one

WELCOME

ABOUT YOU

Today's Date: ___/___/___ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age:_____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

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

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two

INSURANCE INFO

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of

(*Explain what happened*): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ___/___/___

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your

If so, please explain: _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom? _____ Phone#: _____

three

PLEASE CONTINUE ON BACK

four

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

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HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any **past** serious accidents with dates: _____

_____

Family Health History: _____

_____

Do you: Take Supplements or Vitamins? ❑Yes ❑ No / Exercise? ❑Yes ❑ No

Are you on a special diet: ❑ Yes ❑ No / Since: ____/____/____

Do you smoke? ❑ No ❑ Yes / How Much? _____ How Long? _____

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? _____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Nursing? ❑ Yes ❑ No

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ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: ❑ CASH ❑ Check

_____ /

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..
Please describe your condition:

_____

_____

SHOW US WHERE IT HURTS

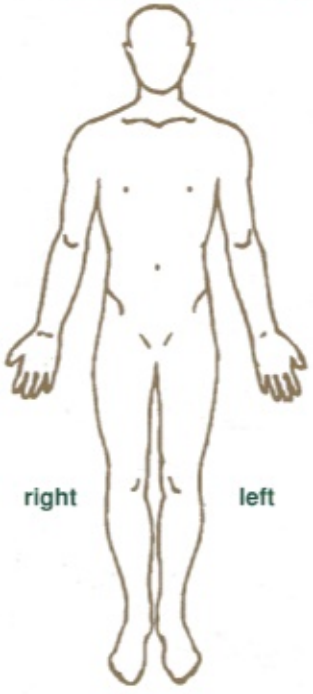
Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

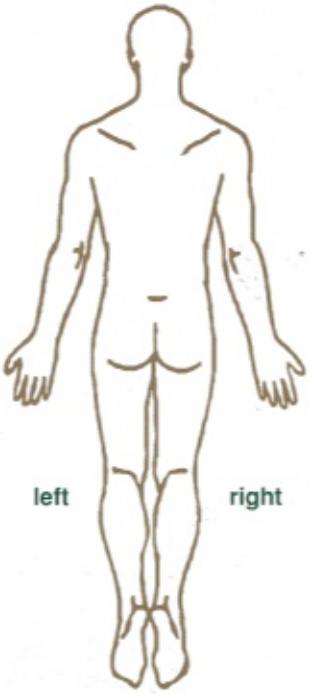
◯ Circle any area of pain not represented by a symbol.

Example

Right



Front



Back

Left

DOCTOR'S NOTES

_____

_____

_____

_____

_____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

portola valley
chiropractic

OFFICE FINANCIAL POLICY

FIRST VISIT: Payment in full is required for the evaluation and treatment on your first visit. We will verify your insurance coverage at that time and adjust accordingly.

ANCILLARY PURCHASES: Nutritional supplements, orthopedic supplies, and all ancillary purchases need to be paid for at the time of receipt, as insurance will not cover these items.

MISSED APPOINTMENTS: We have a 24-hour cancellation policy. The patient must contact Portola Valley Chiropractic via phone, email, or other communication at least one business day prior to their appointment to cancel without a charge. If you cannot make a Monday appointment then please give notice on the previous Friday. There is a $35 charge for a missed appointment. Massage and stretching sessions will be charge in full if proper notice is not given.

HEALTH INSURANCE: As a courtesy, Portola Valley Chiropractic will bill your insurance. Many insurance companies cover chiropractic care, however, they do not always guarantee payment. Policy deductibles and payment percentages often differ, and it is ultimately the patient's responsibility to pay their bill even if they have insurance.

MEDICARE: At this time we do not accept Medicare benefits. All patients who have Medicare must pay out of pocket and sign the ABN form in order to continue care at Portola Valley Chiropractic.

CASH PAYMENTS: It is our policy to collect at the time of treatment or on the last treatment of the week.

AUTO ACCIDENT: If you have Med-Pay on your auto insurance policy, you must file a claim with your auto insurance to receive coverage. Regardless of who is at fault, Med-Pay is used to cover your medical bills up to a certain amount. If there is Med-Pay you will be assigned an adjustor and claim number and will receive all necessary billing information from your insurance company.

WORKER'S COMPENSATION: If you are injured at your workplace or during your work schedule, inform you employer immediately and let them know that you wish to seek care with Portola Valley Chiropractic. To be covered by worker's compensation, you must receive authorization from your employer and your worker's compensation carrier BEFORE treatment can be rendered.

I understand and agree to the following terms and conditions:

_____ Date: _____ /_____ /_____

Signature

portola valley
chiropractic

Informed Consent for Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or mechanical devices in order to move your joints. You may feel a "click" or "pop" such as the noise when a knuckle is "cracked". You may feel and hear the joint move, or not, depending on the technique used. Various ancillary procedures such as hot or cold packs, electro-muscle stimulation, ultrasound or traction may also be used.

Safety of Chiropractic: Millions of chiropractic adjustments are given safely and effectively each year however as with any health care procedure certain complications may occur. The risk of cerebrovascular injury or stroke could occur upon injury to the arteries of the neck. Experts estimate this occurrence to be one in a million to one in ten million.
(You are more likely to be struck and killed by lightning)
The probability of other serious complications is also very rare such as ligament tears, fractures, dislocations or injury to intervertebral discs.

Other treatment options: include the following depending on your condition

- Over the counter analgesics (NSAIDS)
  The risks of these medications include irritation to the stomach, liver and kidneys. The risk of death from taking these medications is 1 in 2,500
- Prescription medications or Hospitalization
  Drug reactions during hospitalization can run as high as 30% as well as a significant risk of contracting infection.
- Surgery
  Surgical risks include blood clots and complications from anesthesia.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and possibly induce chronic pain. It is quite probably that delay of proper treatment will complicate the condition and make rehabilitation more difficult.

I have read and understand the information regarding chiropractic treatment. I am free to discuss the risks/benefits of treatment at any time with my doctor and at this time give my full consent to treatment.

_____ _____ _____

signature print name date

portola valley
chiropractic

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

Portola Valley Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Portola Valley Chiropractic is required by law to comply with this notice.

Portola Valley Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Jessica Reynolds by calling the office at (650) 851-4860. If Jessica Reynolds is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

COMPLAINTS

Complaints about your privacy rights or how Portola Valley Chiropractic has handled your health information should be directed to Jessica Reynolds by calling the office at (650) 851-4860. If Jessica Reynolds is not available, you may make an appointment for a personal conference in person or by telephone within two working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____ / _____ / _____

I have read the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide Portola Valley Chiropractic with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date