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 SS#: _____

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 (*Please circle*): work, sports, auto, trauma or chronic.

(*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 (*Please Circle*): work, sleep, or daily routine.

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

six

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)

_____ Initials 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).

- 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:

_____

_____

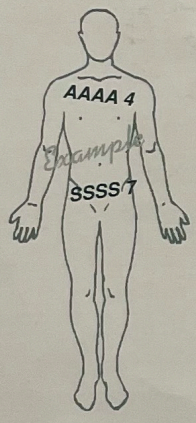
Signature: _____ Date: ____/____/____

SHOW US WHERE IT HURTS

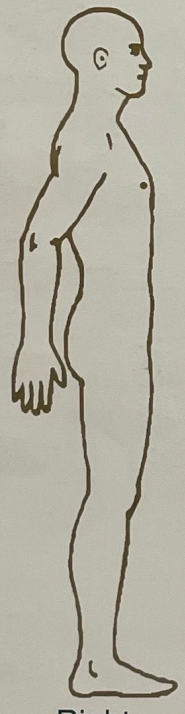
Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

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

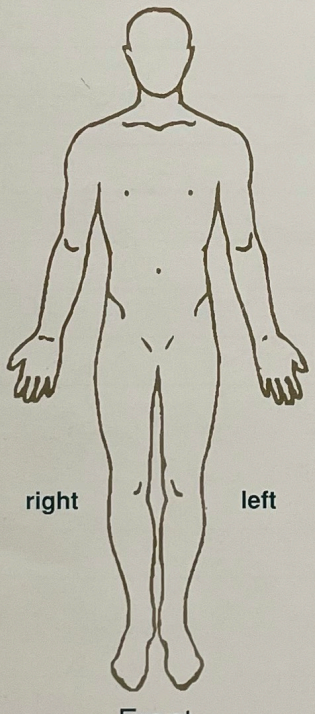
◯ Circle any area of pain not represented by a symbol.



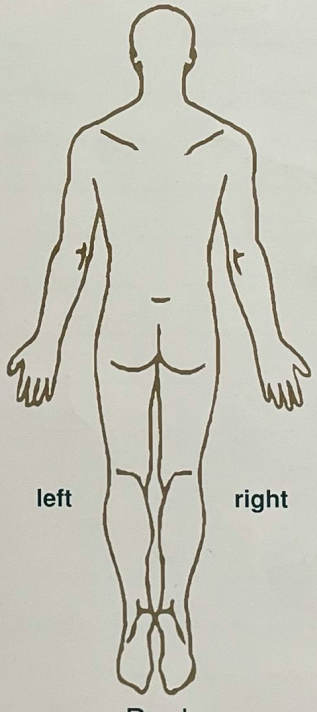
Example



Right



Front



Back

Left

DOCTOR'S NOTES

_____

_____

_____

_____

_____

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

Rancho Spine & Disc

Dr. Frank Castiglione, D.C.

INFORMED CONSENT FOR
MEDICAL / CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of medical care and chiropractic adjustments and procedures, including various modes of physical therapy and diagnostic x-ray, on me (or on the patient named below, for whom i legally responsible) by the medical doctor or doctor of chiropractic named below and/or associated with or serving as back-up for the doctor named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctors named below and/or with other office or clinic personnel the nature and purpose or chiropractic there are some risk and complications, 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, and is in my best interests.

I have read or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient Information

Patient's Name _____ Date _____

Signature of Patient _____

Witness Signature _____

To be completed by patient's representative if patient is a
(1)minor , (2) physically or (3) legally incapacitated.

Signature of Representative _____

Relationship to patient _____ Date _____

Name(s) of Doctors treating this patient:

Doctor of Chiropractic: Dr Frank A. Castiglione D.C.

9605 Arrow Rte Suite B Rancho Cucamonga, CA 91730 (909) 257-7044

Rancho Spine & Disc

Dr. Frank A. Castiglione, D.C.
9605 Arrow Rte Suite B Rancho Cucamonga, CA 91730
(909) 257- 7044

Broken or Missed Appointment Without 24 Hour Notice Policy

Dr. Castiglione is completely committed to your health care and has made a commitment to be available for you when you schedule your appointment.

You are expected to honor your appointment time.

When you schedule an appointment time and do not show up or call within 24 hours notice, Dr. Castiglione cannot get that time back nor can anyone else be scheduled.

If you know you are going to miss an appointment please call or text the office within 24 hour notice or you will be billed for your regular office visit fee and will lose your visit with Dr. Castiglione just as he lost his time.

We understand emergencies happen beyond our control so will be allowed one warning with no charge.

Sign _____ Date _____

Print Name _____

Witness _____ Date _____

HIPAA Notice of Privacy Practices

Castiglione Chiropractic Centers, Inc.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information, hereby after referred to as "PHI", to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, and related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a health agency that provides care to you. Your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose, treat, or approve treatment to you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you would be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment(s).

Other Permitted and Required Uses and Disclosures: Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. For example, we may publicly display your likeness with your consent. We may use or disclose your PHI in the following situations without your authorization: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers' Compensation, Inmates, and any other third party as required by law. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosures indicated in this authorization.

Your Rights: The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even, if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes that have occurred. You then have the right to object and/or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of out legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (909) 237-6546.

Your signature below is your acknowledgement that you have received, read, and agree to this Notice of our Privacy Practices.

Patient Signature: _____

Parent or Guardian Signature: _____ Date: _____

For Administrative Use Only:

Witnessed by: _____ Date: _____ Account #: _____
Chart #: _____ If Patient Refused to Sign, Check Here ☐