



TIMOTHY D GROTH, MD. PC.  
CHIROPRACTIC CARE  
1500 MIDDLE COUNTRY RD.  
CENTEREACH, NEW YORK 11720  
PHONE: (631)736-4414  
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Dear Patient,

Welcome to our office! We look forward to meeting with you, reviewing your medical history, and working together to relieve your pain and rehabilitate your condition.

Enclosed you will find a patient questionnaire. It is very important that you take the time to complete this prior to your initial visit. This information will help us understand your condition and overall health, so we can best treat your pain, and all aspects of your spine related disorders.

We are a multi-disciplinary office, and offer integrative and collaborative care, which includes Chiropractic Care, Pain Management (MD/DO/NPs/PAs), Massage Therapy, and Physical Therapy. Research has shown that collaborative care results in better clinical outcomes and faster results.

Due to HIPAA regulations, it is your responsibility to obtain as many medical records as possible that are available to you. This includes office visit notes and diagnostic testing (i.e., MRIs, X-rays, CT scans, EMG reports). Complete and accurate information will enable us to meet your medical and other needs appropriately. Failure to do so, may result in a delay of treatment, as our review of records are essential in determining the best way to relieve your pain.

Please be sure to complete and sign the "Authorization to Obtain Health Information" form. If you need copies of your records from this office, we require two weeks notice to process. A signed written request must be presented to our office with specific details of the records you are requesting.

**Please bring the following to your appointment:**

1. Driver's license/ Photo ID
2. Health Insurance cards
3. Imaging reports (MRIs, CTs, X-rays, etc.)
4. If applicable, Referrals or related medical records
5. Co-payment due upon arrival

Thank you very much for your cooperation. We look forward to meeting you.

Sincerely,

Timothy Groth, MD. Medical Director and Director of Pain Management  
David BenEliyah, DC. Director of Chiropractic Services



**PATIENT DEMOGRAPHICS**

Date: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Email: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**INSURANCE INFORMATION**

(For NF/WC Cases, skip this section & fill out next page)

**Primary Insurance:** \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Phone #: \_\_\_\_\_

I authorize my insurance benefits to be paid directly to Timothy D. Groth, MD. PC. I understand that I am financially responsible for any fees and balances.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**WORKER'S COMP/ NO FAULT QUESTIONNAIRE (IF APPLICABLE)**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Do you have No Fault Insurance? YES NO Date of Accident: \_\_\_\_\_

Do you have Workers Comp Insurance? YES NO Date of Accident: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Address: \_\_\_\_\_

Claim #: \_\_\_\_\_ WCB #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

**Is this injury from a motor vehicle accident?**

Date of Accident: \_\_\_\_\_

Were you the: Driver Passenger Front seat Back seat

Road Condition: Dry Wet

Were you wearing a seat belt? YES NO

Was it a frontal/ rear or side impact collision?

Did you hit your head? YES NO Did you lose consciousness? YES NO

Did you go to the hospital? YES NO Did you go by ambulance? YES NO

Treatment given at hospital: \_\_\_\_\_ Imaging: \_\_\_\_\_ Medications: \_\_\_\_\_

Did you have any prior accidents in the past before this one? YES, when \_\_\_\_\_ NO

Did you have any neck or back issues prior to this accident? YES NO

If yes, did they resolve and completely go away? \_\_\_\_\_

Have you seen any other doctors prior to seeing us for this accident? YES NO

If yes, who/when \_\_\_\_\_

**Is this injury from a work-related accident?**

Date of Injury: \_\_\_\_\_

Are you employed: \_\_\_\_\_

Occupation: \_\_\_\_\_

Did you file an injury report with your employer: YES NO

Are you currently working? YES NO

Did you go to the hospital? YES NO

Did you have any prior work-related injuries? Yes, type of injury: \_\_\_\_\_ NO

Have you seen any other doctors prior to seeing us for this accident? YES NO

If yes, who/when \_\_\_\_\_

**If your case is NF or WC, do you have an attorney? YES NO**

Attorney Name: \_\_\_\_\_ Law Firm: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INITIAL CONSULT**

Where Is Your Pain Now?

Please use the appropriate symbols to describe your symptoms and mark the location as accurately as possible on the body drawing.

