South OC Chiropractic
23792 Rockfield Blvd., Suite 210 Lake Forest, CA 92630
tel: (949) 470-4757 I fax: (949) 470-7777
www.southocchiropractic.com

1 PATIENT INFORMATION

Patient Name: Dr./Mr./Mrs./Ms._____
Last Legal First Middle Initial

Today's Date:_____Phone #:(___)_____Cell #:(___)_____

E-mail:_____

Address:_____City:_____State:_____Zip:_____

Age:_____ Birth Date:___/___/_____ Sex: ☐M ☐F DL #:_____

Please circle: Single/Married/Other:_____

In case of emergency contact:_____Relationship:_____Phone #:_____

Patient's Employer: _____

Work Address: _____City:_____State:_____Zip:_____

Phone #: (___)_____Ext:_____ Occupation: _____

Who may we thank for referring you? Event you attended?: _____

_____

Preferred Appointment Reminder Method: ☐Text ☐Email ☐Card

2 PAYMENT/INSURANCE

Who is responsible for payment: ☐ Self ☐ Other (Relationship to patient) _____

Form of payment: ☐ Cash ☐ Credit Card ☐ Debit Card ☐ Insurance ☐ Personal Injury ☐ Other_____

INSURANCE (if applicable)

Name of Insurance:_____

Subscriber Name:_____ID Number: _____Group Number: _____

Address:_____City:_____State:___Zip:_____

Phone #:(___)_____ Birth Date: ___/___/___

Insured's Employer (if different from patient): _____ Phone #:(___)_____

Work Address: _____ City:_____State:___Zip:_____

Note: *Fill out this section only if insured is different than patient.*

Subscriber Name:_____Relationship to insured: _____

Address: ☐ Same as above (If different fill out below)

Address:_____City:_____State:___Zip:_____

Phone #:( )_____ Birth Date: __/__/__

Insured's Employer (if different from patient): _____ Phone #:( )_____

Work Address: _____ City:_____ State:___ Zip:_____

3 CHIEF COMPLAINT

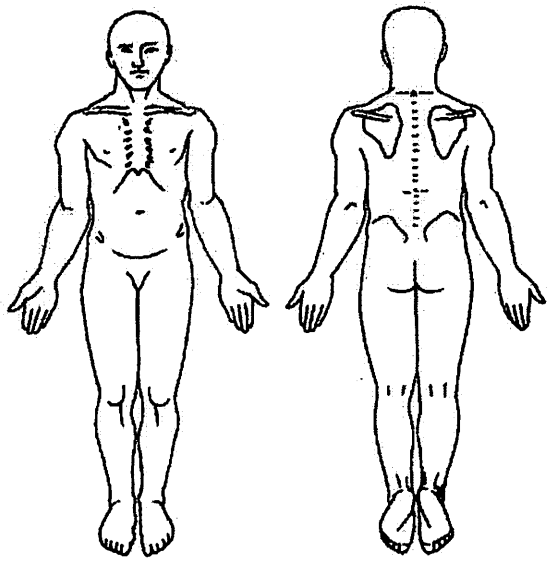
1. Are your present symptoms or conditions related to, or the result of an auto accident, work-related injury, or other personal injury *someone else might be legally liable for?* ☐ Yes ☐No
2. Chief Complaint:_____

   _____
3. When did your condition first begin? Year:_____Month:_____ Day/Date:_____
4. Is this condition getting progressively worse? ☐ Yes ☐No ☐Unknown
5. Have you had anything like this before? No/Yes: when?:_____
6. How often does the problem re-occur?:_____
7. Is the pain constant or does it come and go? _____
8. Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐ Recreation ☐N/A ☐Other:_____
9. What makes it feel better?_____
10. What makes it feel worse?_____
11. Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐ Numbness ☐Aching ☐Shooting

    ☐Burning ☐Tingling ☐Cramps ☐ Stiffness ☐Swelling ☐Other_____

PLEASE MARK THE AREA(S) ON THE DIAGRAM WITH THE APPROPRIATE SYMBOL(S) FOR THE SENSATION(S) YOU FEEL:

ACHING: == SHARP/STABBING: // PINS & NEEDLES: 00 NUMBNESS: ++ BURNING: xx



PLEASE CIRCLE & PUT YOUR LEVEL OF PAIN NUMBER IN CIRCLE IN LEFT DIAGRAM:
(1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY									
1	2	3	4	5	6	7	8	9	10

4 MEDICAL HEALTH HISTORY

Have you ever been to chiropractor before? No/Yes, What for?_____

Are you, or might you be pregnant? No/Yes Do you have a pacemaker? No/Yes

What treatment have you already received for your condition?

