PATIENT INFORMATION

25 Smith Street Suite 202
Nanuet, NY 10954
P: 845-623-6333 F: 845-684-2640
www.HudsonHealthSpine.com

Thank you for choosing Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC. How did you hear about us?
□ Internet □ Family □ Friend □ Sign □ Promotion: _____ □ Patient: _____ □ Other: _____

PATIENT RESPONSIBILITIES to Hudson Health & Spine and /or Hudson Health Physical Therapy, PLLC
- Give accurate and complete health information concerning your past illness, hospitalizations, medications, allergies, pain and other pertinent information
- Provide accurate information about current insurance, billing information, and personal and update if there is any change.
- **All sections with * are required**

PATIENT INFORMATION						**(DATE: / /)**
Name:				Sex: M / F	DOB: / /	Age:
SSN: - -		E-mail:				
Home Phone:			Cell Phone:			
Home address:		City:		State:	Zip:	
Occupation:	Employer:		Work Phone:			
Work address:		City:		State:	Zip:	
□ Single	□ Married	□ Widowed	□ Divorced	□ Legally Separated	□ Domestic Partner	

INSURANCE INFORMATION				
Primary	Insurance name:	ID #	Group #	
	Insured's Name:		Insured's DOB: / /	
	Phone #:	SSN - -	*Relationship to Patient:	
2ndary	Insurance name:	ID #	Group #	
	Insured's Name:		Insured's DOB: / /	
	Phone #:	SSN - -	*Relationship to Patient:	

BILLING INFORMATION	□ Patient self		
Name:	DOB: / /	*Relationship to Patient:	
SSN - -	Home Phone:	Cell Phone:	
Address: :	City:	State:	Zip:

- ***EMERGENCY CONTACT :** _____ Relationship:_____ Phone : _____
- **PRIMARY CARE PHYSICIAN**:_____ Phone :_____

Office Address:_____City_____State_____Zip_____

- **PLEASE ANSWER THE FOLLOWING QUESTIONS**

1. Have you ever received Chiropractic care? □ No □ Yes If "Yes", When? _____
2. Have you ever received Physical Therapy? □ No □ Yes If "Yes", When? _____
3. X-Rays taken? □ No □ Yes If "Yes", When? _____ Body parts? _____
4. CT taken? / MRI taken? □ No □ Yes If "Yes", When? _____ Body parts? _____
5. Previous Motor Vehicle Accident? □ No □ Yes If "Yes", When? _____

6. Previous Work-Related Injuries? ☐ No ☐ Yes If "Yes", When? _____

7. Are you currently pregnant? ☐ No ☐ Yes

8. Exercise: ☐ None ☐ Light(1-2/week) / ☐ Moderate(3-4/week) / ☐ Daily(5-6/week)

Type : ☐ Cardio / ☐ Yoga / ☐ Pilates / ☐ Weights ☐ Other _____

9. Current Medications: ☐ None

Product Name	Symptoms	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Previous Surgeries: ☐ None ☐ Yes: _____

11. Previous Hospitalizations: ☐ None ☐ Yes: _____

12. Previous Significant Illnesses: ☐ None ☐ Yes: _____

13. Previous Injuries and Traumas: ☐ None ☐ Yes: _____

14. Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problem ☐ Stroke ☐ Rheumatoid Arthritis

• CHECK OR CIRCLE ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY & CURRENT SYMPTOMS

☐ Allergies _____
☐ Cancer:_____
☐ Fever
☐ Lyme Disease
☐ Anemia
☐ Bruise Easily
☐ Diabetes: Type I / ☐ Type II
☐ Thyroid Hypo / ☐ Hyper
☐ Depression
☐ Anxiety
☐ Fatigue
☐ Gallbladder Symptoms
☐ Kidney Problems
☐ Hepatitis / Liver Problems
☐ Gout
☐ Convulsions / ☐ Epilepsy
☐ Insomnia / ☐ Trouble Sleeping
☐ Loss of Memory
☐ Loss of Concentration

☐ Loss of Smell / ☐ Taste
☐ Buzzing / ☐ Ringing Ears
☐ Vision Blurred
☐ Dizziness / ☐ Vertigo
☐ Menstrual Pain / ☐ PMS

