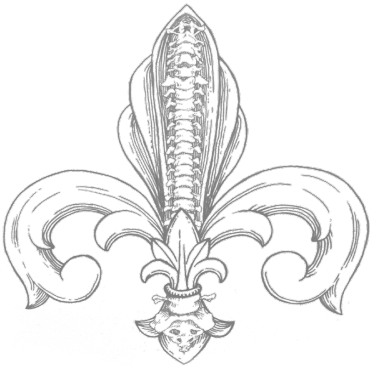
# St.Thomas Chiropractic & Wellness

**Dr. Derek St. Thomas, DC, Cert. MDT**

228 W. 71st St, New York, NY 10023

(646) 678-2225

derek@stthomaschiro.com



# New Patient Form

## Patient Information

**Referred By:** _____ **Date:** _____

**Patient Name:** Last _____ First _____ SSN#_____

**Address** _____ **City** _____ **State** ____ **Zip** _____

**Email:** _____ **Home #** _____ **Cell #** _____

**Sex:** M F **Marital Status:** M S D W **Date of Birth:** _____ **Age:** _____

**Occupation:** _____ **Employer:** _____

**Employer Address** _____ **City** _____ **State** ____ **Zip** _____

**Emergency Contact:** _____ **Relationship:** _____

**Home Phone** _____ **Cell Phone** _____

## Credit Card Payment Authorization

I _____, hereby authorize Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness at 228 West 71st St, New York, NY 10023, to charge my credit card for services rendered, missed appointments and/or products supplied for a period of one year from the date below. It is my responsibility to notify Dr. Derek St.Thomas, DC/St.Thomas Chiropractic & Wellness of any changes regarding this credit card authorization.

**Name on Card:** _____

**Signature:** _____ **Date:** _____

**Credit Card Type:** *M/C* *VISA* *AMEX* *DISCOVER*

**Credit Card Number #** _____

**Exp Date:** _____ **Sec Code:** _____ **Billing Address/Zip Code:** _____

# AUTHORIZATIONS & ACKNOWLEDGEMENTS

*While it is never our intention to bring anything of a potentially negative bent into a health and healing relationship, we, along with other health care providers and hospitals, are obliged by the state of New York to ask that you read and sign the following:*

**TREATMENT AUTHORIZATION:** I (print name) _____ authorize Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness including but not limited to spinal adjustments, joint mobilizations, magnetic resonance therapy, shockwave therapy, myofascial release, active release, instrumented assisted soft tissue manipulation/mobilization, therapeutic massage, percussive massage, infrared light therapy (Celluma), active and passive stretching, therapeutic exercises, neuromuscular reeducation techniques, for myself and/or my minor or child by Dr. Derek St.Thomas, DC, Cert. MDT dba St.Thomas Chiropractic & Wellness.

**INFORMED CONSENT:** Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include; sprain/strain injuries, irritation of a disc condition, mild bruising, petechiae, skin irritation and in rare instances, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be correlated with a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and your spinal health. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness to be able to anticipate and explain all possible risks and complications of treatments. I understand that results are not guaranteed.

In addition, I understand that Dr. Derek St.Thomas, DC, Cert. MDT will review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

**MEDICAL DOCTOR:** Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness believes your medical doctor is a vital part of your healthcare team. As such, upon your request, we will send evaluations and progress reports to the physicians listed below:

**Doctor's Name**:_____

**Specialty:** _____ **Address:**_____

**City:** _____ **State:** _____ **Zip Code:** _____

**FINANCIAL RESPONSIBILITY FOR ALL ST.THOMAS CHIROPRACTIC & WELLNESS SERVICES:**
I understand and agree to the following policies regarding fees and financial responsibilities: Payment is required at or before each visit services are rendered and are as follows: New/First Patient Office Visit Fee: $450.00 and Existing Patient/Follow-up Office Visit Fees: $250.00. I acknowledge that I am responsible for charges incurred for all treatments. I further understand, that Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness to take action to secure payment of an outstanding balance owed.

