Confidential Patient Information

C

Patient Information **Acct #** _____

Name_____ Date_____

Address _____City _____State _____Zip _____

Home Phone _____ Cell Phone _____ Email _____

Social Sec. _____ Birth Date _____ Age _____ Height_____ Weight_____ Gender M F Status M S W D

Occupation _____ Employer _____ Yrs. Employed _____

Employers Address _____ Work Phone _____

No. Children _____ Children ages _____ Spouse's name _____

Spouse's Occupation _____ Employer _____

Person to contact in an emergency_____ Phone #_____

Who may we thank for referring you to our office? _____

Responsible Party

Name of person responsible for payment of this account_____

Relationship to patient _____Phone #_____

Address _____City _____State _____Zip _____

Insurance Information: _____

Reason for visit: _____Check spine / extremity _____Accident _____Injury

Symptoms

1. What is your **number one** problem or the **one area** of greatest pain? _____
2. Please rate the level of pain on the following scale: **0 is no pain, 10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain. Not at all **0 1 2 3 4 5 6 7 8 9 10** extreme
3. When did this problem/pain start? _____ [ ] Gradual [ ] Sudden [ ] Progressive
4. What do you think caused the problem? _____
5. How often do you experience the pain
   ___ 1-2 hours per day ___ About half of the day
   ___ Most of the day ___ The pain never goes away
6. Does this pain radiate (travel) to other parts of your body? Explain _____
7. How does the pain effect your daily activities?
   ___ It does not effect my daily activities ___ I have had to change how I do things
   ___ I have had to stop doing some of my daily activities ___ I am unable to perform daily activities
8. What **increases** your pain? (sitting, standing, driving)_____
9. What **decreases** your pain? (ice, heat, laying down, rest, stretching) _____
10. Have you ever experienced this problem before? [ ] Y [ ] N When?_____
    How/where were you treated? _____ Outcome?_____
11. List any **other** complaints currently bothering you and rate your pain level for each.
    a. _____ Not at all **0 1 2 3 4 5 6 7 8 9 10** extreme
    b. _____ Not at all **0 1 2 3 4 5 6 7 8 9 10** extreme
    c. _____ Not at all **0 1 2 3 4 5 6 7 8 9 10** extreme
    d. _____ Not at all **0 1 2 3 4 5 6 7 8 9 10** extreme

12. Have you ever been involved in an automobile collision? [ ] Y [ ] N Were you injured? [ ] Y [ ] N If this is the reason for your visit, please skip the rest of 12 and fill out the Personal Injury Questionnaire.
    Date _____ Were you: [ ]Driver [ ]Passenger [ ]Front Seat [ ]Back Seat
    Were you wearing seatbelts? _____ Were you struck from: [ ]Behind [ ]Front [ ]Left Side [ ]Right Side
    Approx. speed of your car_____mph Other car_____mph Describe the accident in your own words: _____
    _____
    _____

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Last Name _____ First Name _____Date _____Acct# _____

13. Have you/do you participate in contact sports or activities that produce(ed) injury? [ ] Y [ ] N Explain _____
    _____
14. Have you ever been injured at work? [ ] Y [ ] N Date _____
    Explain _____
15. List all medication you are currently taking (prescribed and over the counter) _____
    _____
16. List all surgeries you have had (with date) _____
    _____

If you have experienced any of the following conditions in the past mark a "**P**" on the line provided. If you are currently experiencing any of the following conditions please mark a "**C**" on the line provided. (check all that apply)

___	Heart attack	___	Stroke	___	Arthritis	___	Gall bladder trouble
___	Diabetes	___	Glaucoma	___	Fainting spells	___	Kidney stones
___	Difficulty with urination	___	Bloody stools	___	Difficulty with bowel movements		
		___	Diarrhea	___	Menstrual cramping	___	Loss of hearing
___	Prostate trouble	___	Anemia	___	Cancer	___	Asthma
___		___	Ulcers	___	Diverticulosis	___	Epilepsy
___	Dizziness	___	Loss of memory	___	Chest pain	___	Shortness of breath
___	Constipation	___	Headache	___	General fatigue	___	Sudden weight loss
___	Nausea	___	Muscle cramping	___	Soreness in joints	___	Knee pain
___	Ears ringing	___	Tuberculosis	___	Migraine	___	Ankle/foot pain
___	Gout	___	Osteoporosis	___	syphilis	___	Sprained ankle[ ]R [ ] L
___	Knee/hip replacement	___	Broken bones (specify) _____				

General Activities (check all that apply)

