CHIROMEDICA

Chiropractic Clinic

NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date: _____

Name: (First)_____ (Last)_____ (M.I.)_____

Home Address_____

City_____ State_____ Zip _____

Home Phone☐ (____)_____ Work Phone☐ (____)_____Cell Phone☐ (____)_____

(Please indicate the preferred contact number)

Birth Date_____ Age_____ Sex M ☐ F ☐ Children's name(s) and age(s) _____

Email Address_____ _____

(Your email will be added to Chiromedica's database - we will not sell or give away your info)

Favorite hobbies or interests_____

Emergency Contact_____ Telephone (____)_____

Physician_____Telephone (____)_____

Who may we thank for your referral?_____

Employment Status ☐Full-time ☐Part-time ☐Not working ☐Student

Employer _____Telephone (____)_____

Injury Type ☐Work ☐Auto ☐Other Injury Date _____

Attorney Involved ☐No ☐Yes If Yes, then Attorney Name_____

Address_____ Telephone (____)_____

INSURANCE PATIENTS ONLY

Primary Insurance_____ Telephone (____)_____

Insured Name _____Subscriber's ID#_____D.O.B._____

Secondary Insurance _____ Telephone (____)_____

Insured Name _____Subscriber's ID#_____D.O.B._____

Please note that you are financially responsible for any charges not covered by your insurance plan.

The above is accurate to the best of my knowledge.

Patient Signature _____ **Date** _____
(Parent/Guardian, if patient is a minor)

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MEDICAL HISTORY

Patient Name _____ Birth Date _____

Type of Injury / Condition _____ Onset / Injury Date _____

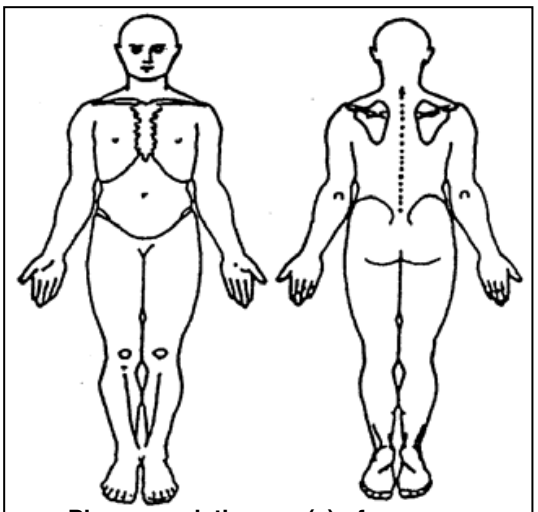
Have you consulted another doctor / practitioner for this health concern? Y / N

If yes, name _____ date _____

Are your health concerns: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you ever been to a chiropractor before? Y / N

If yes, who was the chiropractor? _____



Please mark the area(s) of concern

Have you had any imaging performed:

- ☐ X-Ray
- ☐ MRI
- ☐ Ultrasound
- ☐ CT Scan
- ☐ Doppler

Have you recently noted any of the following:

- ☐ Weight Loss /Gain
- ☐ Weakness
- ☐ Pregnant
- ☐ Pain at Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps in Legs
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change in Vision/Hearing
- ☐ Insomnia

Do you have now or have you ever had any of the following:

- ☐ Neck pain
- ☐ Headache
- ☐ Migraines
- ☐ Tingling/numbness
- ☐ Arm/hand pain
- ☐ Mid-back pain
- ☐ Low back pain
- ☐ Leg/ankle pain
- ☐ Knee pain
- ☐ History of fracture/broken bones
- ☐ Blood pressure problems/stroke
- ☐ Paralysis
- ☐ Depression
- ☐ Loss of sleep
- ☐ Painful menstruation
- ☐ Leg or ankle swelling
- ☐ Indigestion/heartburn
- ☐ Loss of consciousness/fainting
- ☐ Cancer
- ☐ Motor vehicle accident
- ☐ Sports injury

Explain & give approximate dates for any items indicated above _____

_____

Are you currently taking medications? Yes / No Name or Type of Medication _____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

What are your current physical or fitness goals? _____

Is there anything else you would like to include or ask your chiropractor? _____

Patient Signature _____ **Date** _____
(Parent/Guardian, if patient is a minor)

CHIROMEDICA

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OFFICE POLICY

INSURANCE PATIENTS ONLY

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Chiromedica** to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Chiromedica. ____ ***(initial)***

FINANCIAL POLICY: If you have provided your insurance information to our office, then we bill your insurance company as a courtesy and will assist you to the best of our abilities with getting your claim paid. However, you are financially responsible for any charges not covered by your insurance plan. In an effort to keep our fees low and your costs manageable, we will collect a co-payment at the time of service. Please note that what we collect in the office may only a ***portion*** of your balance. Actual patient responsibility can only be determined once your insurance company has processed a claim. If you have further financial obligation than what we collected in the office, you will receive a statement from our billing company. You are ultimately financially responsible for medical services rendered to you.
We have reviewed these benefits with you and you agree to pay your portion of your bill. ____ ***(initial)***

SELF PAY PATIENTS ONLY

FINANCIAL POLICY: For patients without insurance, we offer self-pay rates. Payment for self-pay services is due at the time of service. We also offer discounted packages which must be purchased in advance. I understand my responsibility for the payment of my account. ____ ***(initial)***

CANCELLATION & NO-SHOW POLICY

Appointments you schedule are reserved especially for you. If you need to reschedule or cancel an appointment, we request and appreciate a minimum of 24-hours notice. For the best customer service, we ask that you make schedule changes during our normal business hours.
Appointments cancelled with less than 24-hours notice will be assessed a fee as follows: $30 for chiropractic office visits and $50 for massages. This fee is not covered by insurance and is your responsibility to pay at the time of your next visit. ____ ***(initial)***

CONSENT FOR THE TREATMENT OF A MINOR

As parent and/or legal guardian, I authorize Chiromedica to treat the minor patient named in the attached forms while I am not present.

Parent/Guardian Signature _____**Date** _____

Print Patient Name _____

Signature _____ **Date** _____
(Parent/Guardian, if patient is a minor)

CHIROMEDICA

NOTICE OF PRIVACY PRACTICES

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment
We may disclose your health information to our billing service and your insurance provider for the purpose of payment and/or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Contact
We may contact you for appointment reminders
For Example:

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time and/or in the event that you miss your appointment we will call to re-schedule. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

Change of Ownership
In the event that Chiromedica is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that Chiromedica is not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Chiromedica amend your protected health information. Please be advised that Chiromedica is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Chiromedica.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Chiromedica reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Chiromedica is required by law to comply with this Notice.

Chiromedica is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

If you have any questions and/or complaints regarding this notice or if you want more information about your privacy rights, please contact: Angie Garza, Office Manager by calling the office at 415-567-2225. If Ms. Garza is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Chiromedica with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

. ***CHIROMEDICA***

Chiropractic Clinic

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic Indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME:

PATIENT SIGNATURE:	**DATE:**

(Or Patient Guardian/Parent/Representative -- provide name and relationship if signing for patient)