New Patient Intake Form

Name: _____ Birth date: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Cell: _____ Cell Provider: _____ Are Texts OK? ☐ No ☐Yes

Occupation: _____ Employer: _____ Work Phone: _____

Subscriber Name: _____ Health Plan: _____

Subscriber ID#: _____ Group#: _____ Spouse Name: _____

Spouse Employer: _____ Primary Care Physician: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

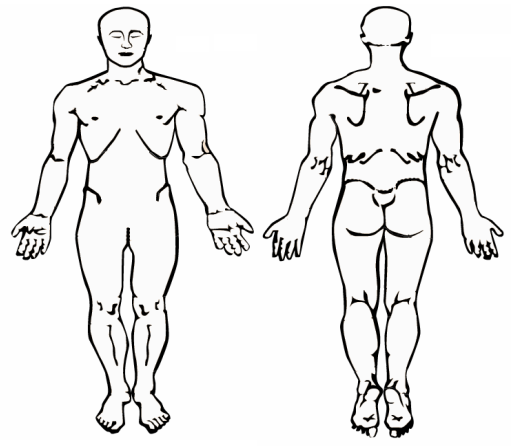
☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain

☐ Other: _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began: _____



Current complaint level (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

no pain unbearable pain

How often are your symptoms present?

(Intermittent) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (constant)

Have you had spinal x-rays, MRI, CT scan for your area(s) of complaint? ☐ No ☐ Yes

Date(s) taken: _____ Area(s) taken: _____

Please check all the following that apply to you:

☐ Recent Fever

☐ Diabetes

☐ High Blood Pressure

☐ Heart Problems (explain) _____

☐ Stroke (date) _____

☐ Corticosteroid Use (cortisone, prednisone, etc.)

☐ Dizziness / Fainting

☐ Numbness in Groin / Buttocks

☐ Cancer / Tumor (explain) _____

_____

☐ Osteoporosis

☐ Epilepsy / Seizures

☐ Urinary Problems

☐ Abnormal Weight ☐ Gain ☐ Loss

☐ Other Health Problems (explain) _____

_____

☐ Marked Morning Pain / Stiffness

☐ Pain Unrelieved by Position or Rest

☐ Pain at Night

☐ Visual Disturbances

☐ Surgeries _____

_____

_____

☐ Medications _____

_____

_____

For Men:

☐ Prostate Problems

For Women:

☐ Taking Birth Control Pills

☐ Menstrual Problems

☐ Currently Pregnant, Number of Weeks _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure

☐ Heart Problems / Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge. 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 doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or clinical peer may need to contact my physician if my condition needs co-managed. Therefore I give authorization to my chiropractor to contact my physician if necessary.

Patient (or Guardian's) Signature _____ Date _____

Referred by _____

Country Club Chiropractic and Wellness

1878 W El Norte Pkwy, Escondido, CA 92026 (760)741-7110

Notice of Privacy Practices (HIPAA)

We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes:

Treatment: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider in our office if it is necessary to refer you to them for services

Payment: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information without your written consent, written authorization, or oral agreement under the following circumstances:

- If we provide services to you while you are an inmate.
- If we provide services to you in an emergency situation.
- If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so
- If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
- If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care and your location, general condition or death.
- If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.
- If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.
- If we are required to disclose your health information to the Food and Drug Administration.
- If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.
- If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.
- If we are required to disclose your health information to a health oversight agency for oversight activities required by law.
- If we are required to disclose your health information in response to a court order or a subpoena.
- If we are required to disclose your health information to a law enforcement official.
- If we are required to disclose your health information to a coroner, medical examiner or funeral director.
- For research purposes.
- If we in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health and safety of others.
- If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

Health Care Authorization (PHI)

This describes how "Patient Health Information" (PHI) may be used. Patients are requested to authorize this office to use or disclose protected health information for the purposes of processing claims and collecting balances.