☐NSAIDS ☐Medications ☐Surgery ☐Physical Therapy

☐Pain Meds ☐Chiropractic ☐None ☐Other:_____

In total how much time have you spent on any of the above treatments? ☐ 0-4 wks ☐ 4-8 wks ☐ More than 8 wks

Name and address of other doctor(s) who have treated you for your condition?_____

_____

When was your last physical exam?_____Results:_____

_____

Date of Last:

Physical Exam: _____ Spinal Exam: _____ Spinal X-ray: _____ Chest X-ray: _____

MRI, CT-Scan, Bone Scan: _____ Blood Test: _____ Urine Test: _____

Mark "Yes" or "No" to indicate whether you have experienced each of the following and complete the information below:

AIDS/HIV	☐Yes ☐No	Alcoholism	☐Yes ☐No	Hernia	☐Yes ☐No	Pinched Nerve	☐Yes ☐No
Allergies	☐Yes ☐No	Chicken Pox	☐Yes ☐No	Herniated Disk	☐Yes ☐No	Pneumonia	☐Yes ☐No
Anemia	☐Yes ☐No	Clotting Disorder	☐Yes ☐No	Hypertension	☐Yes ☐No	Prostate Problem	☐Yes ☐No
Anxiety/Depr.	☐Yes ☐No	Diabetes	☐Yes ☐No	Liver Disease	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Appendicitis	☐Yes ☐No	Eating Disorder	☐Yes ☐No	Migraines	☐Yes ☐No	Rheu. Arthritis	☐Yes ☐No
Arthritis	☐Yes ☐No	Emphysema	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Stroke	☐Yes ☐No
Auto. Disorder	☐Yes ☐No	Epilepsy/Seizure	☐Yes ☐No	MS	☐Yes ☐No	Thyroid Diseases	☐Yes ☐No
Cancer	☐Yes ☐No	Heart Disease	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Other:_____	

Please list all current **medications, vitamin/mineral supplements, herbs**, including dosage:_____

_____

_____

List any known **allergies**:_____

If you **smoke or have ever smoked**, describe how much, and for how long:_____

Describe **your** typical **alcohol intake** (#of drinks per day/per week):_____

Please list and describe all significant **previous injuries with dates (sprains, fractures, accidents,** etc.):_____

_____

_____

Please list and describe all significant **previous surgeries with dates**:_____

_____

_____

Please list your usual forms of **exercise and sports, work activity, values (family, financial, mental, spiritual, social, physical, work)**:

_____

_____

5 FAMILY HISTORY

Please list any significant **health problems** of parents, grandparents, or siblings **(cancer, diabetes, heart disease, high blood pressure, kidney disease, migraines, stroke, thyroid, etc.)**:_____

_____

_____

_____

Now comes a man. Any one man is a SMALL thing. This man gives an adjustment. The adjustment is a SMALL thing. The adjustment replaces the subluxation. That is a SMALL thing. The adjusted subluxation releases pressure upon nerves. That is a SMALL thing. The released pressure restores health to a man. That is a BIG thing to that man

-D.D. Palmer

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CONSENT TO CHIROPRACTIC CARE

Congratulations for choosing the safest and most natural health care program ever conceived: Chiropractic.
This painless, logical, and effective approach to health has been serving everyday people for over 100 years. It is licensed in every state, and in many countries as well. Chiropractic has the least chance of side effects of any other type of health care. Mild headaches and muscles soreness may sometimes occur.

Let's look at a few statistics about possible serious side effects:

The #1 cause of death in the US is from correctly and incorrectly prescribed pharmaceutical drugs. (CDC, FDA, NIH sites, also Gary Null: Death By Medicine)
Stroke is one of the most common causes of death in the US. With people going to doctors all the time it is probable that many will have had a recent doctor visit. But causation is another matter entirely.
There is no absolutely known material risk of chiropractic care being greater than risks from medical treatment. In fact, when all the factors are taken together, deaths and injuries from a combination of medical mistakes and intentional drugs dwarf any injuries from chiropractic.

