Christos Vasakiris, D.C.,D.A.C.A.N.
350 West Montauk Highway
Lindenhurst, N.Y , 11757

PLEASE PRINT

Patient Name _____ SS# _____

Address _____ City _____

State _____ Zip Code _____ Birth Date ____/____/_____ Age _____

Circle one: Marital Status: S/M/D/W/P
How Did you find us?_____
Your Occupation _____ Years at this job _____

Your Employer's Name &
Address_____

Cell Phone (____) _____ Work Phone (____) _____
Home Phone # (____) _____

E-Mail Address:_____

MEDICAL PHYSICIAN'S NAME _____
ADDRESS _____

EMERGENCY CONTACT
NAME:_____PHONE_____

If the patient is a minor, permission is hereby given to the doctors in this office to perform an examination and treatments. I am his/her legal guardian.

Parent Signature _____

INSURANCE INFORMATION: (choose one)

Medical Insurance company name: _____
Policy #: _____ Group #: _____
Insured person's name _____ SS#: _____

No-Fault Insurance Company: _____
Policy Number (Insurance Card) _____ Phone #: _____
Mailing Address _____

Worker's Compensation Carrier Name/Phone#_____
Claim # _____ Policy # _____ Date injured _____

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____ hereby states that by signing this consent, I acknowledge and agree as follows.
PATIENT NAME

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosure of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out it's health care operations. The Practice has further explained to me that the Privacy Notice will be available to me in the future upon my request. The Practice has further explained to 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 the Consent.
2. The Practice reserves the right to change it's privacy practices that are described in it's Privacy Notices, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice a) a postcard mailed to me at the address provided by me; and b) telephoning my home, cellular device or place of employment, and leaving a message on my answering machines or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct it's specific healthcare operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the practice is not required to agree to any restrictions that I have requested. If the practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke consent, in writing, at anytime for *all future* transaction, with the understanding that such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent.
7. I understand that <u>if I revoke consent</u> at any time, <u>the Practice has the right to refuse to treat me.</u>
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 Practice will have the option not to treat me.

I have read and understand the forgoing 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** **Date**

_____ _____
Signature of Legal Representative **Relationship**

PATIENT AUTHORIZATION
FOR THE USE AND DISCLOSURE
OF PROTECTED HEALTH INSURANCE

1. I, _____, hereby authorize Dr.Vasakiris to use and/or disclose to my insurance company, treating physicians, and/or attorney, the following specific protected health information: complete medical record unless otherwise informed.

2. I understand that this authorization is valid until I inform Dr.Vasakiris that this authorization is no longer valid.

3. I understand that the purpose or use of the disclosure I am granting is to protect my patient privacy and personal health information.

4. I expressly acknowledge that this authorization is voluntary.

5. The following is/are other criteria or limitations that I make regarding this authorization:
   _____
   _____

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

9. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form.

10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its consents.

12. This authorization is valid as of ___/___/_____, the date I have signed below.

_____ _____
Name of Individual (Printed) Signature of Individual Date

_____ _____
Signature of Legal Representative Relationship

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:

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°

Patient Type

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

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)

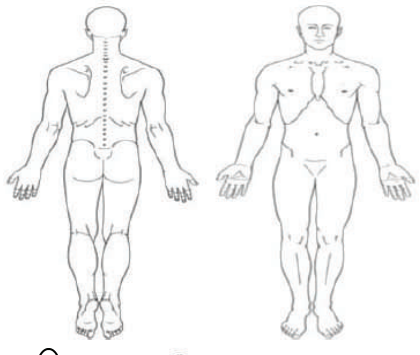
Back Index | LEFS

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:** _____

Please answer all the following questions to the best of your ability.

WHAT IS YOUR MAJOR COMPLAINT? _____
_____
_____
HOW LONG HAVE YOU HAD THIS PROBLEM? _____
PLEASE DESCRIBE WHAT YOU FEEL IS THE CAUSE OF THIS COMPLAINT:
_____
_____

If Your Current Problem is from an AUTO ACCIDENT OR WORK Injury PLEASE SPECIFY:
WORK RELATED **AUTO RELATED**

This Box For Auto & Work injury Only

Please specify the date and time of your injury: Date: _____ Time: _____ Location: _____
If this was a car accident, were you (circle one): DRIVER / PASSENGER in the: FRONT/ BACK of the car or A PEDESTRIAN
How long have you been working at your current job? _____ (circle one): FULL TIME or PART TME
Are you currently working? YES or NO Last Day worked: ____/_____/_____
TO WHOM WAS THE ACCIDENT REPORTED IF IT OCCURRED AT WORK? (ex. Supervisor) _____
Did you report this accident to your insurance company? YES or NO
Please specify exactly what tasks your job involves: _____
_____

If you have been treated or seen by another Doctor or Hospital for this problem, please give us their name and address as well as what the doctor did for you and what they told you.

