK YOUR AREAS OF PAIN:



Health History

DATE OF LAST...

PHYSICAL: _____

SPINAL EXAM: _____

SPINAL X-RAY: _____

DEXA/BONE DENSITY: _____

MRI/CT SCAN: _____

CIRCLE CONDITIONS YOU HAVE:

- | | | |
|---------------------|----------------------------|----------------------|
| AIDS/HIV | Alcoholism | Anemia |
| Appendicitis | Arthritis | Bleeding Disorders |
| Cancer | Cataracts | Diabetes |
| Epilepsy | Fractures | Glaucoma |
| Goiter | Gout | Heart Disease |
| Hepatitis | Hernia | Herniated Disc |
| High Blood Pressure | High Cholesterol | Kidney Disease |
| Kidney Stones | Liver Disease | Migraines |
| Multiple Sclerosis | Osteoporosis | Pacemaker |
| Parkinson's | Pinched Nerve | Pneumonia |
| Prostate Issues | Prosthesis | Rheumatoid Arthritis |
| Stroke | Thyroid Issues | Tumors |
| Ulcers | Connective Tissue Disorder | Other |

IF OTHER, PLEASE EXPLAIN:

EXERCISE LEVEL:

- NONE LIGHT MODERATE
 HEAVY DAILY

WORK ACTIVITY:

- SITTING STANDING
 LIGHT LABOR HEAVY LABOR

Pregnant?

- YES NO NOT APPLICABLE

IF YES, DUE DATE: _____

& congratulations!

Habits

SMOKING PACKS/DAY: _____
 ALCOHOL DRINKS/WEEK: _____
 HIGH STRESS REASON: _____

Medications

Previous Injuries

FALLS: _____
BROKEN BONES: _____
DISLOCATIONS: _____
HEAD INJURIES: _____

& Surgeries

Allergies

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Thank you again for choosing our practice.

Simply Aligned

CHIROPRACTIC

TREATMENT AND POLICY CONSENT

Simply Aligned Chiropractic
3445 Orchard Park Road, Orchard Park, NY 14127
Practice of Dr. Scott Przybyla

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x- rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic.

I have had the opportunity to discuss with the Doctor of Chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

APPOINTMENT POLICY

A fee of \$25 will be charged for missed appointments and those appointments cancelled without 24 hours' notice. Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feels is best for you. The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results. Regardless of how many appointments are scheduled for you each week, please keep in mind that it is the frequency of visits that count, not the days on which you receive the service.

If, for any reason, you are unable to keep an appointment, we ask that you telephone immediately to reschedule that visit. It is the patient's obligation to make up a missed appointment within 7 days of any cancellation to adhere to the appointment program designed for you. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask. Thank you for your consideration of this office policy as we are highly devoted to your health and want the best results for you.

BILLING POLICY

Our office will submit claims to participating insurance plans in accordance with applicable payer requirements. Please understand that verification of benefits is not a guarantee of payment. The patient is responsible for any deductible, copayment, coinsurance, non-covered service, denied claim, or other amount determined by the insurance carrier to be patient/member responsibility. For patients without insurance coverage, without active insurance, or for services not covered by insurance, our out-of-pocket rates are \$65 for a consultation and \$40 for each chiropractic visit thereafter. Payment is due at the time of service unless other arrangements have been made with our office.

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

Signature:

Date:

HIPAA PRIVACY NOTICE

Simply Aligned Chiropractic
3445 Orchard Park Road, Orchard Park, NY 14127
Practice of Dr. Scott Przybyla

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information.
- Give you notice of your legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you (“Health Information”). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice’s privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who participate in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who participates in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIAL SITUATIONS

As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific to our contract.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

National/Protective Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

COMPLAINTS

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

Signature:

Date:

Privacy officer: Hilary Hensley, Office Manager

Contact: (716) 674-0821