Dr. Raymond A. Semente

CHIROPRACTOR
265 LAKE AVENUE – ST JAMES, NEW YORK 11780
TEL: 631 584-7722
FAX: 631 584-6198

Patient Data **Date:** _____

First Name:_____ **Middle Initial:** ____ **Last Name:**_____

Address Line 1

_____

Address Line 2

_____

City _____ **State** _____ **Zip Code** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Cell Phone (____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** Male Female Height: _____

Weight: _____

Social Security Number: _____-_____-_____

Marital Status: Single Married Widowed

Employment Status: Employed Unemployed Retired Disabled

Employer: _____ Employer Phone#: _____

Address: _____

_____

Emergency Contact: _____

Contact Name _____ **Relationship to Patient:** _____

Emergency Contact Phone #:_____

Are you pregnant? Yes_____ **No** _____**N/A**_____

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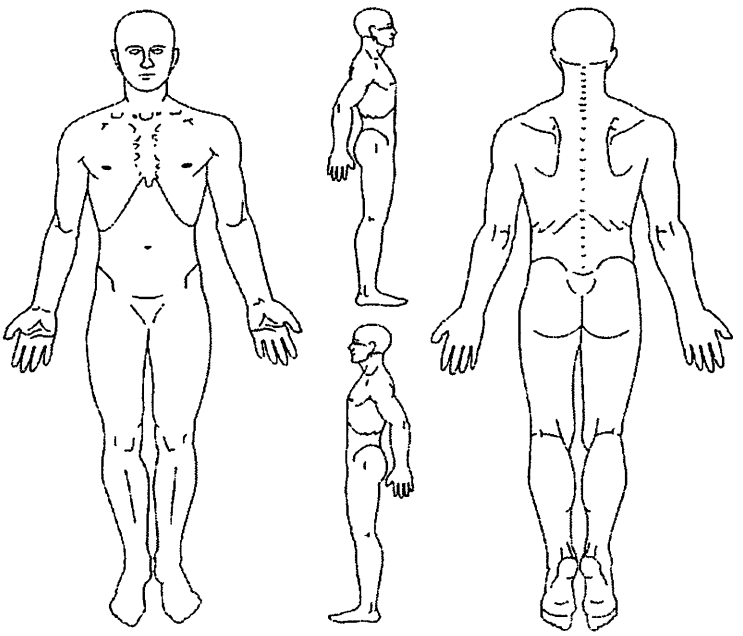
Indicate on the body diagram where you are experiencing pain/discomfort:



Date your symptoms began: _____

Are your symptoms a result of:

Motor Vehicle Accident Work Related Accident Other_____

How did your symptoms begin? _____

_____

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Payment/Insurance Information:

Who is responsible for your bill? Self Health Insurance Spouse Worker's Comp

Auto Insurance Medicare Medicaid Other _____

Personal Health Insurance Carrier: _____

Insurance ID #:_____ **OR** Claim #: _____

Policy Holder's Name: _____

Group # _____

Policy Holder's Date of Birth _____ / _____ / _____

Primary Care Physician _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? Yes No Date: ____/____/____

Time: _____am / pm

To the best of my knowledge all the above information is accurate and correct.

I hereby acknowledge and understand I am responsible for my bills for professional services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Dr. Raymond A. Semente will prepare any forms and reports and that he may releases any information concerning my casein preparation to be paid directly. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if for any reason the insurance company refuses to pay any part of my bill that I am directly responsible for payment. I further understand that if I suspend or terminate my care any fees for professional services rendered will immediately become due and payable

_____ _____

Patient Signature Signature Date

Dr. Raymond A. Semente

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HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Date_____

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Assignment of Benefits and Conditions/Consent for Treatment

CONSENT TO MEDICAL AND SURGICAL PROCEDURE AND PHOTOGRAPHS

The undersigned (hereinafter "patient" which shall also include parents or legal guardians if the patient is a minor or lacks legal capacity and representative of the patient), consents to the procedures and services that may be performed by Dr. Raymond A. Semente. I consent to the taking of pictures of my medical or surgical condition or treatment, and the use of the pictures and medical history and/or medical records for purposes of my diagnosis or treatment or for education or training programs conducted by the above provider. I understand that I have the right to request the cessation of recording or filming. This office will gown female and male patients during initial examination and x-ray procedures. All patients should leave their underclothing on as any examination or x-ray procedure will not be compromised. All patients will be shielded. On subsequent office visits, all pants, shoes, socks, or shorts should be left on. Gowns on all patients open to the back and all undergarments do not need to be removed. This notice is provided to inform you of your evaluation procedures prior to examination. Some patients may not wish to be gowned upon subsequent examinations. Please notify our office if this applies to you.