ACHING      ^^^^^^^^

STABBING    //////////////

TINGLING    =====

BURNING     xxxxxxxxx

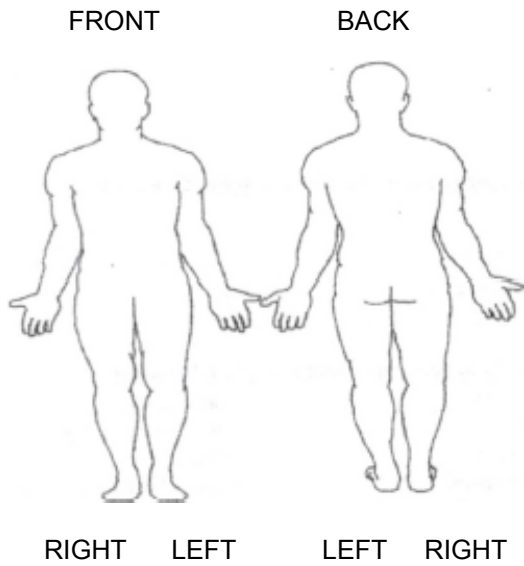
NUMBNESS   ooooooooo

ALLERGIES:

DIABETIC: (TYPE 1 OR 2)    A1C: \_\_\_\_\_

BLOOD THINNERS:

INSURANCE:



How bad is your pain?

(No Pain)    1    2    3    4    5    6    7    8    9    10    (Worst)

List current medications for your pain:

\_\_\_\_\_  
\_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)**

REFERRED: \_\_\_\_\_

PAIN: \_\_\_\_\_

\_\_\_\_\_

WHEN: \_\_\_\_\_

BETTER: \_\_\_\_\_

WORSE: \_\_\_\_\_

P: \_\_\_\_\_

I: \_\_\_\_\_

T: \_\_\_\_\_

S: \_\_\_\_\_

B/P:                      HEIGHT:                      WEIGHT:                      POC:

**PATIENT PAIN PROFILE**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Date problem started: \_\_\_\_\_ Did your pain begin suddenly or gradually? \_\_\_\_\_

Describe your pain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pain level (1-10) without medications: \_\_\_\_\_ With medications: \_\_\_\_\_

Do you experience any weakness?	LEFT- ARM / LEG	RIGHT- ARM / LEG
Do you experience numbness/tingling?	LEFT- ARM / LEG	RIGHT- ARM / LEG
Which hand is dominant?	LEFT	RIGHT
Does pain interrupt your sleep?	YES	NO

Has pain changed your normal activities? ( ✓ )

Sleeping	Dressing	Enjoyment of life
Walking	Hobbies	Relationships
Eating	Sports	Work/Housework
Exercising	Mood	Other _____

What percentage has your pain/injury adversely affected your Activities of Daily Living? \_\_\_\_\_ %

What percentage has your pain/injury decreased your Quality of Life? \_\_\_\_\_ %

Please indicate below what makes your pain better ( **B** ) or worse ( **W** ):

Heat _____	Humidity _____	Standing _____	Laying down _____
Ice _____	Cold _____	Sitting _____	Massage _____
Noise _____	Coughing _____	Sneezing _____	Bowel movements _____
Stairs _____	Fatigue _____	Alcohol _____	Anxiety/Emotions _____

Please indicate any treatments you have undergone for your pain problem. Place a (+) to those that were effective and (-) next to those that did not help:

Acupuncture	Chiropractic	Massage
Bed Rest	TENS	Traction
Physical Therapy	Relaxation Therapy	Psychotherapy
Trigger Point Injections	Epidural Steroid Injections	Other Cortisone Injections
Nerve Blocks	Other (specify) _____	

**MEDICAL HISTORY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood thinners: \_\_\_\_\_

**Indicate any current/ previous medical problems or conditions ( ✓ ):**

- |               |                        |                       |
|---------------|------------------------|-----------------------|
| Anemia        | Chemotherapy/Radiation | Kidney Problems       |
| Anxiety       | Depression             | Liver Problems        |
| Arthritis     | Diabetes               | Low Blood Pressure    |
| Asthma        | Epilepsy/ Seizures     | Migraines             |
| Back Problems | Glaucoma               | Mitral Valve Prolapse |
| Blood Clots   | Hepatitis              | Polio/Meningitis      |
| Cancer        | Hiatal Hernia/Reflux   | Stroke/TIA            |
| CAD/Angina/MI | High Blood Pressure    | Thyroid Problems      |
| CRPS          | Jaw Problems/TMJ       | Ulcer                 |
|               |                        | Other: _____          |

**List all previous surgeries/hospitalization and when:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List any medications you take (dosage and frequency):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all allergies and related reactions:**

