Sheridan Chiropractic, Inc.

Shamus Sheridan, D.C. | Sean Sheridan, D.C. | John Chapman, D.C.

CONFIDENTIAL PATIENT REGISTRATION & HISTORY

PATIENT INFORMATION:

Today's Date: _____ How did you hear about us? _____

Name: _____

DOB (Month/Day/Year): ____ / ____ / _____ Age: _____ Gender: M // F SS#: _____-____-_____

Home Address: _____ City: _____ Zip Code: _____

Cell #: _____ Home #: _____ Work #: _____

Email Address: _____

EMPLOYER NAME: _____ Occupation: _____

Address: _____ City: _____ Zip Code: _____

Phone #: _____ Fax: _____ # Hours/Week Worked: _____

EMERGENCY CONTACT: _____ Relation: _____ Phone #: _____

HEALTH INSURANCE INFORMATION:

Insurance Company: _____ Phone #: _____

Policy Holder Name: _____ Policy #: _____

Relationship to Policy Holder: _____ Group #: _____

PRIMARY PHYSICIAN INFORMATION:

Physician Name: _____ Phone #: _____

Address: _____

CURRENT COMPLAINTS

What are your current complaints? _____

When did your symptoms first appear? _____

Do your symptoms interfere with: ❒ Sleep ❒ Daily Routine ❒ Work ❒ Recreation

Are you working less hours/days as a result of your complaints? ❒ Yes ❒ No

If yes, please explain: _____

Activities or movements that are painful to perform:

❒ Sitting ❒ Standing ❒ Walking ❒ Bending ❒ Laying Down

How would you rate your symptoms:

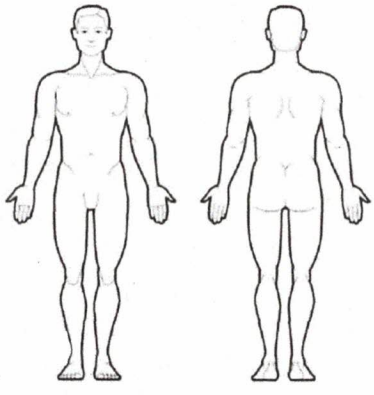
❒ Mild ❒ Moderate ❒ Severe

How would you rate your current pain level?

No pain		Minimal		Slight		Moderate			Severe Pain	
0	1	2	3	4	5	6	7	8	9	10

Are your symptoms: ❒ Improving ❒ Unchanged ❒ Worsening

Mark with an "X" on the areas of your pain on the diagram to the right.



HOSPITALIZATION / EXAMINATION HISTORY:

Have you been to the hospital for *this* condition? ❒ Yes ❒ No When did you go? _____

Name of the hospital: _____ How did you get there? ❒ Self ❒ Others ❒ Ambulance

Were x-rays taken? ❒ Yes ❒ No If yes, what areas? _____

Were you prescribed medication? ❒ Yes ❒ No What medication? _____

Have you seen any other doctor or received any other treatment for your current condition? ❒ Yes ❒ No

If yes, explain: _____

Doctor's name & address: _____

Phone #: _____ Date seen: _____ Diagnosis: _____

DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED: (Place "X" in boxes that apply)

Test	Region/Body Parts	Date	Test	Region/Body Parts	Date
❒ Examination	_____	_____	❒ EMG/NVG	_____	_____
❒ MRI/CT	_____	_____	❒ _____	_____	_____

HEALTH HISTORY/INJURIES/TREATMENTS:

INJURIES YOU MAY HAVE HAD IN THE PAST **DATES**

Auto Accidents: _____ _____

Work Injuries: _____ _____

Broken Bones: _____ _____

Other: _____ _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERED FROM:

❒ Muscle Disorder	❒ Asthma	❒ Osteoarthritis	❒ Coughing Blood
❒ Nervous System Disorder	❒ Broken Bones	❒ Epilepsy	❒ Circulatory Problems
❒ Bone Disorder	❒ Intestinal Problems	❒ Alcoholism	❒ Kidney/Bladder Problems
❒ Rheumatoid Arthritis	❒ Seizures/Convulsions	❒ Drug Addiction	❒ Heart Disease
❒ Allergies	❒ Congenital Disease	❒ Strokes	❒ Tumors
❒ HIV	❒ Excessive Bleeding	❒ Cancer	❒ Depression
❒ Gallbladder Issues	❒ High Blood Pressure	❒ Ulcer	❒ Ear/Throat Infection
❒ Diabetes	❒ Low Blood Pressure	❒ Hernias	❒ Pacemaker

