NEW PATIENT PAPERWORK

60 Madison Ave · Suite 1012 · New York, NY 10010
212.696.9355 · hello@msqchiro.com
www.madisonsquarewellness.com

DATE:______________

CONTACT

Name____ Age_______ Date of Birth______________

Address____
Street Apt. City State Zip

Sex_____________Gender_____________Marital Status__________________

Email ________________________________ Phone (cell)___________________ Office____________________

Employer Name____ Occupation_________________________

Emergency Contact ____________________Phone________________Relationship to Patient______________

Primary Care Physician____ Phone__________________

INSURANCE

Insurance Company_______________________________________ Member ID#___________________________

Policy Holder's Name_____________________________________ Date of Birth_______________

YOUR VISIT

How did you hear about our office? ____

Reasons for consulting our office:

Complete relief of symptoms

Maintenance of a chronic issue

Wellness care to optimize your health

Other_________________________________

Please list your health concerns below, in order of importance.

	Health concern	What have you tried to address it?
1.		
2.		
3.		
4.		

Which of the following have you received in the past:

Chiropractic Physical Therapy Acupuncture

What are your health goals and expectations? ____

When was the last time you felt your best? ____

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HEALTH HISTORY

Please indicate any of the following that are part of your health picture past or present.

Musculoskeletal
- Arthritis
- Fractures
- Hernia
- Herniated discs
- Numbness/tingling
- Osteoporosis
- Tumors/growths

Head and neck
- Allergies
- Asthma
- Concussion
- Headaches
- Migraines
- Sinus issues
- Vertigo/balance issues

Sleep, etc.
- Epilepsy/seizures
- Excessive fatigue
- Fainting/syncope
- Sleeping problems

Blood
- Bleeding disorder
- Diabetes
- Hepatitis
- High cholesterol
- HIV/AIDS

Gastrointestinal
- IBS
- GERD/acid reflux
- Ulcers

Systemic
- Cancer
- Heart disease
- Kidney problems
- Liver problems
- Prostate problems
- Stroke
- Thyroid issues
- Urinary problems

Psychiatric
- Depression
- Eating disorder
- Anxiety
- Alcoholism
- Drug dependency
- Psychiatric care
- Chronic irritability

Reproductive
- Currently pregnant?
- Fertility issues
- Irregular periods
- PMS/PMDD

Do you smoke? Cigarettes p/day _______ Do you drink? Drinks p/day _______

If 1 is no stress and 10 is extreme stress, how stressful is your life? Occupational_________Personal________

What do you feel is your primary cause of stress?____

List any significant **physical trauma** from birth to present.___________________________________

List any significant **emotional trauma** from birth to present.__________________________________

List all **surgeries**	Approximate date

List all **medications** you are currently taking	Condition prescribed for

SIGNATURE

I certify that I have read and answered accurately all of the above questions. I authorize Madison Square Chiropractic & Wellness to release any information to any third party payer and/or any licensed health care practitioner regarding my care. I authorize and request my insurance company to pay directly to Gregory M Shure Chiropractic PC any monies for my care, otherwise payable to me. I understand in the event that for any reason the insurance company fails to make payment for services rendered, such payments are ultimately the responsibility of the patient.

Signature of Patient____Date_______________

CREDIT CARD PAYMENT AUTHORIZATION

60 Madison Ave · Suite 1012 · New York, NY 10010
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We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

- I authorize the provider and/or managed care organization, to release any information required to process insurance claims.
- I fully understand I am solely responsible for any balance resulting from **unpaid services** by my insurance company.
- I understand that MSQ Wellness has a 5 hour Cancellation Policy for **ALL MASSAGE** appointments. If a massage is cancelled under 5 hours prior, I will be charged $40 for the hour.
- I authorize MSQ Wellness to charge the below referenced credit card in payment for any check which I have received from my insurance carrier (for an unpaid visit) and not forwarded as agreed [Certain Blue Cross Blue Shield plans- the patient receives the insurance check directly and are required to bring the insurance check into the healthcare provider].
- I understand the above information and understand it is my responsibility to inform this office of any changes to the information I have provided below.

We will notify you before any charges will be applied to your credit card.

Patient Name: ____

Card Type:______________

Account Number: ____

Expiration Date: _________CW2 number on back of card: _______

Name as it appears on card: ________________________________

Billing Address____

Street Apt. City State Zip

Card Holder Signature____ Date_______________

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL DOCUMENT

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In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Madison Square Wellness, all medical benefits and/or insurance reimbursement. If any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation. I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian: ____ Date________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations. You also have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the office. Please understand that the revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation.

I, _______________________, have been informed of, and given the right to review and was offered a copy of your Notice of Privacy Practices. I understand that by signing the consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities, and health care operations.

Patient Signature: ____ Date________________