\_\_\_\_\_  
\_\_\_\_\_

**Indicated if you have experienced any of the following ( ✓ ):**

- |                    |                         |                      |
|--------------------|-------------------------|----------------------|
| Blackout/Dizziness | Headaches/Migraines     | Motion Sickness      |
| Chest Pain         | Indigestion             | Shortness of Breath  |
| Constipation       | Loss of Bladder Control | Skin Rashes          |
| Diarrhea           | Loss of Bowel Control   | Swollen or Sore Legs |

**Family History ( ✓ all that apply):**

- |                    |          |               |                     |        |
|--------------------|----------|---------------|---------------------|--------|
| Back/ Neck Surgery | Diabetes | Heart Disease | High Blood Pressure | Stroke |
| Other: _____       |          |               |                     |        |

**Social History**

Occupation: \_\_\_\_\_ Work Status: YES NO Disability %: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ # of children (if applicable): \_\_\_\_\_  
 Do you smoke? YES NO If yes, what \_\_\_\_\_ how much \_\_\_\_\_  
 Do you drink alcohol? YES NO If yes, frequency \_\_\_\_\_ how much \_\_\_\_\_  
 Do you use or have used recreational drugs (i.e., marijuana, cocaine, heroin)? YES NO  
 Last time used: \_\_\_\_\_

**ORT**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Please fill out check boxes:**

	YES	NO	OFFICE USE ONLY	
1. Family history of substance abuse			<b>F</b>	<b>M</b>
a. Alcohol			<b>1</b>	<b>3</b>
b. Illegal drugs			<b>2</b>	<b>3</b>
c. Rx drugs			<b>3</b>	<b>4</b>
2. Personal history of substance abuse				
a. Alcohol			<b>3</b>	<b>3</b>
b. Illegal drugs			<b>4</b>	<b>4</b>
c. Rx drugs			<b>5</b>	<b>5</b>
3. Age between 16-45 years old			<b>1</b>	<b>1</b>
4. History of preadolescent sexual abuse			<b>3</b>	<b>0</b>
5. Psychological disease				
a. Attention-Deficit Disorder, Obsessive-Compulsive Disorder, Schizophrenia			<b>2</b>	<b>2</b>
b. Depression			<b>1</b>	<b>1</b>
			<b>Scoring Total:</b>	

**Nothing above applies**



## LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

### Section 1 - Pain Intensity

- I can tolerate the pain without having to use painkillers.
- The pain is bad but I can manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

### Section 2 -- Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

### Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

### Section 4 – Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than one-half mile.
- Pain prevents me from walking more than one-quarter mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### Section 5 -- Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.  
 (Score \_\_\_ x 2) / ( \_\_\_ Sections x 10) = \_\_\_\_\_ %ADL

### Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

### Section 7 -- Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

### Section 8 – Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

### Section 9 – Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain is bad but I manage journeys less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

### Section 10 – Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at the present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Comments \_\_\_\_\_

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

## NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

### Section 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### Section 2 -- Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

### Section 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

### Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

### Section 5-Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.  
 (Score  x 2) / (  Sections x 10) =  %ADL

### Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

### Section 7—Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

### Section 8 – Driving

- I drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I can't drive my car at all.

### Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

### Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

**Comments** \_\_\_\_\_ %ADL

**2023 MIPS FORM**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

1. Are you a tobacco user? Yes No

\*For office use only: was the patient counseled? \_\_\_\_\_(Y/N)

2. Have you been diagnosed with Depression? Yes No

If answered NO:

Do you feel down, depressed, or hopeless? Yes No

Do you feel tired or have little energy? Yes No

3. Do you have essential Hypertension (high blood pressure)? Yes No

Blood Pressure: \_\_\_\_\_

\*Do not take blood pressure readings the same day as a test/procedure requiring a change in diet/medication on or one day before the day of visit (i.e., vaccinations, steroid injections, lidocaine injections, etc.)

4. Patients aged 50-74: Have you had your colonoscopy within the last 9 years? Yes No

If YES- Date of last colonoscopy: \_\_\_\_\_

5. Patients aged 65 and older: Have you had any falls in the past 12 months? Yes No

If YES- Approximately how many falls: \_\_\_\_\_

If YES- Were any of them severe falls: \_\_\_\_\_

6. Women aged 21-64: Have you had a cervical cancer screen in the past 3 years? Yes No

If YES- Date of last screening: \_\_\_\_\_

7. Women aged 50-74: Have you had a mammogram in the past 27 months? Yes No

If YES- Date of last mammogram: \_\_\_\_\_

**SOAPP®-R**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.	Never	Seldom	Sometimes	Often	Very often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

**DIAGNOSTIC TESTING QUESTIONNAIRE**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

If you currently feel or have felt any of the following symptoms within the past month, or have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your doctor determine what diagnostic tests\* might be appropriate for you.