PERSONAL BELONGINGS

It is understood and agreed that the provider shall not be liable for the loss or damage to any money, jewelry, documents, furs, or other articles of any value.

PATIENT PERSONAL HEALTH INFORMATION

The patient agrees and provides consent to the provider to discuss and disclose his/her personal health and medical information (PHI) with any of its staff, its representatives and third parties for purposes of the treatment, payment of services, or operations.

AUTHORIZATION TO FILE CLAIMS AND APPEALS

The patient agrees and proves consent for the provider, its staff, and/or their preferred legal group to do the following on my behalf: (1) file patient medical claims with my health plan; (2) file any necessary appeals of denied or partially paid patient medical claims with my plan or regulatory authorities on my behalf; (3) file any necessary external appeals with regulatory authorities; (4) file litigation if necessary

CHARITY CARE POLICY

The patient acknowledges that he/she is aware of the Provider's Charity Care Policy. If a patient believes that they qualifies for a partial or total reduction of patient responsibility, coinsurance, or deductible under such policy, the patient must notify the provider in writing and provide a copy of his/her Federal Income Tax Return for the tax year prior to the year services were rendered.

PATIENT ACKNOWLEDGMENT

I _____ (print name), hereby acknowledge that at the beginning of my treatment or services rendered by the provider, I have been furnished with the HIIPA policy and I voluntarily sign this acknowledgment that I consent and agree to this conditions of treatment for services to be rendered by the provider.

_____ _____

Signature of Patient Date Acknowledged

Dr. Raymond A. Semente
265 Lake Avenue – St. James, NY 11780
Tel. 631- 584-7722
Fax 631-584-6198

Authorization To Charge Credit Card

The office will bill your insurance carrier for today's and any future services. The amount billed will be adjusted by your insurance carrier to payable fees as per your insurance policy and could possibly be applied to your deductible if you have one.

The amount charged to your credit card **cannot** exceed the amount on the Explanation of Benefit and/ or check paid to you provided by your insurance carrier.

These charges will be authorized on a recurring basis should treatment services be continued beyond today's date, but at no time will charges exceed the insurance carriers payment for any services rendered, on any date I receive services. This authorization is also valid for any uncollected and unpaid co-payments.

Name on the Credit Card : _____

Credit Card Number : _____

Expiration Date: _____ CVC: _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Credit Card (Circle): Visa MasterCard Amex Discover

	Patient authorizes Dr. Raymond A. Semente to initiate charge on my (our) Credit Card indicated above and I (we) authorize the credit card company to accept the charges on the same such Credit Card. I (we) authorize Dr. Raymond A. Semente to apply current and future payments to the designated credit card as the treatment for services become due. Authority is to remain in full force and effective until Dr. Raymond A. Semente has received written notice of its termination in such time as manner as to afford reasonable opportunity to act upon the notice.

Patient Signature : _____

Printed Name: _____ Date: _____

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

[1] MD/DO [2] DC [3] PT [4] OT [5] Both PT and OT [6] Home Care [7] ATC [8] MT [9] Other ____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type

(1) New to your office
(2) Est'd, new injury
(3) Est'd, new episode
(4) Est'd, continuing care

Cause of Current Episode

(1) Traumatic
(2) Unspecified
(3) Repetitive
(4) Post-surgical →
(5) Work related
(6) Motor vehicle

Date of Surgery

Type of Surgery

(1) ACL Reconstruction
(2) Rotator Cuff/Labral Repair
(3) Tendon Repair
(4) Spinal Fusion
(5) Joint Replacement
(6) Other _____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1° ____.____
2° ____.____
3° ____.____
4° ____.____

Nature of Condition

(1) Initial onset (within last 3 months)
(2) Recurrent (multiple episodes of < 3 months)
(3) Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942
○ 98941 ○ 98943

Current Functional Measure Score

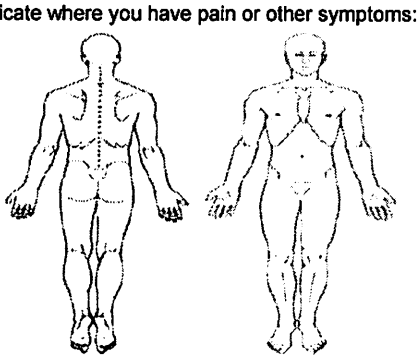
Neck Index | DASH | (other)
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X _____ **Date:** _____

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.

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

Neck Index Score

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