

**Bialecki Family Chiropractic**  
**3140 Sheridan Drive Suite 140 Amherst New York 14226**  
**716-240-9365**

**No-Fault Questionnaire**

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Employer's Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Auto Insurance Company for the Vehicle YOU were in: \_\_\_\_\_  
\_\_\_\_\_

Date of Accident: \_\_\_\_\_ Claim#: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Have you retained an Attorney: \_\_\_\_\_ If yes, Attorney's Name: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Nature of Accident:**

Where were you seated in the vehicle? \_\_\_\_\_ How many people were in the Car? \_\_\_\_\_

Which direction were you headed? (North) (South) (East) (West). Where did the accident occur?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you Struck from: (Behind) (Front) (Left Side) (Right side). Were the police notified? \_\_\_\_\_

Do you have a police report? \_\_\_\_\_ Were you seated belted? \_\_\_\_\_

Any injuries prior to this motor vehicle accident? \_\_\_\_\_ If, yes please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your own words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

Where were you taken after the accident? \_\_\_\_\_

Have you been treated by another doctor since the accident? \_\_\_\_\_ If yes, please list names and addresses: \_\_\_\_\_

Since your injury occurred, are your symptoms: (Improved) (Worse) (The Same)

Do you have any activity restrictions as a result of this injury? \_\_\_\_\_ If yes, please describe in detail: \_\_\_\_\_

Circle any of the following symptoms you have noticed since the accident:

- |                     |                  |                       |                      |
|---------------------|------------------|-----------------------|----------------------|
| (Headache)          | (Fainting)       | (Irritability)        | (Light bothers eyes) |
| (Face Flushed)      | (Pins & Needles) | (Feet Cold)           | (Nervousness)        |
| (Chest Pain)        | (Cold Sweat)     | (Shortness of Breath) | (Loss of taste)      |
| (Hands Cold)        | (Loss of Memory) | (Neck Stiffness)      | (Dizziness)          |
| (Fatigue)           | (Tension)        | (Loss of balance)     | (Depression)         |
| (Sleeping Problems) | (Diarrhea)       | (Constipation)        | (Back Pain)          |
| (Ears Ringing)      | (Fever)          | (Numbness in fingers) |                      |
| (Loss of smell)     | (Stomach upset)  | Other: _____          |                      |

Have you lost any time from work as a result of this accident? \_\_\_\_\_ If yes, what was your last day that you worked? \_\_\_\_\_

**TERMINATION OF CARE WAIVER**

I hereby acknowledge and understand that if I do not keep scheduled appointments as recommended to me by my attending doctor at this chiropractic office, Dr. John M. Bialecki has full and complete right to terminate my case that I am under his care for. Also, that any outstanding amount on my account are my responsibility. I, the undersigned also state that all information provided to Dr. John M. Bialecki is true to my knowledge.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent and/or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider/Staff Signature

\_\_\_\_\_  
Date

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, \_\_\_\_\_, ("Assignor") hereby assign to Dr. Bialecki, ("Assignee")  
(Print patient's name) (Print hospital or health care provider name)

all 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 Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on \_\_\_\_\_, not withstanding 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 INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRADUDLENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

\_\_\_\_\_  
(Print name of Patient) (Signature of Patient)  
\_\_\_\_\_  
(Date of Signature)

\_\_\_\_\_  
(Address)

Dr. John M. Bialecki  
(Print name of Provider) (Signature of Provider)  
\_\_\_\_\_  
(Date of Signature)

3140 Sheridan Drive Suite 140  
Amherst, New York 14226  
(Address)

**MEDICAL RECORDS AUTHORIZATION**

I Hereby authorize: \_\_\_\_\_  
(Hospital, Urgent Care Facility, Primary Physician, Physical Therapy, Chiropractor, etc)  
to disclose the following protected health information for ALL RECORDS REAGRDNIG TREATMENT  
FOR DATE OF INJURY: \_\_\_\_\_

**RELEASE RECORDS TO: John M Bialecki, DC,FPSC(C),NRCME**  
**3140 Sheridan Drive Suite 140**  
**Amherst, NY 14226**  
**Phone: 716-240-9365**  
**Fax: 716-240-9368**

Disclosure of information is authorized for the following purposes of Evaluation & Treatment on:  
\_\_\_\_\_

I UNDERSTAND that I may refuse to sign this authorization. My refusal does not affect my  
treatment. I may revoke this authorization at any time, in writing, and that if I choose to do so, my  
request to revoke will not affect any actions taken by Bialecki Chiropractic before receiving my  
revocation.

I UNDERSTAND that there is a potential for information use or disclosed pursuant to this  
authorization to be subject to redisclosure by the recipient and no longer be protected by federal or  
state law.

THE EXPIRATION DATE cannot be greater than 90 days from the date of the request  
\_\_\_\_\_

I fully understand and accept the terms of this authorization:

**PATIENTS NAME:** \_\_\_\_\_  
(please print: If name was different due to marital status please include the previous name)

**ADDRESS:** \_\_\_\_\_  
**CITY -STATE - ZIP CODE:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_  
**FORM COMPLETED BY:** \_\_\_\_\_ (SELF, PARENT, GUARDIAN, OTHER)

**PATIENTS BIRTHDATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **TODAYS DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SIGNATURE:** \_\_\_\_\_

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