Please check ( ✓ ) all that apply:

	Low back/ Radiating pain		Neck/ Radiating pain
	Numbness, Tingling, or Burning Sensation in legs or feet		Numbness, Tingling, or Burning Sensation in arms or hands
	Weakness in legs		Weakness in arms
	Diabetes		Loss of sensation in hands
	Neuropathy		Muscular Dystrophy
	Spinal Stenosis/ Pain when walking		Muscle cramping
	Tendinitis		Arthritis
	Joint pain (knee/hip/shoulder/wrist)		Joint Instability
	Blurred vision/ Double vision		Hearing problems
	Hypertension		Hypotension
	Dizziness/ Vertigo		Headaches/ Migraines
	Loss of balance/ Unsteady gait		History of falls due to dizziness
	Trauma/ Head injury		Thyroid Dysfunction
	Car accident/ Work injury		Circulation issues

\_\_\_\_\_  
 Patient Signature

\*Electromyography/ Nerve Conduction Studies, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Joint/ Neuro Musculoskeletal Ultrasound





**AUTHORIZATION TO OBTAIN HEALTH INFORMATION**

**FOR OFFICE USE ONLY**

Doctor, Hospital Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize you to disclose health information of the above named individual to:

**TIMOTHY D GROTH, MD. PC.  
PAIN MANAGEMENT**  
994 WEST JERICHO TURNPIKE SUITE 104  
SMITHTOWN, NY 11787  
PHONE: (631)543-1440  
FAX: (631)670-7567 (Medical Records)  
FAX: (631)543-1930 (Main)

**TIMOTHY D GROTH, MD. PC.  
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Please select from below any information you would like to be sent to TIMOTHY D. GROTH, MD. PC. to aid in your diagnosis and treatment. Please provide dates of service where it applies.

- Operative Report
- Anesthesia Record
- Discharge Instructions
- Discharge Summary
- EKG
- History and Physical
- Laboratory Results
- Consultation Reports from \_\_\_\_ to \_\_\_\_
- Medications Sheet
- Physicians Progress Notes from \_\_\_\_\_ to \_\_\_\_\_
- Physicians Orders from \_\_\_\_\_ to \_\_\_\_\_
- Imaging Reports from \_\_\_\_\_ to \_\_\_\_\_
- Entire medical record
- Other (specify) \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse. For AIDS or HIV status, the Department of Health Authorization form must be completed, instead of this authorization.

I understand I have the right to revoke this authorization at any time; I must do so in writing and present my written revocation to medical records. Unless revoked, this authorization will expire on the following date, event, or condition.

\_\_\_\_\_  
(You may indicate "none" if you wish to indicate a specific date)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain copies of the information to be used or disclosed, as provided in the applicable Federal and State law. If I have questions about the disclosure of my health information, I can contact the medical records department.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_



TIMOTHY D GROTH, MD. PC.  
CHIROPRACTIC CARE  
1500 MIDDLE COUNTRY RD.  
CENTEREACH, NEW YORK 11720  
PHONE: (631)736-4414  
FAX: (631)736-7490

**NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

- \*Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- \*Obtain payment from third party payers.
- \* Conduct standard healthcare operations, such as quality assessments and Physician certifications.

I understand that I may request in writing that Timothy D. Groth, MD. PC. restrict how my private information is to be used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Timothy D. Groth, MD. PC. is not required to agree to my requested restrictions, but are bound to abide by such restrictions to them.

**List below any friend or family member(s) you give the authority to release Protected Health Information concerning your care, if you are unable to come to the office.**

**I have read and/or received a copy of the HIPAA Notice of Privacy Practices.**

_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient
_____	_____
Name	Relationship to patient
_____	_____
<b>Patient Signature</b>	<b>Date</b>

**NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST**

Please be advised that corporations, including local physicians own the North Shore Surgi-Center and Suffolk Surgery Center, one of whom is Timothy D. Groth, MD. These physicians have become owners as a result of their commitment to quality healthcare and services to their patients.

