Starr Sports Chiropractic, Physical Therapy, Acupuncture. NP (Adult Health) PLLC.
853 Broadway, Suite 1105 • New York, NY 10003
Tel: (212) 614-8800 • Fax: (212) 614-8027

Name: _____ Email: _____
Phone: (Home) _____ (Mobile) _____ (Work) _____
Address: _____ City: _____ Zip: _____
Birth Date: ____/____/_____ □ Male □ Female Spouse/Parent Name: _____
# of Children: _____ □ Married □ Single □ Divorced □ Widowed
Are you Pregnant**?** □ **YES** □ **NO** **Due Date:**_____
Occupation: _____ Social Security #: _____

How were you referred to our office? _____
If from the internet, name of search engine and key words used: _____
Have you ever had Chiropractic Care before? _____ If yes, when? _____

List your chief complaints in order of severity; Check all those that describe your condition:

Complaint 1: _____ For How Long? _____
What originally caused this problem? _____

Feels Like:
□ Sharp □ Throbbing □ Shooting □ Cramps □ Stiffness □ Dull Ache □ Numb/Tingling
□ Burning □ Other: _____

Bothers Me:
□ Constant (100%) □ Frequent (50%-75%) □ Intermittent (25%-50%) □ Occasional (1%-25%)

It Has Been:
□ Getting Worse □ Staying Same □ Getting Better

Pain Scale: (0=No Pain – 10=Severe Pain)
□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

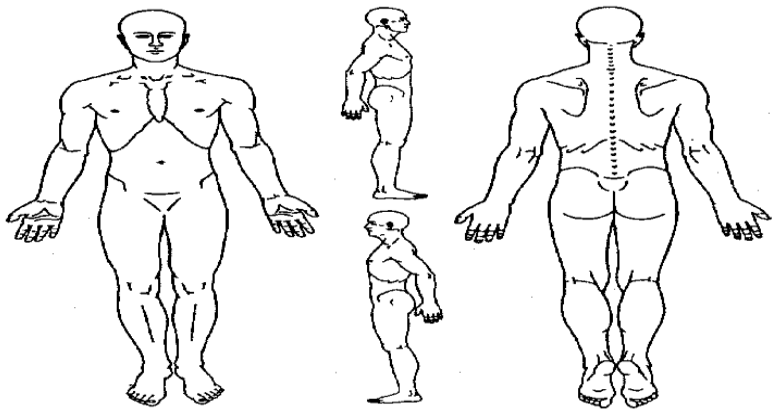
During The Day It Is:
□ Worse in the AM □ Stays the same throughout the day □ Worse in the PM

The Following Increases Pain:
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____

The Following Decreases Pain:
□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____

Does The Pain Travel/Radiate? :
□ Yes □ No If yes, where_____ to _____

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas.



Does your condition interfere with you:

Work	□ NO	□ MILD	□ MODERATE	□ SEVERE
Sleep	□ NO	□ MILD	□ MODERATE	□ SEVERE
Daily Routine	□ NO	□ MILD	□ MODERATE	□ SEVERE
Recreation	□ NO	□ MILD	□ MODERATE	□ SEVERE

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Does your condition interfere with any of the following:

□ Computer Use	□ Cleaning	□ Shopping	□ Relationship	□ Social Life
□ Sports	□ Cooking	□ Gardening		
□ Reading	□ Watching Kids	□ School		
□ Exercise	□ Yard Work	□ Self Care		
□ Vacuuming	□ Driving	□ Other: _____		

Health History (Check if you have ever had any of the following:)

□ Abdominal Aortic Aneurysm	□ Emphysema	□ Multiple Sclerosis
□ Acid Reflux	□ Epilepsy	□ Mumps
□ AIDS/HIV	□ Erectile Dysfunction	□ Neck Pain
□ Alcoholism	□ Eye Troubles	□ Osteoporosis
□ Allergies	□ Fractures	□ Pacemaker
□ Allergy Shots	□ Glaucoma	□ Parkinson's
□ Anemia	□ Goiter	□ Pinched Nerve
□ Anorexia	□ Gonorrhea	□ Pneumonia
□ Anxiety	□ Gout	□ Prostate Problems
□ Appendicitis	□ Headaches	□ Psychiatric Care
□ Arthritis	□ Heart Disease	□ Rheumatoid Arthritis
□ Asthma	□ Heart Issues	□ Shortness of Breath
□ Bleeding Disorders	□ Hepatitis	□ Stroke
□ Bulimia	□ Hernia	□ Suicide Attempt
□ Burning Feet	□ Herniated Disc	□ Swollen Ankles
□ Buzzing/Ringing in Ears	□ Herpes	□ Throat Conditions
□ Cancer	□ High Cholesterol	□ Thyroid Conditions
□ Cataracts	□ Hip Pain	□ Tuberculosis
□ Chemical Dependency	□ Hypertension/ HBP	□ Tumors/Growths
□ Chicken Pox	□ Indigestion	□ Typhoid Fever
□ Chronic Bronchitis	□ Infertility	□ Ulcers
□ Chronic Fatigue	□ Insomnia	□ Unexplained Memory Loss
□ Chronic Sinus Infections	□ Kidney Disease	□ Unexplained Weight Loss
□ Chronic Tonsillitis	□ Kidney Stones	□ Unexplained Weight Gain
□ Constipation	□ Leg Pain	□ Upper Back Pain
□ Coronary Artery Disease	□ Liver Disease	□ UTI
□ Depression	□ Low Back Pain	□ Vaginal Infections
□ Diabetes	□ Measles	□ Venereal Disease
□ Diarrhea	□ Menstrual Problems	□ Vertigo
□ Difficulty Swallowing	□ Mid Back Pain	□ Whooping Cough
□ Digestive Problems	□ Migraines	□ Other:_____
□ Dysmenorrhea	□ Miscarriage	
□ Eczema	□ Mononucleosis	

