Welcome to

Gary Yen, DC, PC.

38 West 32nd Street, Suite 501 | New York, NY 10001
Phone: 212-868-0509 | Fax: 212-760-0895

Patient information (please print):

FIRST NAME _____ LAST NAME _____ DATE_____

ADDRESS _____ APT _____ CITY _____ STATE_____ ZIP _____

HOME PHONE ( )_____ CELL ( )_____ EMAIL _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed GENDER ☐ Male ☐ Female

AGE _____ DATE OF BIRTH _____ # OF CHILDREN _____ SOC SEC # _____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____CITY_____ STATE___ ZIP _____ PHONE ( )_____

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

Patient Condition:

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? ☐ NO ☐ YES WHEN? _____ Dr. _____

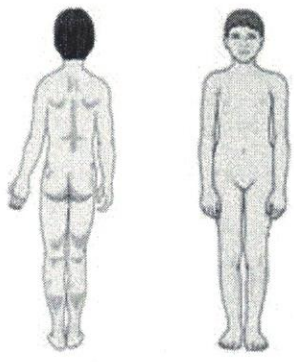
DESCRIBE YOUR SYMPTOMS: _____

IS THE CONDITION GETTING PROGRESSIVELY WORSE? ☐ NO ☐YES ☐ I DON'T KNOW

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (Please list) _____

WHAT TYPE OF PAIN ARE YOU EXPERIENCING?

☐ **Sharp**	☐ **Dull**	☐ **Throbbing**
☐ **Aching**	☐ **Stiffness**	☐ **Tingling**
☐ **Numbness**	☐ **Shooting**	☐ **Other:** _____



Mark an "X" where you feel pain

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

☐ **Constantly** (76-100%) ☐ **Frequently** (51-75%)
☐ **Occasionally** (26-50%) ☐ **Intermittently** (0-25%)

WHAT ACTIVITIES MAKE YOUR SYMPTOMS ***WORSE***?

☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lifting** ☐ **Lying Down** ☐ **Other**_____

WHAT ACTIVITES MAKE YOUR SYMPTOMS ***BETTER***?

☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lifting** ☐ **Lying Down** ☐ **Other**_____

HAVE YOU HAD SIMILAR SYMPTONS IN THE PAST? ☐ NO ☐ YES (Please explain) _____

WHAT KIND OF WORK ACTIVITIES DO YOU PERFORM?

☐ **Sitting** ☐ **Standing** ☐ **Light Labor** ☐ **Heavy Labor**

HOW OFTEN DO YOU EXERCISE?

☐ **None** ☐ **Light** ☐ **Moderate** ☐ **Daily** ☐ **Heavy**

Health History:

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING? (Please circle all that apply)

☐ AIDS/HIV	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lumps
☐ Cancer	☐ Diabetes	☐ Epilepsy	☐ Gout	☐ Heart Disease	☐ Kidney Disease
☐ Dizziness	☐ Stroke	☐ Headaches	☐ Tumors	☐ Osteoporosis	☐ Pacemaker
☐ Prostate problems	☐ High Blood Pressure	☐ Digestive disorders	☐ Other _____		

PLEASE LIST ANY PREVIOUS INJURIES OR SURGERIES: _____

ARE YOU PREGNANT? (**For women only**) ☐ NO ☐ YES If yes, how long? _____

Insurance Information:

DO YOU HAVE HEALTH INSURANCE? ☐ NO ☐ YES
(If yes, please complete the following and provide us your insurance card so we can make a copy for our records)

NAME OF INSURANCE COMPANY(S) _____

GROUP # _____ MEMBER ID # _____

PLEASE COMPLETE THIS SECTION ONLY IF YOUR CONDITION IS THE RESULT OF AN ACCIDENT

Please check one: ☐ Auto Accident ☐ Work Accident ☐ Other _____ Date of injury _____ Time _____

How did the accident occur? _____

Did you report your injury? ☐ NO ☐ YES To whom? _____

Did you go to the hospital? ☐ NO ☐ YES Which hospital? _____

By Ambulance? ☐ NO ☐ YES X-rays taken? ☐ NO ☐ YES By Whom? _____

Date(s) of hospitalization _____ Medication prescribed _____

Are you currently working? ☐ NO ☐ YES Date you last worked _____

Have you been treated by any other doctor for this injury? ☐ NO ☐ YES By whom? _____

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to **Gary Yen, DC, PC**, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. I understand that I am financially responsible for all charges whether or not paid by insurance. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Patient Name Print: _____ Patient's Signature _____ Date: _____

AUTO AND OTHER ACCIDENTS – NOTICE OF LIEN TO ATTORNEY

I, the undersigned, hereby authorize and direct you, my attorney, to pay directly to **Gary Yen, DC, PC** such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith. I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were execute by him. I further agree that in the event this lien is litigated that in the prevailing party will be awarded attorney fees and costs.

