BOSTEN CHIROPRACTIC

FOR OFFICE USE ONLY

Dr. _____

PERSONAL HISTORY

Date _____ Time _____

Drivers License #: _____

PERSONAL

Name: _____ (Name title, first name, and last name) Sex: _____ M or F Marital Status: _____ M,S,D,W Date of Birth: _____ month day year Home Phone: _____ Area Code Number

Address: _____ (Include street type, such as ST., AVE., Etc.) City: _____ State: _____ Zip Code: _____

Name(s) of family members that are being or that have been treated here: _____

Who referred you to our office? _____ Your Occupation: _____

Social Sec.# _____ Cell Phone: _____ E-Mail _____

Bus. Phone: _____ Area Code Number Company Name: _____

Employer: _____ Location: _____

Spouse's First Name: _____ Spouse's Cell Phone: _____

Nearest relative not living with you: _____ Name Telephone

Person to contact in case of emergency: _____ Name Telephone

HEALTH REPORT

Is this visit for an annual physical? Yes _____ No _____ Height: Feet _____ Inches _____ Weight: _____

Please describe the principal health problems for which you came to this office: _____

_____

_____ Duration of Condition: _____

List any other doctors seen for this: _____

List diagnosis(es) and type of treatment(s): _____

_____

Have you lost any days of work? Yes _____ No _____ Dates: _____

Have you had similar accidents or injuries before? Yes _____ No _____ If yes, explain: _____

_____

List the names of any relatives that have or have had a similar problem: _____

Have you or any relative received chiropractic treatment previously? Yes _____ No _____ If yes, explain: _____

_____

Have you been treated for any health condition by a physician in the last year? Yes _____ No _____ If yes, explain: _____

_____

List the approximate dates of any operations or unusual diseases you have had: _____

_____

If your condition is due to an accident that your group insurance will cover, please complete the following:

Date _____ Time _____ AM _____ PM _____ of accident.

Please describe the accident: _____

If your condition is due to an accident in which an attorney is involved, please complete the following:

Date _____ Time _____ AM _____ PM _____ of accident.

Name of Attorney _____

Address _____ Phone _____

If your condition is due to a work-related accident, please answer the following:

Have you notified your employer? Yes _____ No _____ If yes, who or what department? _____

Date injured _____ Time _____ AM _____ PM _____ Date last worked _____

Injured at: _____ (Address, City, County and State)

FEMALES ONLY: When was your last period? _____ Are you pregnant? Yes _____ No _____ May be _____

HEALTH QUESTIONNAIRE:
Please indicate for each of the following questions below your experience by use of one of the following codes
Codes: 1 for never had; 2 for previously had; 3 for presently have.

MUSCULO-SKELETAL SYSTEM

CODE

090 _____ Low back problems
030 _____ Pain between shoulders
020 _____ Neck problem
035 _____ Arm problems
125 _____ Leg problems
545 _____ Swollen joints
150 _____ Painful joints
365 _____ Stiff joints
550 _____ Sore muscles
440 _____ Weak muscles
170 _____ Walking problems
555 _____ Ruptures
560 _____ Broken bones

GENITO-URINARY SYSTEM

CODE

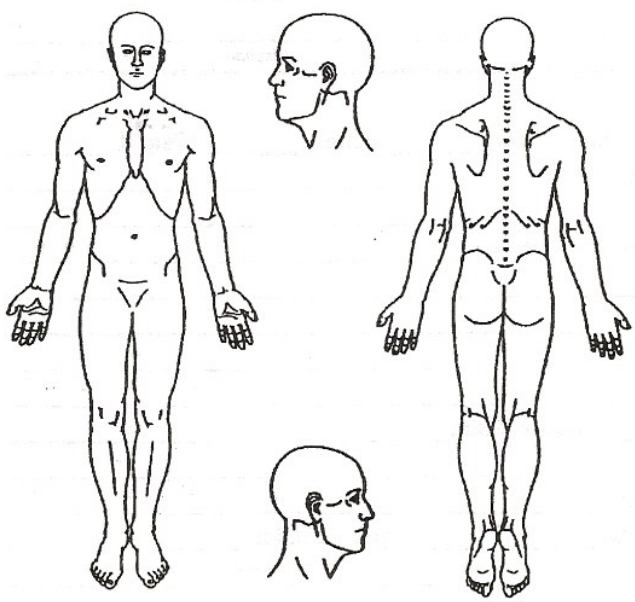
265 _____ Bladder trouble
277 _____ Excessive urine
278 _____ Scanty urination
275 _____ Painful urination
275 _____ Discolored urine

FEMALE

CODE

260 _____ Vaginal discharge
260 _____ Vaginal bleeding
260 _____ Vaginal pain
565 _____ Breast pain
565 _____ Lumps on breast

Please mark your areas of pain on the figures below.