___	Sleep on waterbed	___	Read in bed	___	Fall asleep in recliner/ on couch
___	Sleep on stomach	___	Excessive Texting	___	Use 2 or more pillows to sleep with
___	Sewing	___	Lift weights/wt. mach.	___	Play video games (___hrs/day)
___	Exercise _____x/wk	___	Jog _____x/wk	___	Computer use (___hrs/day)
___	Swim	___	Use treadmill	___	Watch television (___hrs/day)
___	Smoke ____ pack/day	___	Drink Water ___oz/day	___	Drink Soda ____ cans/day

Please add anything else you would like the doctor to know/other health issues/ or other activities _____
_____
_____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____Date _____
(signature of parent/guardian if the patient is a minor)

Doctor's Comments: _____
_____
_____
_____
_____D.C. Signature _____

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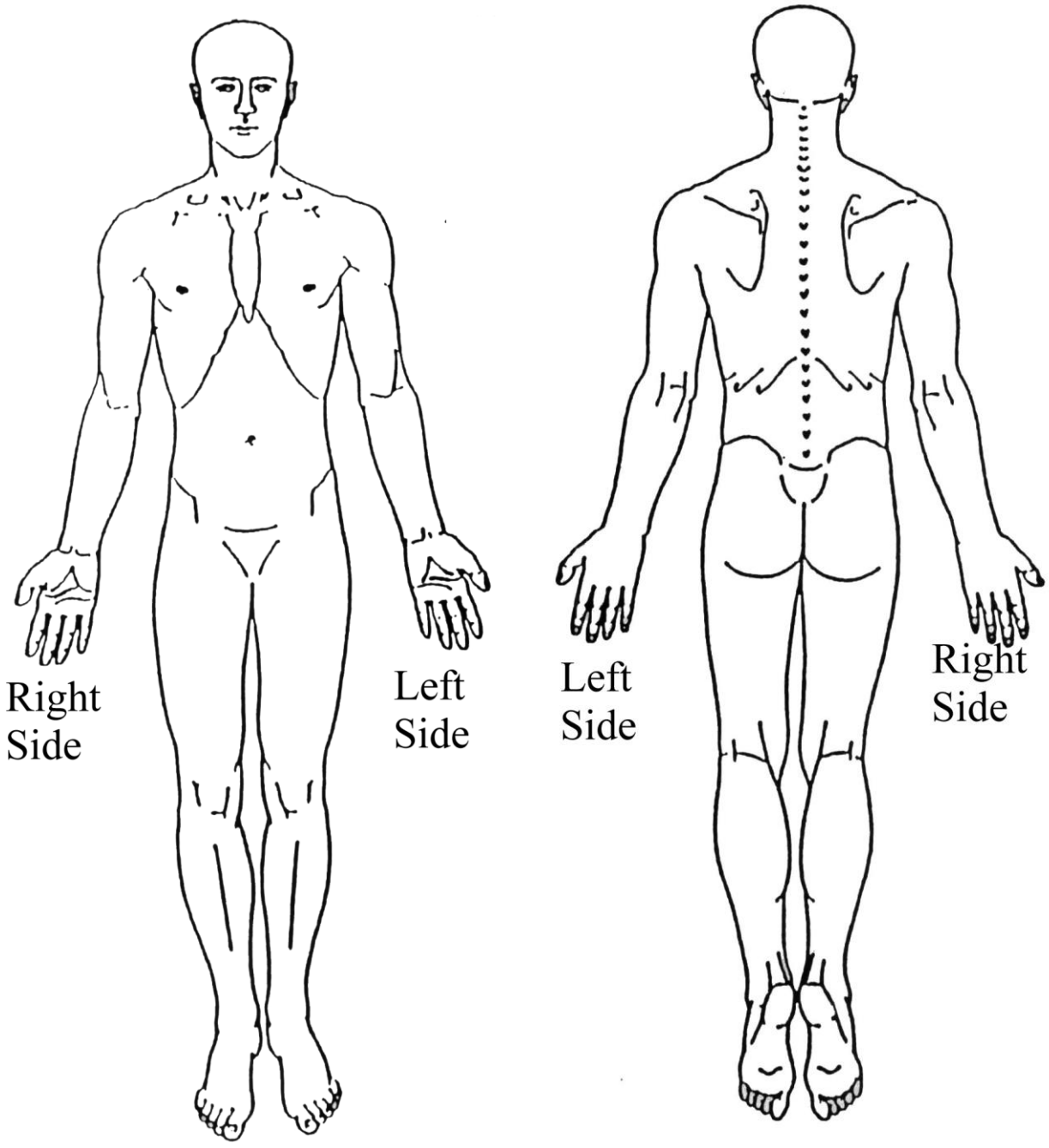
Body Diagram

Circle areas of complaint and describe symptoms. Acct # _____

Last Name _____ First Name _____

XXX Sharp Pain OOO Dull Ache /// Burning Pain

^^^ Numbness *** Pins & Needles or Tingling ↓Use arrows to show path of radiating pain.