**CANCELLATION AND/OR NO-SHOW POLICY:** St.Thomas Chiropractic & Wellness urges you to keep every appointment, as consistent treatment provides optimal benefit. In the event you need to cancel an appointment, we require at least 48 hours' notice for new and existing patients. Any patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a $450 charge (new patients) or $250 charge (existing) for each occurrence. Arrival more than 15 minutes after the time of your scheduled appointment may be considered a failed appointment. If the doctor decides to treat you for whatever time is remaining from your appointment, then your treatment will be reduced to ensure that we are still being fair and reasonable to the next patient that did arrive on time.

**NO GUARANTEES:** I recognize that the practice of Chiropractic is as much an art as a science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any treatment and/or therapy rendered with/at Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness.

**REVOCATION OF AUTHORIZATIONS:** These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

**PATIENT ACKNOWLEDGEMENT:** I attest, to the best of my knowledge, all the information I provide to Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness is accurate and true. I certify that I am here to receive chiropractic care and for no other purposes. I do not represent a third party. By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my doctor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including my individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the Chiropractic treatments offered or recommended to me by Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness. I intend this consent to apply to all my present and future Chiropractic care visits with Dr. Derek St.Thomas, DC, Cert. MDT/St.Thomas Chiropractic & Wellness.

**Patient Name(Print)** **Signature** **Date**

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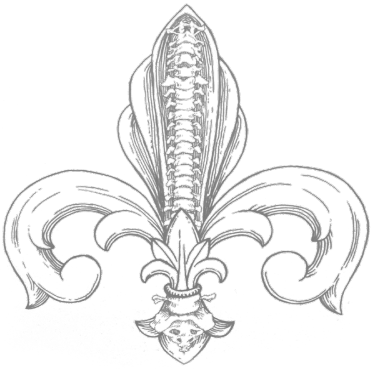

# Patient Intake Form

## Reason for Visit:

**Describe Symptoms:** _____

_____

_____

_____

**What caused your symptoms?** _____

_____

_____

_____

**Since the onset, you are feeling:** Better Worst The Same

**Your symptoms are:** Constant Intermittent Episodic Momentary

**Rate your pain on a scale of 0-10 based on the below criteria:**

**(0-10) At Best _____ At Worst _____ Average _____ Currently _____**

**Please circle all that apply:** Achy Sore Strained Sharp Stabbing Shooting Swollen Bruising Burning Numbness Tingling Radiating Weakness Heaviness Balance Issues Coughing Sneezing Icy/Cold Sensations Hyper-Sensitivity other, please describe: _____

**Number of Previous Episodes:** 0 1 2 3 + Year of First Episode: _____

**Previous History (include treatments):**

_____

_____

_____

_____

_____

_____

**Choose from the list and Circle all that make you feel <u>worse</u>**

Bending Sitting/Rising Standing Walking Lying Running Cycling Stairs
AM/As the day progresses/PM Being still/On the move Not sure/Seems Random

**Circle all that make you feel <u>better</u>**

Bending Sitting/Rising Standing Walking Lying Running Cycling Stairs
AM/As the day progresses/PM Being still/On the move Not sure/Seems Random

**Does coughing or sneezing reproduce the pain?** Yes No

**Any numbness or tingling or electric shock sensations?**

No Currently At Onset Occasional

**Any changes to bowel or bladder function?** Yes No

**If Yes, circle any that apply:** Loss of Control Inability to empty Increased Urinary Frequency

**Pain worse at night?** Yes No **Does the pain wake you up?** Yes No

**Unexplained Weight Loss?** No Yes_____ lbs lost in _____ weeks/months

**Medical History (**anything pertinent such as recent surgeries, traumas, hospitalizations, auto or other work-related accidents**)**

_____

_____

_____

_____

_____

_____

_____

**Family Medical History** (history of heart disease, cancer, stroke, diabetes, hypertension, autoimmune, inflammatory, arthritic conditions, etc.)

_____

_____

_____

_____

_____

_____

_____

**Current or recent medication** (please list any recent medications that you have taken or take on a regular basis)

_____

_____

_____

_____

_____

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Dr. Derek St.Thomas, DC to provide me with chiropractic care, in accordance with this state's statutes.

