746 S. Main Avenue, Suite D, Fallbrook, CA 92028 / ph (760) 728-8999 / fax (760) 728-0821
29115 Valley Center Road, Suite L, Valley Center, CA 92082 / ph (760) 749-7611 / fax (760) 749-5961

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Name: First _____ Middle _____ Last _____

If patient is a minor, name of parents/legal guardian: _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Ph. _____ E-Mail _____

Date of Birth: _____/_____/_____ Sex: ❑Male ❑Female SSN _____

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

Occupation _____ Employer _____ Phone _____

How did you hear about our office? _____

INSURANCE INFORMATION

Name of Insured _____ Relationship _____ Date of Birth _____

Insurance Company _____ Phone _____

Address _____

Insured's ID# _____ Group/Plan _____ Policy # _____

Person Responsible for this account (if other than patient) _____ Relationship _____

Address _____ Phone _____

AUTHORIZATION AND RELEASE - I authorize the relase of any information, including the diagnosis and the records of any treatment of examination rendered to me or my child, necessary to communicate with personal physicians and other healthcare providers and payors and to secure payment of benefits. I understand and agree to allow this office to use Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. I understand and agree to allow this office to contact me via phone, fax, email, etc.

PRIVACY POLICY - We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE OF PRIVACY PRACTICES provided in this office, as well as on our website.

FINANCIAL POLICY - I have received a copy of this office's FINANCIAL POLICY, and agree to be fully financially responsible for my (or my child's) account. I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future.

ASSIGNMENT OF BENEFITS - I authorize and request my insurance company to pay directly to the doctor or the doctor's group, insurance benefits otherwise payable to me, regarding services performed in this clinic.

Patient Signature (Parent if Minor) _____ Date _____

I authorize this office to communicate with _____ (relationship _____) regarding my health and financial records.

Patient Signature (Parent if Minor) _____ Date_____

746 S. Main Avenue, Suite D, Fallbrook, CA 92028 / ph (760) 728-8999 / fax (760) 728-0821
29115 Valley Center Road, Suite L, Valley Center, CA 92082 / ph (760) 749-7611 / fax (760) 749-5961

HEALTH HISTORY - Page 1 of 2

Patient Name _____

Chief Complaint _____

Date Problem Began: _____/_____/_____ Is your problem: ❑Work Related? ❑Auto Related?

Describe your current problem and how it began: _____

_____

_____

How often are your symptoms present? ❑0-25% ❑26-50% ❑51-75% ❑76-100%

Can you perform your daily activities? ❑Yes ❑No If no, please describe: _____

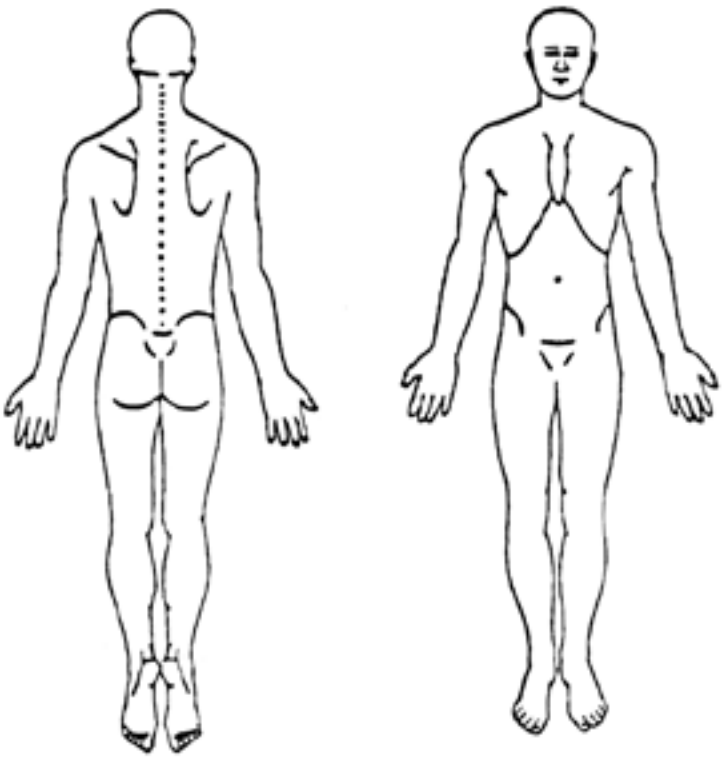
_____

What is your pain **RIGHT NOW?** No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Pain Scale

- 0-1 **Minimal:** The pain is an annoyance but does not stop me from working.
- 2-3 **Slight:** I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
- 4-6 **Moderate:** The pain causes a marked handicap in my ability to work but I can continue.
- 7-8 **Moderate To Severe:** The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
- 9-10 **Severe:** The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Using the pain scale above, mark the areas of **PAIN** on the the diagram to the right with a "**P**" and the pain level (example **P-4**). Also, mark the areas of **NUMBNESS** with an "**N**" and **TINGLING** with a "**T**."