Risk of stroke from chiropractic? Virtually zero chance of stroke from chiropractic. The largest study ever done-the 2008 study in Canada-www.belleviewchiro.com/index.php?p=213660-looking at 12 million people over 9 years, showed that 53% of strokes had visited their MD within 30 days prior, while only 4% had visited their DC. No evidence of excess risk of stroke associated with chiropractic care.
In 2001 the Canadian Medical Association Journal found there is only a one-in-5.85-million risk that a cervical manipulation from an MD, PT, or DC would be followed by a stroke. Author David Cassidy, a professor of epidemiology at the University of Toronto said patients had already damaged the artery before seeking help from either a medical doctor or a chiropractor, and then the stroke occurred after the visit.
Speaking of risks associated with chiropractic, we should look also at the risk associated with NOT GETTING adjusted. This risk was one of the 4 components of risk in the Association of Chiropractic Colleges guidelines on informed consent in 2008. Disc degeneration, loss of mobility, loss of overall tone, decreased quality of life-these are real risks of the untreated spine as time goes by.
Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:
a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques:
b) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and *effect* relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibly of such injuries resulting from upper cervical spinal adjustment is extremely remote;
c) There is rare reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.
Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spam, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment os substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same treatments.

I acknowledge the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Patient Signature	Print Name	Date

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SOUTH OC CHIROPRACTIC NOTICE OF PRIVACY PRACTICES

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who will follow this notice?

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and location of this practice may share medical information with each other for treatment, payment purposes or heath care operation as stated in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task Will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category *of* uses *or disclosures. Not all possible uses or disclosures* are *listed.*

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies or prior injuries or surgeries that could influence our treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can be Made Without Your Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate. to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration {FDA)
- Other healthcare providers treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations

- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment and other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medial information about your, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization and we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding:

Disclosures and Changes to Your Medical Information

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or heath care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request you must tell us what information you want to limit.

Right to an Accounting of Non-standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April14, 2003. Your request should indicate in what form you want the list (example: paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, our request must be made in writing and submitted to the Privacy Officer at this practice. In addition you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Your Access to Medical Information

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Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about your, you must submit your request in writing to the privacy officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed heath care professional chosen by this practice will review your request and the denial. The person conducting the review will not be that person who denied your request. We will comply with the outcome of the review.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current notice, please request one in writing from the Privacy Office at this practice.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communication sent. To request confidential communication, you must make your request in writing to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate any reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complains must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I _____, have received a copy of South OC Chiropractic's Notice of Privacy Practices.

_____

Print Patient's Name

_____

Patient Signature or Legal Guardian

_____

Date:

For Office Use Only
If patient wishes not to sign this notice, please indicate time and date notice was given, also state reason and provide documentation that the patient refused to sign waiver.
(Employee signature is sufficient)

South OC Chiropractic Financial Agreement

We will work diligently with your insurance company to ensure your claims are processed and paid. Ultimately, if the insurance company denies payment, it may become your responsibility to render payment for services. We work hard to ensure you receive the best treatment possible and working together is necessary for this approach. Please notify SOUTH OC CHIROPRACTIC when a credit card number has changed or expired.

PLEASE READ EACH BULLET POINT.

- If my insurance company does not make payment to SOUTH OC CHIROPRACTIC for services rendered, I will become personally responsible for the charges. I will have 15 days to clear my account by calling my insurance company after being notified by this office. If the account is not cleared within 15 days, I hereby authorize SOUTH OC CHIROPRACTIC to charge any outstanding amount to my credit card.

- Insurance checks that I receive will be promptly brought to the office. Inability to do so within 7 days of receipt of insurance checks authorizes SOUTH OC CHIROPRACTIC to charge the credit card on file for the unpaid charges on my account.

- Cash balance on my account will be paid within 30 days of notification of the amount owed. If a balance remains past 30 days, I hereby authorize SOUTH OC CHIROPRACTIC to charge the full amount to my credit card on file.

- When not using health insurance for my treatment, I authorize the use of this card ***for payment of services rendered at SOUTH OC CHIROPRACTIC at the time services are rendered until written notice is provided to terminate.*** (i.e. Physical Therapy, Acupuncture and Chiropractic copays, massages, medical payments, etc.)

- I understand there is a **$35.00 NO SHOW/SAME DAY CANCELLATION FEE** for all services except chiropractic, unless a 24 hour notice is provided prior to appointment.

I authorize the above named business to charge the credit card indicated in this authorization form for services rendered. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company when charged for services rendered.

I understand and agree to all the information written above.

Patient's Name: _____

Cardholder's Name: _____

Credit Card Number: _____

Expiration Date: _____ CVC: _____

Cardholder's Signature: _____ Date: _____