# Fingers From Heaven

**Connie Tjaden, L.Ac., LMT**
**15 Echo Avenue**
**Mount Sinai, New York 11766**
**631-680-9458**

## REGISTRATION FORM

**Patient Name**: _____ **Date:** _____

**Age:** _____ **Date of Birth**: _____ **Gender: M / F**

**Address:** _____**City:** _____ **State:** _____ **Zip:** _____

**Home Phone:** _____ **Work Phone:** _____

**Cell Phone:** _____ **Email Address:** _____

**SS #:** _____

**Emergency Contact:** _____ **Phone:** _____

**Connie Tjaden L.Ac., LMT, is an Out of Network Provider,**
**but may assist with insurance reimbursement.**
**All payments are due at the time of treatment.**

**Primary Insurance**: _____**Policy #**_____

**Insurance Phone Number**: _____

**Insurance Policy holder (name):** _____

**Group Number:** _____ **E. Payor ID:** _____

**Relationship to Patient:** _____ **Date of Birth**: _____

**Address (if different from above)**_____

**Assignment and Release of Information statement**: I certify that the information given by me is correct. I understand that this information is entered into a database, and I hereby authorize the release of information related to my medical care as requested, by government agencies and/or insurance carriers. I hereby assign benefits, and understand that in the absence of accepted insurance coverage, I/Legal guardian am responsible for full payment of services rendered. **Litigation Disclaimer:** It is understood, and agreed, that I am requesting examination and treatment for medical purposes only, and not requesting any information in connection with pending or proposed litigation.

**Authorized Signature/Guardian:** _____**Date:** _____

# Fingers From Heaven

**Connie Tjaden, L.Ac., LMT**
**15 Echo Avenue**
**Mount Sinai, New York 11766**
**631-680-9458**

## REGISTRATION FORM

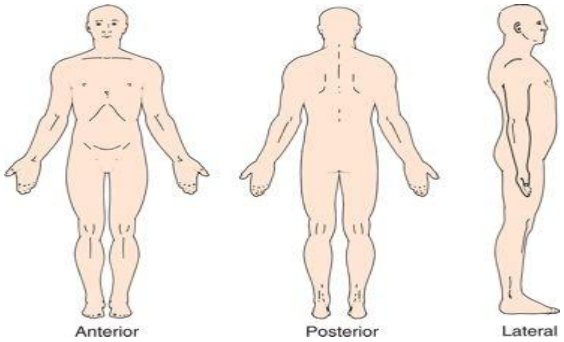
Name: _____

Chief Complaint: _____

Date of injury or symptom onset: _____

Please describe the injury or problem:

_____




**Where is your pain?** Please mark the drawing

*Please indicate your pain level* *0 = No pain 10 = Extreme pain*

1. Right now 0 1 2 3 4 5 6 7 8 9 10
2. At best 0 1 2 3 4 5 6 7 8 9 10
3. At worst 0 1 2 3 4 5 6 7 8 9 10

4. What makes it better? _____ 5. What makes it worse? _____

Circle the words which best describe your symptoms:

| | | | | |
|---|---|---|---|---|
| Dull/Achy | Shooting | Awareness | Sharp/Stabbing | Burning |
| Throbbing | Heaviness | Weakness | Tightening/Constricting | Numbness |

**Previous Treatments:**

Please list all treatments that you have tried for you condition including physical/occupational therapy, massage, acupuncture, chiropractic, injections, and medications (please list type of injection and/or medications).

_____

_____

**Past Medical History/Past Surgical History**

Please list any ongoing medical problems (High blood pressure, Diabetes, Thyroid disorder, Cancer, Bleeding disorder, Heart disorder, Asthma, Arthritis, Headaches)

_____

_____

Are you allergic to any medication? Y or N If yes, please list.

_____

**Family History**

Does anyone in your family have any of the following problems?

Heart disease High blood pressure Cancer Nerve Disorders Stroke Diabetes Blood problems
Other_____

Do you smoke or drink alcohol? Yes No Are you currently pregnant? Yes No

The information I have provided is accurate and complete, to the best of my knowledge:

**Signature: _____ Date: _____**

# Fingers From Heaven

**Connie Tjaden, L.Ac., LMT**
**15 Echo Avenue**
**Mount Sinai, New York 11766**
**631-680-9458**

## CONSENT FORM

I, _____ understand that as part of my health care, **Fingers From Heaven**, will create and maintain, health records describing my health history, symptoms, examinations, and test results, diagnosis, treatment, and any plans for future care or treatment.

