DR. STEVEN BREINES

Name_____ Preferred Name _____Male___ Female___ Date_____

Home Address_____ City/State/Zip_____

Date of Birth _____ Home Phone # _____Cell # _____ Work # _____

E-mail: _____ Married___ Single___ Divorced ___ Widowed ___ Name of Spouse_____

Occupation _____ Employer's Name &Address_____

Insured Info (If Different):_____

How Were You Referred? _____ Family Physician_____

Height _____Weight _____ Current Smoker___ Former ___ Never Smoked ___ Exercise: Daily ___ Weekly ___ Never ___

Medications: _____

Surgeries/Hospitalizations:_____

Medical Conditions: _____

Family History: Diabetes ___ Hypertension ___ Heart Disease ___ Cancer ___ Arthritis ___ Other _____

Allergies: _____ Recent Testing: _____

Primary Reason For Visit: _____ Prior Chiropractic Care: Yes ___ No ___

How & When Did Your Symptoms Begin? _____

How often do you experience your symptoms?

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

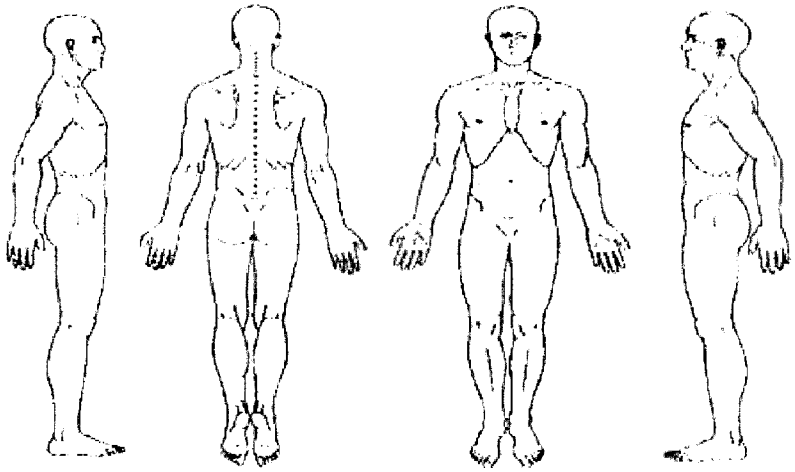
What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

Indicate where you have pain or other symptoms



How bad are your symptoms at their:

	None										Unbearable
a. worst:	⑩	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⑩	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

How do your symptoms affect your ability to perform daily activities?

⑩	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

What activities make your symptoms worse: _____

What activities make your symptoms better: _____

Have you had similar symptoms in the past? ① Yes ② No

Patient Signature _____ ***Date*** _____

Dr. Steven Breines

PATIENT PRIVACY CONSENT

_____ hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Office of Dr. Steven Breines Privacy Notice ("The Office") has been offered to me to review and/or read prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Office to provide treatment to me, and also necessary for The Office to obtain payment for that treatment and to carry out its health care operations. The Office explained to me that the Privacy Notice will be available to me in the future at my request. The Office has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Office reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand and consent to, the following used by The Office: a) telephoning my home and leaving a message on my answering machine or with the individual answering the phone regarding an appointment. b) displaying my name on the waiting room referral board.

4. The Office may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for The Office to treat me and obtain payment for that treatment, and as necessary for The Office to conduct its specific health care operations.

5. I understand that I have a right to request that The Office restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or other health care operations. However, The Office is <u>not</u> required to agree to any restrictions that I have requested. However, if The Office agrees to a requested restriction, then the restriction is binding on The Office.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation will not apply to the extent that The Office has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, The Office has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then The Office will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor) Relationship

Dated Signed ___/_____/_____

INSURANCE ASSIGNMENT AND RELEASE OF RECORDS

I _____hereby authorize payment of benefits directly to Dr. Breines for services rendered. I further authorize Dr. Breines to release of request to process this claim or provide appropriate care. I certify that the information reported with regard to my insurance coverage is correct.

I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company any time in writing.

DATE_____ SIGNATURE_____

DR. STEVEN BREINES
3885 Hylan Boulevard
Staten Island NY, 10308
(718) 967-3500

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care involves the use of different types of examination and treatment procedures focusing on, but not limited to, the musculoskeletal system. At this office we use different forms of physiotherapy, manual spinal manipulation, therapeutic exercise, therapeutic massage and other forms of manual treatment. Although chiropractic care is a noninvasive conservative treatment, with all forms of medical care there are risks and benefits.

Since each individual's response to a specific treatment can vary widely, it is not always possible to accurately predict your response to a certain treatment or modality. There is always a risk that your treatment may cause pain or injury including but not limited to soreness, bruising, worsening of your prior condition, and in very rare instances fracture or stroke may occur.

You have the right to ask Dr. Breines the type of treatment he is planning based upon your history, diagnosis, symptoms and test results as well as alternate forms of treatment for your condition. You may also discuss with Dr. Breines any potential risks and benefits of a specific treatment that he recommends. You have the right to decline any portion of your treatment at any time before or during your treatment session.

I have read, or have had read to me, the informed consent for chiropractic care. I have also had an opportunity to ask Dr. Breines any questions regarding its contents. I understand the risks associated with chiropractic care as outlined to me in the above document. By signing this consent form I agree to receive chiropractic care at the office of Dr. Steven Breines.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor) Relationship

Dated Signed _____/_____/_____