Patient Name Print: _____ Patient's Signature _____ Date: _____

Gary Yen D.C., P.C.
Chiropractor
38 West 32nd Street Suite 501
New York, NY 10001
P: 212.868.0509 | F: 212.760.0895

INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All balance (i.e. co-payment, deductible, treatments, etc.) will be paid in full upon services rendered on the same day, U also understand that if I suspend or terminate my treatment, any fees or professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he or she deem appropriate. It is also my duty to ask the doctor to discuss the practice of chiropractic regarding risks to treatment such as spinal manipulation and also other treatment options. I do wish to rely on the doctor to exercise judgment during the course of treatment base on the facts known, is my best interest. It is understood and agreed, the amount paid the doctor, for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at anytime while a patient of this office. Request of medical records/files and x-rays only can be released through a written consent from the patient.

Patient signature: _____ Date: _____

Consent to treat a minor: _____

Guardian or spouse's signature of authorizing care: _____

Gary Yen, D.C., P.C.

Chiropractor
38 West 32nd Street Suite 501
New York, NY 10001
P (212) 868-0509 F(212) 760-0895

THIS NOTICE MUST BE PROVIDED TO YOU AS MANDATED BY FEDERAL LAW. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective April 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established privacy rules ("HIPAA") governing protected health information. This notice tells you about how it may be used and about certain rights that you have.

Use and disclosure of protected information

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you (such as if we consult a specialist we may provide laboratory or test data to that specialist subject to more stringent New York laws, such as restrictions on disclosure of more private information not related to special treatment).

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you (such as health plan requires that we provide them with a diagnosis code for your visit and a description of services rendered).

Federal law provides that we may use your medical information to obtain payment for health care operations without further specific notice to you, or written authorization by you (such as our billing company may see your name, dates of treatment and procedure codes during processing of our claims).

We may disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Required by law to report child abuse;
4. Required by law, such as the Department of Health;
5. Required by law in judicial or administrative proceedings;
6. Required by law enforcement purposes by a law enforcement official;
7. Required by law to avert a serious threat to health or safety;
8. Required by law and required by military authorities if you are a member of the armed forces of the United States.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone at your residence to remind you of your appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device with any person who answers the phone at your residence.

Gary Yen will never leave your personal information on any home answering device, or with any person answering your phone without your express authorization either oral or written.

Gary Yen will not discuss your personal information with any spouse, family member, or relative without your express authorization either oral or written. Even if authorization was granted in the past for a prior condition, a new authorization is necessary for each new discussion.

Gary Yen and his professional corporation, Gary Yen, D.C., P.C. are not in partnership nor have any financial affiliation with John Moises, the physical therapist, and Dr. Karen Chase, acupuncturist or any other provider in the office (including, but not limited to the massage therapist, occupational therapist) who share space in the office. John Moises, Dr. Karen Chase, Dr. Gary Yen's practices are three separate and distinct entities.

You can make reasonable requests, in writing for us to use alternative methods of communication with you in a confidential manner. Space for this is provided below.

Other uses of disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will father notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations or as requested by your written authorization, as permitted or required under 45 CFR § 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or for public health purposes.

Obligations that we have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy policies.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there. I have received a paper cop of this notice.

_____ _____

Signature Print Name

_____

Date

I make the following special request for confidential communications:

AUTHORIZATION TO PAY PHYSICIAN/SUPPLIER

I hereby direct and instruct _____ Insurance Company to pay by check made out and mailed directly to:

Gary Yen, D.C., P.C.
38 W 32nd Street Suite 501
New York, NY 10001

If my current policy prohibits direct payment to my Doctor, then I hereby authorize you to make the check payable to me and mailed as follows:

_____ (Patient's Name)
C/O Gary Yen, D.C., P.C.
Chiropractor
38 West 32nd Street Suite 501
New York, New York 10001

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment towards the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.
I also authorized the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

ERISA Authorization
I hereby designate, authorize, and convey to **Gary Yen, D.C.,P.C.** to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from **Gary Yen, D.C., P.C.** and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

Date: _____ Patient Name: _____

_____ _____
(Witness) (Signature of Policyholder or Claimant)

I hereby acknowledge and understand that I have been informed that my insurance carrier may not accept assignment of benefits from my doctor and that all insurance payments (i.e. checks) will be sent directly to me.

I have agreed to turn over the check(s) and the EOB (explanation of benefits) to Gary Yen, D.C., P.C. I also acknowledge that if the checks are cashed and not returned over the said provider upon receipt, I will be billed and charged for all services rendered with an added interest charge of 3.5% per month after the patient first received the checks. I, the patient will also be responsible for the legal/court fees incurred while or during the collection process (if necessary) if I fail to comply with the above agreement.

Date: _____ Patient Name: _____

_____ _____
(Witness) (Signature of Policyholder or Claimant)