NAME OF DOCTOR: _____ SPECIALTY: _____
TREATMENT GIVEN: _____
SPECIAL TESTS (x-rays, etc.): _____
WHAT DID THEY SAY? _____

IS YOUR CONDITION GETTING: (circle one) WORSE BETTER SAME
WHAT HAVE YOU BEEN DOING FOR THIS INJURY AT HOME? _____
PRIOR TO THIS INJURY, HAVE YOU HAD A SIMILAR COMPLAINT? YES or NO
_____
_____
DO YOU NOTICE ANY ACTIVITY RESTRICTIONS TO YOUR DAILY ROUTINE SINCE THE INJURY?
_____
HOW HAS THE PAIN AFFECTED YOUR SLEEP HABITS? _____
_____
WHAT MAKES YOUR PAIN WORSE? _____
WHAT MAKES YOUR PAIN BETTER? _____

IS THERE ANY OTHER AREA OF YOUR BODY THAT CAUSES YOU PAIN? (circle one) YES or NO
If yes, where? _____

HAVE YOU EVER HAD A PREVIOUS MOTOR VEHICLE ACCIDENT OR JOB INJURY IN YOUR LIFE? (circle one) YES or NO If yes, when and how? _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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 _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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 _____

PREVIOUS MEDICAL HISTORY

Smoker? Yes/No Packs/Day _____ Alcohol intake weekly yes/no (circle one)
Recreational Drugs (ever) Yes/No Allergies_____

Describe all surgeries

_____
_____

Describe all fractures _____

Describe all Medical Problems (Diabetes, High Blood Pressure,Heart, Kidney, etc.)

_____
_____

Describe all Hospitalizations:

_____
_____

List all Medications or Pills You Currently are Taking:

- _____
- _____
- _____
- _____

Have you ever had any of the following tests performed? & Why!

- MRI
- CAT SCAN
- X-RAYS
- EMG/NCV
- MYELOGRAM
- PAIN INJECTIONS

HAVE YOU EVER BEEN DIAGNOSED OR SUSPECTED OF HAVING CANCER?
_____

HAVE YOU EVER HAD A MOTOR VEHICLE ACCIDENT? WHEN?
_____

HAVE YOU EVER BEEN INJURED ON THE JOB BEFORE? WHEN?
_____

CHECK OFF ALL CONDITIONS THAT YOU MAY HAVE CURRENTLY OR HAVE HAD IN THE PAST

□ ATHRITIS	□ THYROID PROBLEMS	□ ULCERS
□ ARTERIOSCLEROSIS	□ HIGH BLOOD PRESSURE	□ PAIN UPON URINATION
□ ANEMIA	□ EPILEPSY	□ BLOOD IN STOOLS
□ ASTHMA	□ GALL BLADDER	□ DIFFICULTY SLEEPING
□ ALCOHOLISM	□ LIVER	□ VENEREAL DISEASE
□ WEAKNESS OF MUSCLES	□ INTESTINAL PROBLEMS	□ FEVER
□ HEAD TRAUMA	□ DEPRESSION	□ HEART ATTACK
□ SWELLING FEET	□ HEADACHES	□ FAINTING
□ BLOOD PROBLEMS	□ NECK PAIN	□ WEIGHT LOSS
□ DIABETES	□ NUMBNESS arms/legs	□ STROKE
DO YOU HAVE A PACEMAKER? (CIRCLE ONE)		YES or NO

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem necessary concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof. I have received the Notice of Privacy Practices (HIPPA) and I have been offered a copy of such.

ACKNOWLEDGEMENT & UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services at **Dr. Christos Vasakiris, D.C., P.C.'s office** and that I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined that either:

(a) There is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor of make other provisions for the protection of the interest of the doctor, or

(b) If the liability claim exists and my attorney refuses to agree to protect the doctor, or I have not engaged the services of an attorney:

then payment for the services rendered by the doctor at **350 West Montauk Highway Lindenhurst** will be made on a current and timely basis by myself and paid in full. I agree to take full responsibility for the outstanding balance.

I hearby give consent to Dr. Christos Vasakiris to administer any/all chiropractic services allowed under the scope of practice in New York State which he deems necessary in the treatment and diagnosis of my condition.

PATIENT'S SIGNATURE _____ **DATE** _____