The NorthShore Surgi-Center and Suffolk Surgery Center may have a financial relationship with your physicians as indicated above. You have the right to choose where to receive services, including an entity in which your physician may have a financial relationship. Other medical facility options include:

St. Catherine of Siena Medical Center  
50 Route 25A  
Smithtown, NY 11787  
(631)862-3000

Peconic Bay Medical Center  
1 Heroes Way  
Riverhead, NY 11901  
(631)548-6000

**Please INITIAL \_\_\_\_\_**





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**INFORMED CONSENT FOR CHIROPRACTIC TREATMENT  
AND PHYSIOTHERAPY**

(Including, but not limited to, electrical muscle stimulation, ultrasound, traction, rehab exercises, heat/ice packs, decompression traction, flexion distraction, spinal manipulation, and myofascial release/ trigger point therapy)

By my signature below, I hereby give informed consent for all of the above aforementioned therapies and treatments, in addition to spinal manipulation, as advised by the chiropractors at Timothy D. Groth, MD.PC. locations, and deemed to be medically necessary for my care.

I understand that as in any medical procedure, there are very small risks and very rare complications that can occur with these procedures (estimated to be 1/10th of one percent), such as heat/cold/ electric burns, muscle pulls, neurologic dysfunction, electric shock, and its effects on the neurological and CVS systems, rash, infections, scars, blisters and CVA's, as well as aggravating the condition I am being treated for.

I understand that X-Rays may be taken in-office, as needed and deemed medically necessary by the Chiropractic doctors.

I have been explained the procedures and risks and have had the opportunity to discuss with the staff and doctor, and ask any questions. I have been given the opportunity to decline what I am not comfortable with.

PLEASE INITIAL:

\_\_\_\_\_ I elect to receive chiropractic care, spinal manipulation, and physiotherapy as recommended

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Doctor Signature**

\_\_\_\_\_  
**Date**

**VERIFICATION OF NON-PREGNANCY** (IF APPLICABLE)

I agree to inform the doctors if pregnant, or planning to become pregnant, so the care plan may be adjusted as needed.

By signing this, I do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected, or confirmed at this particular time.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**



TIMOTHY D GROTH, MD. PC.  
994 WEST JERICO TURNPIKE SUITE 104  
SMITHTOWN, NEW YORK 11787  
PHONE: (631)543-1440  
FAX: (631)543-1930

## **FINANCIAL POLICY AND AGREEMENT**

Timothy D. Groth, MD. PC. is committed to serving our patients with professionalism and care. From our patients we expect the same commitment, which includes being on time for your appointment and calling to notify us of any delays or cancellations, financial responsibility, such as copay and deductible payments at the time of your office visit, and informing us of any changes to health insurance.

It is the patient's responsibility to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers, if needed. I understand that providing incomplete or inaccurate information about my insurance benefits may result in the denial of my claim or a delay in payment. Timothy D. Groth, MD. PC. has a contract with my insurance company and will receive payments from my insurance company for covered services provided by my insurance benefits.

I understand that if my insurance benefit requires me to provide a referral, but has not been obtained before my appointment, that I will be responsible to pay in advance an estimate of charges for my office visit or reschedule my appointment.

For services outside of our clinic, such as radiology, laboratory, surgery centers, physical therapy, hospitals, and rehabilitation centers, it is the patient's responsibility to know which facility you are required to use. If you are not sure, please talk to your insurance member services, or one of our staff before scheduling.

For Medicare patients: I authorize payment to be made on my behalf to Timothy D. Groth, MD. PC. for any services rendered to me by my provider. I understand my signature allows payment requests to be made to pay my claims. My signature also authorizes the release of medical information necessary to Medicare and any secondary insurance payer (if applicable) to pay my claim and authorize the release of benefits payable. For visits related to a work injury or auto accident: I agree to provide Timothy D. Groth, MD. PC. all case related information, including case number, policy number, insurance carrier, address, and other contact information at the time of my appointment to ensure appropriate billing for services rendered. If the applicable information is not provided, I agree to pay all charges for my visit.

I understand that all services rendered to me by Timothy D. Groth, MD. PC. are considered medically necessary. Failure to have a procedure performed or noncompliance with my healthcare provider's instructions may be against medical advice and may void my insurance benefits.

I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

I understand that failure to pay any outstanding balances may make my account delinquent, which may result in forwarding to an outside collection agency without notice. If this occurs, I will be responsible for all costs of collection, including, but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

I agree to be financially responsible for payment of services rendered by Timothy D. Groth, MD. PC. Acceptable forms of payment include cash, check or credit cards. There will be a \$50.00 fee for all returned checks. I agree to pay the remaining balance on my account after my insurance claim has been processed immediately upon receipt of statement.

I have read and understand Timothy D. Groth, MD. PC. financial policies and I accept financial responsibility for payment of services and any fees associated with my care.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_