☐ Sinus Problems
☐ Ear Infections
☐ Bladder Infection
☐ Venereal Disease

☐ Constipation / ☐ Diarrhea
☐ Indigestion
☐ Tuberculosis
☐ Weight Loss
☐ Heart Trouble
☐ Chest Pain
☐ Cold, Tingling Extremities
☐ Fainting
☐ Heart Attack

☐ High Blood Pressure
☐ High Cholesterol
☐ Poor Circulation

☐ Arthritis: _____
☐ Headaches / Migraine
☐ Shoulder Pain
☐ Hip Pain
☐ Knee Pain
☐ Neck Pain
☐ Pain down to Arm(s)
☐ Low back Pain
☐ Pain down to Leg(s)
☐ Osteopenia
☐ Osteoporosis
☐ Scoliosis
☐ Multiple Sclerosis
☐ Stroke _____
☐ Parkinson's disease
☐ Other _____

IF YOU CHECKED OR CIRCLED ANY OF THE ABOVE, PLEASE EXPLAIN: _____

_____

_____

● **CHIEF COMPLAINT (MAIN REASON OF YOUR VISIT)**

▪ Is this visit ☐ Work related (WC claim#: _____) ☐ Motor Vehicle Accident related ☐ N/A

▪ Symptoms began on: Date: _____

▪ Describe your symptoms: _____

▪ How did your symptoms start? _____

▪ Have you seen any other Healthcare Provider for this condition? ☐ No ☐ Yes

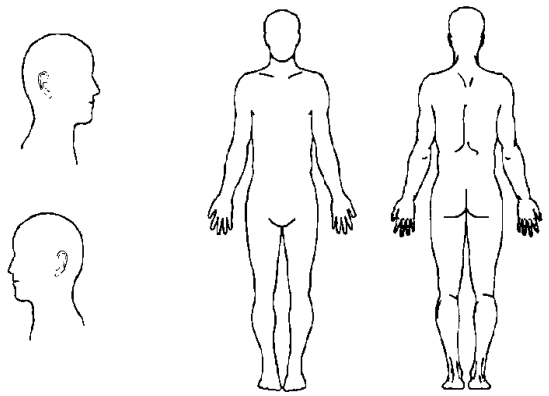
▪ If "Yes", who have you seen? Include Hospital/ER visits, and Provider name. _____

_____

▪ How often do you experience your symptoms? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittent

▪ Onset characteristics: ☐ Occurred suddenly ☐ Occurred gradually ☐ Progressively worsened over time

INDICATE WHERE YOU HAVE PAIN OR SYMPTOMS



Use the following symbols, as applicable, to diagram areas of discomfort

A = Aching	N = Numbness
B = Burning	R = Throbbing
C = Cold	ST = Stabbing
SR= Sore	SH= Shooting
H = Hypersensitivity	T = Tingling

AVERAGE PAIN INTENSITY
(PLACE AN "X" ON THE SCALE)

◄----------►

0 1 2 3 4 5 6 7 8 9 10

No pain Severe

ACCOUNT INFORMATION AND TERMS OF ACCEPTANCE

I hereby authorize the Healthcare Professional to perform diagnostic tests and administer treatment as is necessary. I also authorize the release of my information as required to process any treatment, coordination of care, insurance claims and payment. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize my carrier to send payment directly to Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC. I permit this office to credit my account upon receiving payment.

FINANCIAL OBLIGATION

I recognized that Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC will make every effort to assist me in obtaining insurance coverage. However, it is my responsibility to understand the up to date benefit coverage of my insurance. I understand that I am financially responsible for my health insurance deductible, coinsurance, copayment or non-covered services. In the event that my health plan determines a service to be "non-covered", I will be responsible for the complete charge and agree to pay the costs of all services provided. All payments are due at time of service. If the exact dollar amount has not been determined, I will be asked to pay the estimated amount and will be billed for the balance. If my plan requires a referral, I must obtain it prior to my visit. All balance notifications will be delivered via e-mail, mail, and/or phone calls.

APPOINTMENT AGREEMENT

_____ (Patient Initials) Please contact our office at least 24 hours in advance to reschedule or cancel your appointment. I am aware that I will be assessed a $40 penalty fee for a same day appointment cancellation except unexpected events or emergencies.