GASTRO-INTESTIAL SYSTEM

CODE

570 _____ Poor appetite
575 _____ Excessive hunger
580 _____ Difficult chewing
580 _____ Difficult swallowing
585 _____ Excessive thirst
295 _____ Nausea
590 _____ Vomiting food
595 _____ Vomiting blood
085 _____ Abdominal pain
300 _____ Diarrhea
310 _____ Constipation
600 _____ Black stool
600 _____ Bloody stool
311 _____ Hemorrhoids
605 _____ Liver Trouble
081 _____ Gall bladder problems
610 _____ Weight trouble

NERVOUS SYSTEM

CODE

345 _____ Numbness
360 _____ Loss of feeling
351 _____ Paralysis
491 _____ Dizziness
615 _____ Fainting
200 _____ Headaches
320 _____ Muscle jerking
620 _____ Convulsions
480 _____ Forgetfulness
485 _____ Confusion
402 _____ Depression

CARDIO-VASCULAR RESPIRATORY

CODE

060 _____ Chest pain
625 _____ Pain over heart
420 _____ Difficult breathing
495 _____ Persistent cough
630 _____ Coughing phlegm
635 _____ Coughing blood
640 _____ Rapid heartbeat
645 _____ Blood pressure problem
640 _____ Heart problems
650 _____ Lung problems
655 _____ Varicose Veins

EYE, EAR, NOSE, AND THROAT

CODE

455 _____ Eye strain
660 _____ Eye inflammation
665 _____ Vision problems
015 _____ Ear Pain
670 _____ Ear noise
475 _____ Hearing loss
675 _____ Ear discharge
680 _____ Nose pain
715 _____ Nose bleeding
720 _____ Nose discharge
241 _____ Difficult breathing through nose
685 _____ Sore gums
690 _____ Dental problems
695 _____ Sore mouth
700 _____ Sore throat
705 _____ Hoarseness
710 _____ Difficult speech

If you have insurance coverage, we will process your claim as a courtesy to you. If we receive payment from your insurance company, we will reimburse you accordingly.

I understand I am financially obligated to pay all treatments, X-rays and examinations at the time these services are rendered.

Signature _____

To receive our monthly newsletter (health topics, special offers, etc.) please initial the box ☐
and make sure to provide us with your email address: _____

----------**DO NOT WRITE BELOW THIS LINE**----------

POP, PD, PS, (F/A), FT, NOD, LOT, DOC, HP, AEP, NLW, DT, ADR, LFG.

_____

_____

Patient accepted? Yes ____ No ____ Date _____ Doctor's Signature _____

BOSTEN CHIROPRACTIC

2990 S. Sepulveda Blvd. Suite 300A, Los Angeles, CA 90064, Tel (424) 286-1177, Fax (424) 286-1144

INFORMED CONSENT

I hereby request and consent to the performance of treatment, which may be performed during my course of treatment, including chiropractic care and other procedures such as emergency treatment or services, laboratory procedures, x-rays, orthopedic, neurological, biomechanical and kinesiological examinations rendered to me (or on the patient named below, for who I am legally responsible) by Dr._____, D.C. (hereinafter "doctor") and/or others who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor, including those working at this office or any other office or clinic.

I understand and am informed that, in the practice of chiropractic, as in the practice of medicine that there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor or his staff to be able to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure and or treatment, which the doctor feels at the time, based on the facts then known, is in my best interest.

