WELCOME

Date: ______________________

Patient Information

Name: ____
Last First MI

Email address: ____

Mailing Address: ______________________________ City __________ State ______ Zip ______

Phone # (H)________________ (W) ________________ (Other) ____________

Can we call you at work? ❑ Yes ❑ No

Date of Birth: ____________ Sex: ❑ Male ❑ Female **SS#:** ________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: ____________________ Employer: ____________________

Employer Address: ______________________________ Phone: ________________

How did you hear about our practice? ____

Emergency contact: Name: ____________ Relation: __________ Phone #: ____________

Phone #: (H) ________________ (W) ________________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other ________

Has it been reported? ❑ Yes ❑ No If yes, to whom? ____________________

Insurance Information

Policy Holder Name: ______________________________ D.O.B. :________________

Relationship to patient (if other than self): ________________ Phone # ________________

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ____________________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: ____________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

SIGNATURE (X) ______________________________ **DATE** ________________

Form 2

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ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay ____________________ as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of ________________ 20 ____.

X________________________
(patient signature)

____
(please print patient name)

X________________________
(signature of Guardian if applicable)

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Review of Systems

Name________________________________ **Date**________________

Y	N	**Neurological**
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	**Skin**
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

Please check ALL options you have previously tried to assist in above symptoms:

____Over the counter medications
____Prescriptions
____Dietary Changes
____Exercise
____ Consult with specialist
____ Supplements
____ Alternative medication/treatment therapies

Have you ever had any type of food sensitivity or vitamin/mineral testing done? Y or N

If yes, what?________________ When?______________

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Name ______________________________

Date ______________________________

Neurological/MRI/Vascular Patient Questionnaire

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES

____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES

____

3. Do your hands or arms fall asleep regularly? NO YES

____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES

____

5. Do you suffer from a loss of handgrip strength? NO YES

____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES

____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES

____

8. Do our legs or feet fall asleep regularly? NO YES

____

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES

____

10. Do you suffer from cold hands or feet? NO YES

____

11. Do you have frequent falls or find that you trip over your feet while walking? NO YES

____

12. Do you suffer from headaches? If yes, how often, how severem what has been tried? NO YES

____

13. Medicines previously tried, dosage, duration and outcome: ☐Advil ☐Aleve ☐Aspirin ☐Tylenol ☐Steroids ☐Prescriptions

____

14. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES

____

15. Have you had an MRI? If yes: When? For how long? What Kind? NO YES

____

16. Have you used any splint or braces or other prescribed treatment by an MD? Who? When? What? NO YES

____

17. If you have tried any treatments or medications, did this make your problem better? NO YES

____

Initial ______

Name ______________________________

Date ______________________________

Consent to Care

California Licensing boards require certain health care professionals, including physicians and chiropractors, to notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the health care professional is referring the patient and/or in the non-routine goods or services being prescribed by physical, and whether these are available elsewhere on a competitive basis. We support this law because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that we have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further as indicated below, goods or services we have prescribed are available elsewhere in a competitive basis: X-Rays NCV/EMG Vascular Testing Lab Tests Medical Care Chiropractic Care Massage Therapy Physical Therapy Nutritional Counseling Supplements Supports Braces.

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file.

Signature ______________________________ Date ____________________

X-Ray Questionnaire: For Women Only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

- ☐ Yes, I am definitely pregnant or there is a possibility that I may be pregnant at this time.
- ☐ No, I am definitely not pregnant at this time.
- ☐ I request that x-ray films not be taken because: ______________________________

Date of last menstrual period ____________________

Patient Signature ______________________________ Date ____________________

Initial ______

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X______________________________ I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of ____________________.
(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X______________________________ ______________________
Signature of Patient/Guardian Date

X______________________________ ______________________
Witness (Office Staff) Date

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