I understand the above information in its entirety and hereby guarantee that this form was completed accurately as to the best of my knowledge. I also understand that it is my sole responsibility to inform this office, in a timely manner, of any and all changes to this information. I hereby give my authorization to treat my minor as named herein on this form.

_____ _____ _____

Name of Patient (Print) or Legal Representative if patient is minor/Relationship | Signature of Patient/ Legal Representative | Date

NOTICE OF PRIVACY PRACTICES/ PATIENT RIGHT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSURE OF YOUR HEALTH INFORMATION

This office uses and discloses your protected health care information for the following reasons:

- to share with other treating healthcare professionals regarding your healthcare.
- to submit to your insurance company or Workers Compensation claim to verify that treatment has been rendered.
- to determine patient's benefits in a health care plan.
- to assist in overcoming a language barrier when caring for a patient.
- to notify a family member or caretaker about your health condition or in the event of an emergency situation.
- as required by State, Federal or Public Health Law
- if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence.
- appointment date and time reminder to household members, answering machines, e-mail and/or texting.

Any other uses or disclosure will only be made with your specific written prior authorization.

Individual we may disclose Protected Health Information to:

* Check 1 of the following *

☐ Decline to disclose my Protected Health Information to anyone but myself.
☐ You may disclose my Protected Health Information to:

Name:_____ Phone:_____ Relationship:_____

THE PATIENT HAS THE RIGHT TO

- Be treated with consideration, respect and full recognition of his/her dignity and individuality
- revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- speak to our privacy officer who is Dr. Joseph Taccetta and can be reached at 845-623-6333 regarding privacy issues.
- inspect, copy and amend your protected health information as allowed by law.
- request to receive confidential communications from us by alternative means or at an alternative location.
- obtain an accounting of any disclosures or to be notified of any breech of privacy of your protected health information.
- render a complaint to our privacy office or Secretary of Health and Human Services.

This/or These office(s) reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may obtain an updated copy at any time upon request.

I acknowledge that I have received and reviewed this notice with full understanding.

_____ _____ _____

Name of Patient (Print) or Legal Representative if patient is minor/ Relationship | Signature of Patient/ Legal Representative | Date

---

RELEASE OF MEDICAL RECORDS:

I hereby give authorization for the release of my medical records to Hudson Health & Spine and/or Hudson Health Physical Therapy, PLLC

_____ _____ _____

Name of Patient (Print) or Legal Representative if patient is minor/ Relationship | Signature of Patient/ Legal Representative | Date

C H I R O P R A C T I C
INFORMED CONSENT FORM

PATIENT NAME(Print) :_____ DOB: _____

Please read this entire document. It is important that you understand the information contained in this document.

The nature of the chiropractic adjustment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. Dr. Joseph Taccetta will use that procedure to treat you along with other comprehensive treatments. He may use his hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click" sound from the joint. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpitation, vital signs, range of motion testing, orthopedic testing, basic neurological and muscle strength testing, Postural analysis testing, hot/cold therapy, electronic muscle stimulation, ultrasound therapy, therapeutic exercises, soft tissue therapies, mechanical traction, spinal decompression, kinesiology taping, radiographic and/or advanced diagnostic imaging studies

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: muscle strain, burns, cervical myelopathy, costovertebral strains and separations, disc injuries dislocations, and fractures. Some patients will feel some stiffness and soreness following the first few days of treatment. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which the Doctor checks for during the taking of your history, the examination and X-Ray. Stroke and/or vertebral artery dissection cause by chiropractic manipulation of the neck has been subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options

Other treatment options for your condition may include •Self-administered, over-the-counter analgesics and rest, •Medical care and prescription drugs such as Anti-inflammatory, muscle relaxants, and pain-killers, •Hospitalization, and/ or •Surgery. If you chose to use one of the noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow for the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

PLEASE ASK QUESTIONS BEFORE YOU SIGN IF THERE IS ANYTHING THAT IS UNCLEAR.

I have read the above explanation of the chiropractic adjustment and related treatment. I have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

X_____
Signature of Patient
or Legal Representative (if patient is minor)

Date:_____ **Time:**_____

X_____
Doctor's Signature

Date:_____ **Time:**_____