List any other symptoms or health concerns you have: _____

_____

Are you involved in sports or regular exercise? If yes, please describe including frequency: _____

_____

Do you have any hobbies? If yes, please describe: _____

_____

Have you had X-rays, MRI, CT Scan? ❑Yes ❑No If yes, what areas, when and where: _____

_____

_____

746 S. Main Avenue, Suite D, Fallbrook, CA 92028 / ph (760) 728-8999 / fax (760) 728-0821
29115 Valley Center Road, Suite L, Valley Center, CA 92082 / ph (760) 749-7611 / fax (760) 749-5961

HEALTH HISTORY - Page 2 of 2

Patient Name _____

List ALL surgeries (including cosmetic) you have undergone, and when: _____

_____

Other Injuries/Hospitalizations/Surgeries/Illnesses (please check all of the following that apply to you):

	Date		Date
❑History of Recent Infection	_____	❑Recent Fever	_____
❑HIV/AIDS	_____	❑Diabetes	_____
❑High Blood Pressure	_____	❑Stroke	_____
❑Numbness in Groin/Buttocks	_____	❑Arthritis	_____
❑Urinary Retention	_____	❑Dizziness/Fainting	_____
❑Aortic Aneurysm	_____	❑Cancer/Tumor	_____
❑Frequent Urination	_____	❑Prostate Problems	_____
❑Pregnancy, # of births _____	_____	❑Osteoporosis	_____
❑Abnormal Weight Gain / Loss	_____	❑History of Neck/Back Pain	_____
❑Visual Disturbances	_____	❑Recent Trauma	_____
❑Epilepsy/Seizures	_____	❑Hepatitis	_____
❑Alcohol/Drug Addiction	_____	❑Hernia	_____
❑Thyroid Problems	_____	❑Ulcer	_____
❑Constipation	_____	❑Easily Bruised	_____
❑Emotional Disorders	_____	❑Tuberculosis	_____
❑Rheumatic Fever	_____	❑Migraine Headaches	_____
❑Asthma	_____	❑Kidney Disease	_____
❑Hemorroids	_____	❑Gallstones	_____
❑Insomnia	_____	❑Shingles	_____
❑Syphillis	_____	❑Chlamydia	_____
❑Herpes __Genital __Oral	_____	❑Gonorrhea	_____

❑Allergies (including medications) _____

Are you currently seeking treatment with other professionals for any condition marked above? ❑Yes ❑No

If yes, for what and with whom? _____

When was your last physical examination? _____

Please list ALL prescription medications you are currently taking and what you are taking them for: _____

_____

Please indicate the use and frequency of the following:

	How Much per Day		How Much Per Day		How Much Per Day
❑Coffee/Black Tea	_____	❑Water	_____	❑Alcohol	_____
❑Recreational Drugs	_____	❑Soda Pop	_____	❑Tobacco	_____
❑Non-Prescription Medication and what you are taking it for	_____				_____

_____

_____

Family History: ❑Cancer _____ ❑Diabetes ❑High Blood Pressure ❑Cardiovasular Problems ❑Stroke

What type of treatment(s) are you interested in receiving? ❑Medical/Orthopedic ❑Chiropractic ❑Nutrition Therapy

❑Massage Therapy ❑Physical Therapy ❑Unsure

What are your goals regarding treatment?

❑Pain Management ❑Functional Restoration ❑Overall Wellness ❑Other _____

I certify that the information on this questionnaire is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this clinic of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Signature (Parent if Minor) _____ *Date* _____

746 S. Main Avenue, Suite D, Fallbrook, CA 92028 / ph (760) 728-8999 / fax (760) 728-0821
29115 Valley Center Road, Suite L, Valley Center, CA 92082 / ph (760) 749-7611 / fax (760) 749-5961

INFORMED CONSENT

The Nature and Risks of Chiropractic Treatment: Chiropractic, by far, is the safest choice of health care, including dentistry, acupuncture and dermatology. However, since there is a remote chance of complications or iatrogenic mishap, we feel it is the responsibility of this facility to inform you prior to rendering care. The primary treatment used by the doctors of this facility is the spinal/extremity manipulation. We will likely use that procedure to treat you. The doctors will use their hands upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel or sense movement. This is a normal, healthy reaction.