Family History (please list all known conditions/illnesses that may apply):

Mother: _____ Father: _____
Grandparents: _____ Siblings: _____
Other known familial conditions: _____

Patient's Signature: _____ **Date:** _____

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WELCOME GUIDELINES

The purpose of these agreements is to allow us to more completely serve you and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

Relationship

We have the best results when a good relationship is created and maintained between our patients and the staff and doctor. We are available to you via phone and email so that you can express any questions and concerns you have during the course of your treatment.

Treatment

It is our wish that each and every one of our patients receive the very best care and service possible. Your Treatment Program consists of a specific series of treatment given over a pre-planned time span. If you don't follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because treatments will help you recover.
3. If you are unable to make an appointment due to an emergency, please call us and let us know so that we can reschedule your appointment. A no-show appointment is when you fail to show up for an allotted appointment time without a phone call or cancellation notice of at least 24-hours.
4. **Failure to give 24-hour notice of any missed appointments will result in: first missed/late cancel $50.00 fee, second missed/late cancel $100, third and subsequent missed/late cancel $150 fee. All no-show appointments are responsible for same policy fee.**
   ***** AFTER FIRST MISSED/LATE CANCEL/NO SHOW APPOINTMENT CREDIT CARD WILL BE REQUIRED TO BE LEFT ON FILE.

Insurance Assignment of Benefits

Authorization to Release Information:
I hereby authorize your office to release any information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) as necessary to process my insurance claim.

Authorization to Appeal Insurance Company:
I hereby authorize your office to take any necessary actions toward my insurance company when trying to get my claims paid. This includes, but is not limited to, filing an internal and/or external appeal with or against my insurance company, sending any necessary documentation and/or records, filing a lawsuit against my insurance company, and/or any other means the office wants to pursue in trying to collect from my insurance company.

Authorization to Pay Benefits:
I hereby authorize my insurance carrier(s) to make payment directly to the office for the surgical and/or medical benefits payable for the services rendered. Please help us keep your records up to date. If you change your address, phone number, employer, or insurance carrier, please notify us immediately.

In some instances, insurance companies will send checks to you. These checks need to be signed over to us as they are payment for services rendered. Failure to do so will result in us sending you to collections and/or small claims court.

Financial Policies

We will expect you to honor the financial agreements you make with our office. We do not bill patients. If we are forced to bill, you will receive a service charge. Our policy is that a patient does not have a personal cash balance. Any refunds will only be made after your balance is paid and only a credit remains on your account.

Your insurance carrier will be billed according to arrangements made. There is no warranty or guarantee that your insurance carrier will pay your medical claims even after benefit verification. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility. We will not enter into any disputes with your insurance carrier. If any issues arise, we expect our patients to directly assist in the resolution process. Any denied or disputed claims will be treated as uncovered services.

Waiting for the insurance payment is a courtesy and may be withdrawn under certain circumstances. Any insurance checks sent to you or the insurance policy subscriber by your insurance provider should be brought to our office within 14 days of the statement date…even if they are made payable to you (in which case, please sign the back of the check first). Also send the attached insurance payment stub (explanation of benefits) for our records. All payments above $999.00 must be paid with a certified bank check or credit card. If you are unable to hand-deliver to our office within the allotted time frame, you have the option of paying over the phone with a credit card and faxing the EOB statements to our office. Failure to include the EOB along with your payments will result in the responsibility of the full charge for that claim.
Mail to 853 Broadway Suite 1105 NY NY 1003 fax 212-614-8027 or email info@starrnyc.com

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By signing below, you agree not to cash insurance checks or any other form of payment made by your insurance provider to the office. You further acknowledge that if the checks are cashed and not turned over to this office upon receipt, or if we need to refer your account to collections, you will assess a fee of 33.3% of the outstanding balance due. You will also be responsible for any legal fees, court fees and other collection fees that the office may incur if you fail to comply with the above Agreement.