Patient Health Information:

- Will not be sold or shared for advertising.
- Is secured under lock and key.
- Will be provided upon signed request only by you.
- Will not be released to other parties or persons without your express written and signed consent.
- Insurance companies often request specific information from you and/or this office to process your claims. Complete and specific information is required before insurance assignment is accepted and before claims are billed.
- A signed "acknowledgment and authorization" is required from you at the beginning of each year, each new case and any time new benefits are assigned.
- You have the right to inspect or copy your PHI to be disclosed for correction, upon written request.
- You have the right to revoke this authorization at any time in writing prior to services being rendered.
- Should you revoke authorization, we will no longer accept assignment on insurance claims nor bill insurance on your behalf.

I have reviewed and understand both the "Notice of Privacy Practices" and the "Healthcare Authorization" and have been informed of who to contact for information regarding my medical records.

_____ _____

Signature Date

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Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments by means of manual manipulation or mechanical manipulation and other procedures which may include but are not limited to: ice, heat, ultrasound, electric muscle stimulation, cold laser therapy, mechanical or manual traction, therapeutic taping, soft tissue mobilization or treatment, analgesic therapy, pressure point therapy, balance training, therapeutic/rehabilitation exercises, stretches, vibration therapy, nutritional/diet recommendations, and diagnostic x-rays, by any doctors of chiropractic, interns, or any staff at this clinic.

I have had an opportunity to discuss with the chiropractors and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. 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, disc injuries, headaches, strokes, dislocations and sprains, although the possibility of these risks/complications is rare. It is not reasonable to expect the doctor to be able to anticipate and explain all the risks and complications of a given procedure on any particular visit 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.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal and other joint dysfunction and as such, is oriented toward improvement of spinal or other joint function relative to range of motion, muscular and neurological aspects, all as they relate to normal function and activities of daily living. There has been no promise, implied or otherwise of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click”. Correction of this joint dysfunction is called an adjustment, involving a quick, precise force directed over a short distance to a specific bone, soft tissue or joint. There are a number of different techniques utilized to deliver the adjustments, including some specially designed equipment.

It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. All healthcare treatments rely upon information related by the patient, information gathered during examination and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which third-party payers can verify that services billed were actually provided. I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent.

Through questioning and examination, we will do our best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. We may also suggest alternate chiropractic or medical approaches if we detect any contraindications to standard chiropractic treatment.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to any of the above named procedures as treatment as deemed necessary by the doctor. 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.

_____	_____	_____
Print Name	Signature	Date
_____	_____	
Parent/Guardian Signature	Relationship	

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Patient Bill of Rights and Responsibilities

Our office wants to encourage you, as our patient, to speak openly with your medical provider, and to take part in your treatment choices, and to be well informed and involved with your care. We want you to feel as if you are a partner in your care, and thus we want you to be informed of your rights as well as your responsibilities during treatment at our office.

PATIENT'S RIGHTS

- The patient has the right to impartial access to chiropractic care without regard to race; sex; cultural, national or ethnic origins; economic, educational, religious or political affiliation.
- The patient has the right to be interviewed and examined in surroundings that permit reasonable visual and auditory privacy. Individuals not directly involved in his/her care will not be present without the patient's permission. The patient has the right to be advised of the presence of any individual during consultation and/or care and the reason for their presence.
- The patient has the right to have a person of his/her sex present during certain physical examinations by a doctor of chiropractic of the opposite sex and the right not to remain disrobed any longer than is required for accomplishing the examination for which the patient was asked to disrobe.
- The patient should know the identity and professional status of individual(s) providing service to him/her and to know who has the primary responsibility for coordinating his/her care. This includes the right to know the professional relationships among individuals who are caring for him/her as well as the relationship to any other health care or educational institution involved in his/her case.
- The patient has the right to expect information from the doctor of chiropractic coordinating his/her care concerning the diagnosis/analysis, prognosis and the planned course of care in terms that the patient is able to understand. When it is not clinically advisable to give such information to the patient, the information should be made available to a legally authorized representative of the patient.
- The patient has the right to actively participate in any and all decisions regarding his/her care. To the extent permissible by applicable law, this will include the right to refuse care even after being informed of possible adverse consequences of his/her decision. When a patient or his/her legally authorized representative refused procedures which prevent the doctor of chiropractic from providing care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice.
- The patient has the right not to be subjected to any procedure(s) without voluntary consent or the consent of his/her legally authorized representative. When alternatives to chiropractic care exist, the patient can be expected to be informed of these alternatives.
- The patient has the right to expect confidential care of all communications and records pertaining to his/her care. The patient also has the right to have his/her health care record read only by individuals directly involved in his/her care or in monitoring of its quality and by other individuals only on the patient's written authorization or that of his/her legally authorized representative. Written permission shall be obtained before health care records are made available to anyone not directly concerned with the patient's care.
- The patient has the right to leave or voluntarily be discharged from chiropractic care even against the best advice of the attending doctor of chiropractic.
- A patient can expect reasonable continuity of care. He/she shall be informed in advance of the time(s) and location(s) of appointments as well as the name and capacity of the doctor of chiropractic/health practitioner who will be providing care.
- A patient has the right to be advised if the doctor of chiropractic and/or other attending physicians or other associated health care personnel propose to engage in or otherwise perform human experimentation affecting his/her care. The patient has the privilege and right of refusing to participate in any research project. Participation by patient in clinical training programs or in the gathering of data for research purposes should always and everywhere be voluntary.
- The patient has the right to be informed of continuing health care requirements following discharge from care in the out-patient or inpatient setting.
- The patient has the right, upon request, to receive an itemized, detailed and thorough explanation of total charges billed for services rendered, regardless of the source of payment. The patient has the right to timely notice prior to termination