**Patient Name(Print)** **Signature** **Date**

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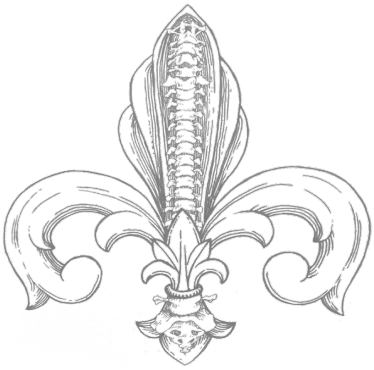

## Notice of Privacy Practices

**By signing and dating this form I acknowledge that I have received a copy of St.Thomas Chiropractic & Wellness's Notice of Privacy Practices:**

Patient's Name (Please print)

Patient's Signature Date

**If executed by a patient's personal representative or legal guardian, please complete the information in the space below:**

Personal Representative's/ Legal Guardian's Name (Please print) Relationship

Personal Representative's/ Legal Guardian's Signature Date

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## HIPPA NOTIFICATION ELECTRONIC MAIL (EMAIL) COMMUNICATIONS

The goal of St.Thomas Chiropractic & Wellness is to make communication between you and Dr. Derek St.Thomas, DC, Cert. MDT as easy for you as possible. As such, you have the right to request communication with you via electronic mail (email). However, prior to consenting to such communication, please take a moment to realize any and all privacy risks associated with this form of communication.

Email communications are a two-way communication. However, responses and replies to emails sent to or received by either you or St.Thomas Chiropractic & Wellness may be hours or days apart. As such, acute conditions should never be addressed using email communication.

Although St.Thomas Chiropractic & Wellness will make every effort to maintain privacy, email messages, on any device, have Internet privacy risks, as there is no way to ensure an email is completely tamper resistant. That being said, you should not use email to discuss anything you wish to remain entirely confidential.

In order to forward and/or process and/or respond to your email, individuals at St.Thomas Chiropractic & Wellness, other than the intended recipient, may have access to or read your email message. Please remember, email communication is not a means of private communication.

This document, along with any and all communications, may become part of your St.Thomas Chiropractic & Wellness medical record.

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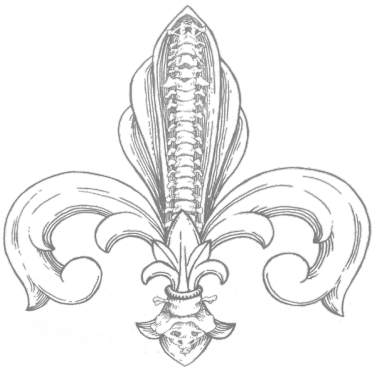

## PATIENT REQUEST FOR EMAIL COMMUNICATION

*Please complete the information below if you wish to communicate with Dr. Derek St.Thomas, DC, Cert. MDT/*St.Thomas Chiropractic & Wellness *via email, knowing there are inherent privacy risks.*

Patient Name: _____

Date of Birth:_____

Email Address: _____

***Please initial each line and sign below:***

_____The email address contained herein is accurate, and I accept full responsibility for messages sent to or from this address.

_____I have read, reviewed, and received a copy of this HIPPA Notification: Electronic Mail Communications.

_____I understand and acknowledge that there are inherent privacy risks when communication is over the Internet.

_____ I agree to hold St.Thomas Chiropractic & Wellness and its agents and representatives harmless from any and all claims and liabilities arising from or related to this Request for Email Communications.

☐Patient does not consent to email communication.

Patient Signature: _____ Date:_____

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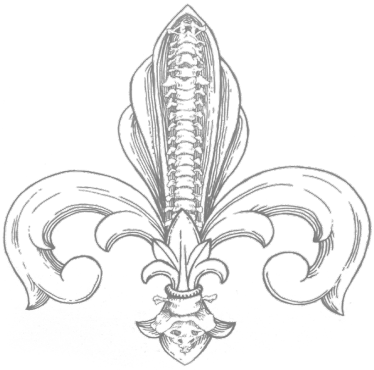

## CONFIRMATION PREFERENCE SHEET

Patient Name: _____

Please circle which you prefer for appointment confirmations:

**TEXT MESSAGE** **E-MAIL**

- For text message reminders, please indicate your cell service provide:

  _____ (ATT, Verizon, Sprint, etc.)

- For email reminders please indicate your preferred e-mail address below:

  _____

  I consent to the use of either my e-mail address or cell phone number for appointment confirmations at St.Thomas Chiropractic & Wellness.

Patient Signature: _____ Date:_____