SURGERIES YOU MAY HAVE HAD FOR <u>THIS</u> CONDITION: **DATE(S)**

Spine Surgeries: ❒ Discectomy ❒ Laminectomy ❒ Fusion ❒ Other: _____ _____

NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR <u>THIS</u> CONDITION:

❒ Medication ❒ Injections ❒ Physical Therapy ❒ Massage ❒ Chiropractic ❒ Acupuncture

❒ Other: _____

Medication(s) Currently Being Taken: _____

Female Patients: Most recent menstrual cycle: _____ ❒ Pregnant: _____ weeks

AUTHORIZATION FOR TREATMENT

I hereby authorize Sheridan Chiropractic to treat my condition as they need appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid to SCI for x-rays is for examination only and the x-ray negatives will remain property of SCI. They will be kept on file where they may be seen anytime while I am treating at SCI. I am responsible for all bills incurred at this office. I will not hold SCI responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis. I agree that the statements made in this questionnaire are true and correct.

Patient's Signature: _____ Date: _____

Sheridan Chiropractic, Inc. Consent to Services

PATIENT RIGHTS **PT INITIALS _____**

Sheridan Chiropractic, Inc. (SCI) respects the unique differences of our patients, and will ensure that healthcare ethics are maintained for all patients. The following rights will be exercised in our patients' behalf:

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment and prognosis.
3. The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options.

CONSENT TO TREATMENT OF A MINOR CHILD *(UNDER THE AGE OF 18)* **PT INITIALS _____**

I authorize chiropractic and/or physical therapy care as deemed necessary to my (relationship) _____.

FEMALE PATIENTS *(ONLY)* **PT INITIALS _____**

This is to certify that, to the best of my knowledge, I am NOT pregnant and that SCI has my permission to take x-rays. Beginning date of last menstrual period _____.

PAYMENT, INSURANCE, MEDICAL RECORDS, AND USE OF NAME **PT INITIALS _____**

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum in now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid it directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for products or professional services rendered will be immediately due and payable.

CONSENT TO X-RAY ASSIGNMENT AGREEMENT **PT INITIALS _____**

I consent to allow SCI to use the services of an outside radiologist if needed to ensure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for the services will be submitted to my insurance carrier, Workers' Compensation carrier of State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to the radiologist or radiology services.

I assign my insurance benefits and rights to payment to the radiologist to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or third-party payer to provide the radiologist or their agents with any information concerning my claim, their services, and/or payment for the services provided.

CONSENT TO CHIROPRACTIC AND/OR PHYSICAL THERAPY SERVICES **PT INITIALS _____**

I hereby request and consent to comprehensive examinations (chiropractic and/or physical therapy, orthopedic, and/or neurological), chiropractic adjustments/treatments (and other procedures including various modes of physiotherapy modalities), physical therapy intervention (including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise program), nutritional counseling/advice, and diagnostic x-rays by SCI (& it's staff), who now or in the future treat me in this office. I have had an opportunity to discuss with the SCI Staff the nature and the purpose of the treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, the practice of chiropractic and in the practice of physical therapy there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and wish to rely on the doctor(s) to exercise judgment during the course of any procedure which the doctor(s) feel at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future condition(s) for which I seek treatment by SCI and/or employed staff.

NO-SHOW/CANCELLATION/LATE POLICY **PT INITIALS _____**

Patient agrees to notify SCI regarding any missed appointments. Patient will respectfully agree to cancel within 24 hours of scheduled time. If patients show up for appointments more than 15 minutes late we may reschedule or full treatment will not be given.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

Printed Name: _____ **Signed**: _____ **Dated**: _____

PATIENT NAME: _____

ARBITRATION AGREEMENT AND INFORMED CONSENT

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 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 state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right 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 also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration and procedural disputes will also be determined by submission of binding arbitration. It is the intention of the parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the healthcare provider's clinic(s) or office(s) or any other clinic or office whether dignitaries to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care providers' associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive belief or punitive damages.

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 thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. 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, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgement for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this arbitration agreement.

Article 4: General Provision: 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 state statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _____. Effective as the date of first professional services.

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.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, weather signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

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 SIGNATURE: _____ **DATE:** _____