It is hereby stated that there could be some risk to treatment as it relates to the use of modalities, including but not limited to the following:

Heat Modalities (Ultrasound, hot packs, hydrocollator packs, and paraffin dips, ultrasound, whirlpools, infrared, diathermy): Burns, blisters, mottling of skin, decreased sensation, increased menstruation, necrosis. **Please initial:**_____

Cold Modalities (Ice packs, ice massage, immersion baths, cold packs, vapocoolant sprays): Frostbite, cold allergies. **Please initial:**_____

Electrical Modalities (Galvanic, Russian, iontophoresis, phonophoresis, interferential, microcurrent, laser, TENS): Burns, swelling, strain, skin irritation. **Please initial:**_____

Manual Modalities (Manipulation, traction, passive motion, active motion, spinal decompression on dry land or pool, stretching, myofascial release, massage; exercise including resistance, isokinetic and spinal decompressing, active and passive range of motion, taping and bracing): fractures, disc injuries, strokes, dislocations, sprains, tears and sprains. **Please initial:**_____

I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patients Printed Name Date

_____ _____

Patient or Guardian's Signature Relationship to Patient

BOSTEN CHIROPRACTIC

2990 S. Sepulveda Blvd. Suite 300A, Los Angeles, CA 90064, Tel (424) 286-1177, Fax (424) 286-1144

FINANCIAL, INSURANCE & OFFICE POLICY

For_____("Patient")
Name of Patient

1. **RELEASE OF INFORMATION**
The undersigned agrees that to the extent necessary to determine responsibility for payment and to obtain reimbursement, this office may disclose portions of the patient's existing record, including his/her medical records, to any person or entity, which is or may be responsible for all or any portion of this office's and/or office-based doctor's charges, including but not limited to insurance companies, health care service plans, workers' compensation carriers, medical or utilization review organization designated by any of the foregoing, or to any other person or entity as necessary in connection with such payment or reimbursement. If additional reports are required, an additional fee will be charged.

2. **ACKNOWLEDGMENT OF PRIVACY RIGHTS**
The undersigned has received a copy of the Privacy Notice (HIPAA) for review, describing how medical information about the patient may be used and disclosed, and how the patient can obtain access to this information.

3. **FINANCIAL OBLIGATION & INSURANCE BILLING POLICY**
Patients are 100% financially responsible for their bill. Payment is due in full at the time of services rendered. The undersigned agrees, whether he/she signs as agent or a patient that in return for the services rendered to the patient, the undersigned hereby individually obligates himself/herself to pay this office in accordance with the regular rates and terms of this office.

We are not providers for Medicare, Blue Cross, Blue Shield, HealthNet or any other managed health care entity. We do not "take" insurance. We do not work with liens. As a courtesy to our patients, this office will bill all payable services to the patient's insurance company. If the patient is eligible to receive benefits from a health care plan for services rendered and billed for by this office and if these funds have been paid to this office by the health care plan, then excess funds remaining after patient's payment in full will be applied towards future services or outstanding account(s). Should the patient discontinue care, any credit balance will be refunded to the patient. The undersigned hereby also authorizes this office to apply any excess funds toward any other outstanding account(s), which the patient may have with this office for any prior services rendered and for which the undersigned is responsible. Should the patient's account become delinquent and be referred to any attorney or collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

4. **PATIENT RESPONSIBILITY**
Please sign in upon arrival for every visit. This informs the staff that the patient is here for their appointment. The sign in sheet is a legal document. Please be aware that insurance companies, when requesting medical records, are also requesting the patient sign in sheets. It is important that you arrive on time for your appointment. If the patient cannot make their scheduled appointment, they must call us at (310)559-6900. We require a 24-hour notice for cancellations; any appointments cancelled less than 24-hours or any "No-Show" for an appointment is subject to a $60.00 fee. This fee cannot be billed to insurance, it is the patient's responsibility and must be paid before continuing treatment.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, patient's legal representative, or is duly authorized by the patient's general agent to execute the above and accept its terms.

_____ _____
Date Patient / Parent / Guardian / Conservator / Financially Responsible Party

If other than patient, indicate relationship:_____

Reason patient is unable to sign:_____

BOSTEN CHIROPRACTIC

2990 S. Sepulveda Blvd. Suite 300A, Los Angeles, CA 90064, Tel (424) 286-1177, Fax (424) 286-1144

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

All Independent Services, Inc. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for All Independent Services, Inc.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient
HIPAA Privacy Standards

_____
Please do not use my name in any fund raising efforts.