**I understand that this information serves as a:**

• Mode of communication among the many health professionals who contribute to my care

• Source of information for applying my diagnosis information to my bill

• Basis for planning my care and treatment

• Means by which a third-party payer can verify that services reported were actually provided

• A tool for routine healthcare operations, such as assessing the quality, and reviewing the competence, of healthcare professionals

• Anonymous data may be used to track clinical progress to use for research purposes

I understand that I am entitled to a more complete description of this information, uses, and disclosures. I understand the organization reserves the right to change their notice and practices, prior to implementation, and will mail a copy of any revised notice, to the address above, that I've provided. I understand that I have the right to object to the use of health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used, or disclosed, to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also fully endorse responsibility for all fees related to my care. I understand that my insurance provider may or may not, reimburse me for these services, and I will remain wholly responsible for payment.

I fully understand, and accept, the terms of this consent.

**Signature: _____ Date: _____**

# AUTHORIZATION TO PAY THE ACUPUNCTURIST/MASSAGE THERAPIST

I hereby direct, and instruct the _____ Insurance Company, to pay by check, made out, and mailed directly to, **Fingers From Heaven, Inc.**

If my current policy prohibits direct payment to any professional, then I hereby authorize you to make the check payable to me, and mail to the providers address as listed below:

_____ (Patient's Name)
**Fingers From Heaven, Inc.**
46 Blackpine Drive
Medford, New York 11763

**This is a Direct Assignment of my rights, and benefits under this policy.**

I agree to pay for services rendered to the above-mentioned patient, as the charge is incurred. I understand that health and no-fault insurance policies, are arrangements between an insurance carrier and myself, and that I am personally responsible for payment, of any, and all services covered, or not covered. If the provider is a contracted provider for my managed care plan, I understand that I am responsible for all co-payments, and non-covered services. I also understand, and agree to pay all co-payments and fees, for non-covered services, prior to seeing the professional. I understand that if I terminate my care and treatment, any fees for professional services rendered to me, will be immediately due, and payable.

I hereby authorize, and direct payment of any medical/professional services expense benefits allowable to professional, as payment toward the total charges for services rendered. This payment will not exceed my indebtedness to the assignee. **This is a direct assignment of my rights under this policy. I agree that a photocopy of this agreement shall serve as the original.**

**Authorization to Release Information**

I hereby authorize **Fingers From Heaven, Inc.,** and their staff, to release or request any information deemed appropriate, concerning my physical condition, to and from the Insurance Company, claims adjuster, nurse case manager, claims reviewer, etc., health care provider or attorney. I also authorize the _____ Insurance Company, to process the claim for reimbursement, for charges incurred by me, as a result of professional services rendered. I hereby release him/her of any consequences thereof. **I agree that a photocopy of this agreement shall be considered the original.**

_____ _____
**(Signature of Policy Holder or Claimant)** **Date**

# Fingers From Heaven

**Connie Tjaden, L.Ac., LMT**
**15 Echo Avenue**
**Mount Sinai, New York 11766**
**631-680-9458**

## NEW YORK STATE MOTOR VEHICLE NO-FAULT INSURANCE LAW
## ASSIGNMENT OF BENEFITS

## (FOR AN ACCIDENT OCCURRING AFTER 3/1/02)

I, _____ ("Assignor") hereby assign **Fingers From Heaven** ("Assignee") all
(Print Patient Name)

Rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault Statute) of the insurance law.

The assignee hereby certifies that, they have not received any payment from, or on behalf of the assignor, and shall not pursue payment directly from the Assignor, for services provided by said Assignee, for the injuries sustained, due to the motor vehicle accident, which occurred on _____, notwithstanding, any other agreement to the contrary.
(Print Accident Date)

This agreement may be revoked by the assignee when benefits are not payable, based upon the assignor's lack of coverage, and/or, violation of a policy condition, due to the actions, or conduct of the assignor.

**ANY PERSON WHO KNOWINGLY, AND WITH INTENT, TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR COMMERCIAL INSURANCE, OR A STATEMENT OF CLAIM FOR ANY COMMERICAL OR PERSONAL INSURANCE BENEFITS, CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACTS MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES, OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES, WITH ANOTHER, TO MAKE A FALSE REPORT OF THE THEFTS, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE, TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES, OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY, NOT TO EXCEED FIVE THOUSAND DOLLARS, AND THE VALUE OF THE SUBJECT MOTOR VEHICLE, OR STATED CLAIM, FOR EACH VIOLATION.**

_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Address of Patient) (Date of Signature)

_____ _____
(Signature of Provider)

_____ _____
(Date of Signature)

Provider**:** **Fingers From Heaven**
**Connie Tjaden, L.Ac., LMT**
**15 Echo Avenue**
**Mount Sinai, New York 11766**

NY Form NF-AOB (REV1/2004)

**AUTHORIZATION**

**I further authorize release of Medical Records, and information to the provider listed on the NYS Form NF-AOB, it's representative, or assigns, and specifically waive, any privilege that may be associated therewith.**