Patient Signature _____Date _____

(Signature of parent if the patient is a minor)

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT & CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor(s) of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working for, or associated with the doctor(s) of chiropractic named below.

I 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, disk injuries, strokes, dislocations and sprains, I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor(s) 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 interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, 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 conditions and for any future condition(s) for which I seek treatment.

To Be Completed by Patient

Patients' name (Print)_____Patients' Signature_____

Date Signed____/____/_____
MM/DD / YYYY

To Be Completed By Patients' Representative If Patient Is A Minor or Physically or Legally Incapacitated

Patients' Name (Print) _____ Representative (Print) _____

Representative's Signature _____ Date _____

Relationship or Authority of Representative _____

To Be Completed By Doctor or Staff

Name of Office: _____Integrity Chiropractic_____

Address: _____15294 Liberty Street San Leandro CA 94578_____

Name of Treating Doctor: ___Dr. Susan Myers_____

Doctor's Signature: _____ Date: _____

Appointments, Calls, Open Room Adjusting & Health Care Information

Dr. Susan Myers and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

None of your information will be released to anyone without your permission, unless otherwise required for insurance purposes. You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

If you are involved in a 3rd party claim, this office has your irrevocable consent to submit records and bills to that 3rd party. Payment is to be made directly from the 3rd party to this office.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments/treatments in a semi-open room style, and other patients may be in the same room. Occasionally comments about your symptoms, improvement or lack there of may be discussed at your office visits.

Please make any appointment changes <u>24 hours prior</u> to your scheduled appointment time. Although on rare occasion circumstances may require you to reschedule for the next day, please call us as soon as possible as there may be another patient who would like that treatment slot.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time.

This notice is effective as of the first visit. This authorization will expire seven years after the date in which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient Signature _____ Date _____
Printed Name _____

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CHOOSE HEALTHY
CASH DISCOUNT PROGRAM

In an effort to make the benefits of Chiropractic Care available to as many people as possible, Integrity Chiropractic offers affordable and fair per visit fees. For those patients on the Choose Healthy Insurance Discount Program with their insurance company the discount is taken off the regular fee of $65. These fees are designed specifically for relief care and are for patients who do not have chiropractic insurance coverage.

In qualifying for these plans, participants agree to the following rules and guidelines:

1. Qualification for a cash plan is based solely on the understanding that the participant cannot afford our usual and customary minimal adjustment fee of $65.00 per visit. If at any time the participant becomes financially able to pay our usual and customary adjustment fee, this plan will be discontinued and our regular fees will apply.

2. Participation in a cash plan is based on a payment at time of service arrangement. Failure to make proper payment will disqualify you from the plan.

3. X-rays, nutritional supplements, orthopedic supports, ice packs and other supplies are not part of the cash plan. There is no reduced fee for these items and the cost is solely the responsibility of the patient.

4. If an account is delinquent long enough to merit the hiring of a collection agency, all contract terms are automatically nullified and our minimal adjustment fee of $65.00 will be applied to all visits received since the start of the discount cash plan.

5. If a refund is requested, all visits up to that point will be recalculated using the regular treatment fee of $65.00 per visit plus any fees associated with use of a credit card for original package payment.

For your convenience, these options for payment are available:

1. Initial Examination: $25
2. Chiropractic Treatment: $42 per visit.
3. Children age 6 and under are no charge with parent treatment. **
   Children 7-12 are $15 with parent treatment. **

   Children 13-18 are $20 with parent treatment. **

   ****Regular fees apply when parent is not being treated at the same visit.**

Additional Services:

Re-evaluation: $25 – New injury, or inactive greater than 6 months.
Infrared Therapy: $10
Ultra Sound: $10
Ice / Heat / Intersegmental traction table/ posture pump/ traction: No Charge

I have read, understand, and agree to all of the terms listed above.

_____ _____

Signature Date

_____ _____

Printed Name Witness

Dr. Susan Myers, D.C.
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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name _____

I hereby instruct and direct the, Primary:_____ Secondary:_____
Insurance Company to pay by electronic transfer or check made out to and mailed directly to:

Dr. Susan Myers, D.C.
15294 Liberty Street
San Leandro, CA 94578
510 326-2145

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/o Dr. Susan Myers, D.C.
15294 Liberty Street
San Leandro, CA 94578
510 326-2145

For professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges or professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

If you are involved in a 3rd party claim, this office has your irrevocable consent to submit records and bills to that 3rd party. Payment is to be made directly from the 3rd party to this office.

A photocopy of this Assignment shall be considered as effective and valid original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

_____ _____
Signature of Policyholder Date

_____ _____
Signature of Claimant, if other than Policyholder Witness