No Guarantee of Results

Patient recognizes that this Agreement is not a guarantee of results, and that it deals solely with financial and time obligations. Any balance due for services is regardless of results.

Cooperation

We are committed to achieving your treatment goals, and your cooperation is very important. If there is anything that can make your visit more comfortable, please let us know.

By signing below, I confirm receipt and understand and agree to the listed policies and procedures contained within:

- **Relationship**
- **Treatment**
- **Cancellation Policy**
- **Insurance Assignment of Benefits**
- **Financial Policies**
- **No Guarantee of Results**

HIPAA NOTICE OF INFORMATION PRACTICES

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for Starr Sports, Chiropractic, Physical Therapy, Acupuncture & NP (Adult Health), P.L.L.C regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Starr Physical Therapy, Chiropractic, & Acupuncture, P.L.L.C and my respective rights contained therein. I also understand that the notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this notice at any time by contacting us at (212) 614-8800.

853 Broadway, Suite 1105 New York, NY 10003.

My signature herein below constitutes full acknowledgement that I have received a copy of the notice of privacy practices for Starr Physical Therapy, Chiropractic, & Acupuncture, P.L.L.C.

Office Policy on Missed, No Show or Cancelled Appointments

Missing. No Show or Changing Appointments – Cancellation Policy

We have set up a specific course for you. A certain number of visits in a set amount of time are required for us to get the best results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day we ask that you give us 24 hours. If the same day is not possible, be sure to make the missed appointment within one week. If there is a cancellation less than 24 hours you will be charged a $50 cancellation fee.

By signing below, I confirm receipt and understand and agree to the listed policies.

CONSENT TO TREAT

A patient coming to the doctor gives his/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

_____ _____/_____/_____

Patient Signature or Responsible Party Date

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CONSULTATION AND FREE EVALUATION: No charge.
The consultation takes place subsequent to the New Patient History Examination. The doctor will discuss with the patient any current complaints. The doctor will also give the patient a brief explanation of Chiropractic and the care he/she will be receiving.

CHIROPRACTIC, PHYSICAL THERAPY & ACUPUNCTURE EVALUATION, EXAMINATIONS & RE-EXAM: $250-$350

DOCTOR-PATIENT CONFERENCE:
The Doctor-Patient Conference is a specific office visit at which time the doctor spends 10-20 minutes relating to the patient his/her examination finding, i.e. physical exam, x-ray examination study. This aids the patient in understanding and participating in his/her health findings and care.

CHIROPRACTIC X-RAY STUDIES: $200-$350 per set
Subsequent to the Consultation and after careful review of the patient's complaints, the doctor will determine if x-rays are necessary for the proper care of the patient.

SPINAL DECOMPRESSION (S9090): $250

CHIROPRACTIC ADJUSTMENT: $95-$125
The Chiropractic Adjustment is the correction (reduction) of a subluxated vertebra of pelvic segment by means of making a specific predetermined adjustment. The Chiropractic Adjustment is made only after careful analysis delivered in a specific manner to achieve a predetermined goal. It is a precise, delicate maneuver requiring special bioengineering skills and deftness.

ACUPUNCTURE TREATMENT $385-$575, 30-55 minutes.

EXTREMITIES ADJUSTMENTS (98943): $95

INTERSEGMENTAL TRACTION (97012): $95
This is a special biomechanical traction/paraspinal muscle therapy that facilitates fluid exchange, restores movement in acutely edematous muscles, and stretches shortened connective tissue.

THERAPEUTIC EXERCISES (97110): $125 Increases range-of-motion in the affected area, increases flexibility and strength.

ELECTRICAL STIM (97014): $95

NEUROMUSCULAR REEDUCATION (97112): $125
Assists in effecting a change to improve balance, coordination, kinesthetic sense and proprioception.

THERAPEUTIC ACTIVITIES (97530,97535, 97537): $125
This procedure involves using functional activities (e.g. bending, lifting carrying, reaching, catching, and overhead activities of home and work.

MANUAL THERAPY TECHNIQUES (97140): $125
Manual therapy techniques include soft tissue and joint mobilization, manual traction, trigger point therapy and myofascial release.

GAIT TRAINING (97116): $90 Gait training employs repetitive exercises to improve gait or maintain strength and endurance.

RANGE OF MOTION TEST (ROM) (95851): $270

MUSCLE TEST (MT) (95831): $200

TAPING (29200,29240,29260,29280,29520,29530,29540): $150

TENS UNIT (E0730): $500

TENS LEADS (A4595): $75

CERVICAL BRACE (L0174): $250

BRACE (L0631): $1300

If you ever have any questions on correspondence or EOB's (explanation of benefits) sent by your insurance please give us a call or come into our office we will help you.

SIGNATURE _____ **DATE** _____

*On EOB (explanation of benefits) insurance may not use actual name of procedure, but instead generalize and write Physical Therapy, even though procedure is being done by Chiropractor. Most procedures can be done by either a Chiropractor or Physical Therapist. Some procedures would also be described as surgery.