_____ _____
**(Signature of Patient)** **(Date)**

# Fingers From Heaven

**Connie Tjaden, L.Ac., LMT**
**15 Echo Avenue**
**Mount Sinai, New York 11766**
**631-680-9458**

## LIEN

**Date:** _____

**Patient:** _____

**DOA:** _____

**Attorney:** _____

_____

_____

I, _____ authorize the above practitioner, **Connie Tjaden, L.Ac., LMT,** to furnish you, my attorney, with a full report of her examination, diagnosis, treatment, prognosis, etc., of myself, in regard to the accident in which I was involved. I hereby authorize and direct you, my attorney, to pay directly to said practitioner, such sum as may be due, and owing her for professional services rendered to me, both by reason of this accident, and by any other bills that are due her office, and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said practitioner. I hereby further give a lien on my case to said practitioner, against any and all proceeds of any 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 fully understand that I am directly, and fully responsible, to said practitioner, for all professional bills submitted by her for services rendered me. This agreement is made solely for said practitioners' additional protection, and in consideration of her awaiting payment. I further understand that payment is not contingent of any settlement, judgment or verdict, by which I may eventually recover said fees.

_____
**(Patient signature)**

The undersigned, being attorney of record for the above named patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said practitioner, named above.

**Date:** _____ **Signed Attorney:** _____

**Attorney: please sign, date and return one copy to this office**

# Fingers From Heaven

**Connie Tjaden, L.Ac., LMT**
**15 Echo Avenue**
**Mount Sinai, New York 11766**
**631-680-9458**

## No-Fault Registration Form

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: _____SS#: _____ D.O.B._____

Telephone: (H) _____ (W) _____(C) _____

Email: _____

Emergency Contact/Relationship: _____ Phone: _____

**No Fault Insurance Information**

Name of Vehicle Ins. Company: _____

Address: _____ City: _____ State: _____Zip: _____

Name of Adjuster: _____ Phone: _____

Policy #: _____ Claim #: _____

Date of Accident: _____ E-Payor #: _____

**Attorney Information:**

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

# Fingers From Heaven

**Connie Tjaden, L.Ac., LMT**
**15 Echo Avenue**
**Mount Sinai, New York 11766**
**631-680-9458**

## No-Fault Registration Form

Name_____ Age_____ Birthdate_____

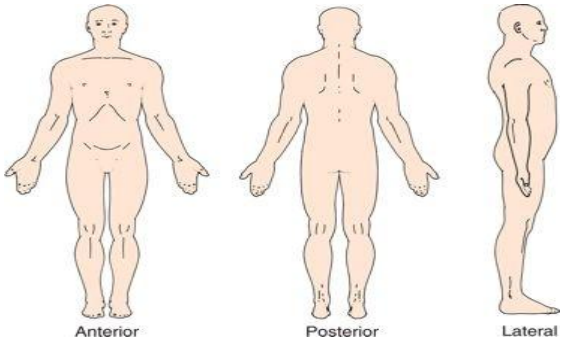
Chief Complaint: _____

Date of injury or symptom onset: _____

Are you currently pregnant? _____

Please describe the injury or problem: _____

_____




**Where is your pain?** Please mark the drawing

*Please indicate your pain level*
*0 = No pain 10 = Extreme pain*

1. Right now 0 1 2 3 4 5 6 7 8 9 10
2. At best 0 1 2 3 4 5 6 7 8 9 10
3. At worst 0 1 2 3 4 5 6 7 8 9 10
4. What makes it better? _____
5. What makes it worse? _____

Circle the words which best describe your symptoms:

Dull/Ache Shooting Awareness Sharp/Stabbing Gnawing Burning Numbness
Throbbing Heaviness Weakness Tightening/Constricting

What diagnostic tests have you had for this condition? (X-ray, MRI, EMG, etc.)

| Diagnostic test | Date | Results |
|---|---|---|
| | | |
| | | |
| | | |

# Fingers From Heaven

**Connie Tjaden, L.Ac., LMT**
**15 Echo Avenue**
**Mount Sinai, New York 11766**
**631-680-9458**

## Consent Form

I, _____ understand that as part of my health care, **Fingers From Heaven,** will create, and maintain, health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment.

**I understand that this information serves as a:**

• Mode of communication among the many health professionals who contribute to my care

• Source of information for applying my diagnosis information to my bill

• Basis for planning my care and treatment

• Means by which a third-party payer can verify that services reported were actually provided

• A tool for routine healthcare operations, such as assessing the quality and reviewing the competence of healthcare professionals

• Anonymous data may be used to track clinical progress to use for research purposes

I understand that I am entitled to a more complete description of this information, uses, and disclosures. I understand the organization reserves the right to change their notice and practices, prior to implementation, and will mail a copy of any revised notice to the address above that I've provided. I understand that I have the right to object to the use of health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed, to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also fully endorse responsibility for all fees related to my care. I understand that my insurance provider may or may not reimburse me for these services, and I will remain wholly responsible for payment.

I fully understand, and accept the terms of this consent.

**Signature: _____ Date: _____**