of his/her eligibility for reimbursement by any third-party payer for the cost of his/her care.

- The patient shall be advised of his/her rights and shall be instructed as to the rules and policies which apply to his/her conduct as a patient in the out-patient and/or in-patient setting.
- The patient shall have all his/her rights also applied to the person or persons who may assume the legal responsibility to make decisions on the patient's behalf regarding the care of the patient should the patient be a legal minor or otherwise incapacitated.
- The patient has the right to expect reasonable safety insofar as the health care environment is concerned.
- The patient, at his/her own request and expense, has the right to consult with another health care practitioner.

PATIENT'S RESPONSIBILITIES

- Provision of Information: A patient has the responsibility to provide, to the best of his/her ability and knowledge, accurate and complete information about present complaints, past illnesses, accidents, hospitalizations, medications, and other matters relating to his/her health. It is the patient's responsibility to report any new episode of trauma or any unexpected changes in his/her health condition to the practitioner. The patient is responsible for letting the doctor of chiropractic know if he/she does not fully comprehend the practitioner's contemplated course of care.
- Compliance with Instructions: A patient is responsible for following the care plan recommended by the practitioner primarily responsible for his/her care. The patient is responsible for keeping appointments and, when unable to do so, for notifying the practitioner or his/her office. If you do not understand the instructions or recommendations that the doctor of chiropractic provides, it is your responsibility to ask questions.
- Refusal of Care: The patient is responsible for the consequences if he/she refuses care or does not follow the practitioner's instructions
- Charges: The patient is responsible for assuring that the financial obligations of his/her health care are fulfilled as promptly as possible. It is also the patient's responsibility to keep the office informed of current insurance information or if there is not insurance that will cover treatment
- Current Information: A patient has the responsibility to keep the office informed of current, complete and accurate contact information, including but not limited to home addresses and phone numbers.
- Respect and Consideration: The patient is responsible for being considerate of the rights of other patients. He/she is also responsible for being respectful of the property of other persons and of the offices and environment in which care is rendered. The patient is responsible for treating the office staff and other patients with courtesy and respect, being mindful of noise levels and privacy

I have read, and acknowledge, that I understand the rights and responsibilities I have in treating in this office.

_____	_____	_____
Print Name	Signature	Date

_____	_____
Parent/Guardian Signature	Relationship

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Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate –** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury. And instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated –** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and the mother's expected child or children.

Article 3: **Procedures and Applicable Law –** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under the contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration, including but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions –** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation –** This agreement may be revoked by written notice delivered to the physician within 30 days if signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect –** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) the patient should initial below.

Effective as of the date of first medical services: _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. (SEE ARTICLE 1 OF THIS CONTRACT)

_____ _____ _____

Patient or Patient Representative's Signature Date Physician's or Authorized Representative's Signature Date

_____ _____

If Representative, Print name and Relationship to Patient Printed name of Authorized Representative's and Title