Some patients will feel some stiffness and soreness following the first few days of treatment. This is a normal, healthy reaction. As with any healthcare procedure, there are certain complications which may arise during a joint manipulation. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The most serious and most publicized by opponents of chiropractic care is vascular injury, specifically if it leads to stroke.

The Probability of Those Risks Occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such outcome. (1) Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare" (muscle or joint injury, fracture and neuropathy).

Ancillary Treatment: In addition to manipulation, the following treatments and diagnostic procedures may be used: ultrasound, ice packs, hot packs, muscle stimulation, galvanic current, traction, physical therapy, massage, x-ray and orthopedic/neurologic testing. Of these ancillary procedures, ultrasound carries the most significant risk. Ultrasound has the potential, which is rare, to cause periosteal burns (irritation of the outer layer of bone).

The Availability and Nature of Other Treatment Options: Other treatment options for your condition include: self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain killers; hospitalization with traction; surgery.

The Material Risks Inherent in Such Options and the Probability of Such Risks Occurring Include: Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks, some with rather high probabilities.

Hospitalization in conjunction with other care, bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure, dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks varies according to many factors.

The Risks and Dangers Attendant to Remaining Untreated: Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN BELOW UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended and waive all doctors and staff of the responsibility for said risks. I understand that, while chiropractic care can be effective in alleviating, reducing or resolving neuromusculoskeletal complaints, there are no guarantees for such results. Having been informed of the risks, I hereby give my consent for the doctors and staff of this facility to render treatment deemed necessary for my condition.

_____ _____

Patient's Name (Please Print) Parent or Legal Guardian, if Patient is a Minor (Please Print)

_____ _____

Patient's Signature (Parent/Guardian, if Minor) Date

_____ _____ _____

Authorized Staff Member (Please Print) Signature Date

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship, as well as provide the highest level of service possible. As you are aware, the health insurance industry has undergone many changes. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

PRIVATE PAY - If you have no health insurance or your insurance policy does not cover our services, payment is expected at the time of service, unless payment arrangements have been made with our office. You may be considered for a reduced fee if payment is made at the time of service. If you are unable to pay in full at the time of service, we will be happy to work out an affordable payment plan. To qualify for payment arrangements, an agreed amount will be automatically charged to your charge or debit card.

HEALTH INSURANCE - Our office participates with many insurance plans. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. We DO NOT bill secondary insurance, but will provide you with information to collect from your secondary insurance. Co-payment is required at the time of service. The amount of co-payment varies with different plans. For patients with an HMO plan, we will do our best to obtain authorization for treatment; however, all charges not covered by your insurance company are your responsibility. HMO plans have limited coverage, including number of visits, and many of the services we provide are not covered by HMO plans. For patients with a PPO plan, we will do our best to determine your co-insurance; however, keep in mind that the amount of reimbursement varies with different plans. While the filing of insurance claims is a courtesy that we extend to our patients, all charges not covered by your insurance company are your responsibility.

PERSONAL INJURY (AUTO ACCIDENTS, SLIP AND FALL, ETC.) - We DO NOT bill third party liability insurance companies, or excess med-pay. If you have had an accident, we will as a courtesy, bill your auto, home, etc. insurance on your behalf. However, you will be responsible for all charges incurred, if you do not have medical payments coverage ("med pay"). We will gladly work on a lien-basis if you are represented by an attorney and defer payment up to six months after your care is complete. At that time, if your case still has not settled, we request that partial payment arrangements are made.

WORKERS' COMPENSATION - If you have been injured on the job, you must report the incident to your employer who will complete a DW1 form. It is your responsibility to provide our office with a copy of the signed DW1 form, or claim information including work comp insurance company, claim number, adjuster, etc. We will then verify that treatment is authorized. If your claim is denied, you will be responsible for treatment rendered.

CANCELLED APPOINTMENTS - If you are unable to keep your scheduled appointment, please call our office a minimum of 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge $25 for appointments that are not cancelled at least 24 hours in advance.

PAST DUE ACCOUNTS – Accounts become past due 30 days after receipt of the latest statement, at which time a late charge of $10.00 will be charged to your account. We will work with you to avoid sending your account to collections. However, if you fail to make arrangements for your outstanding balance and your account becomes 120 days past due, we will turn your account over to a collection agency, and you will be charged 18% interest on the outstanding balance from the date your bill was due, and you will be responsible for all costs and expenses of collection including, but not limited to our reasonable attorneys' fees.