Welcome,

I would like to take a moment and welcome you to our office. You have choices as to where you seek healthcare and I appreciate and feel honored you would choose this office to address your most important asset-your health.

Our goal today is to determine whether chiropractic is a good option for your condition. If it is, then I would love to help you. If it is not, I will refer you to the appropriate provider. Please complete the attached paperwork. It is lengthy and for that I apologize. Thoroughness offers few "shortcuts". If you have any questions, please ask.

The kind referrals of our patients have allowed us to successfully treat many patients. It is my sincere hope that my unique experience and expertise will help lead you to better health as well.

Thanks again for choosing Back and Body Chiropractic. I look forward to serving you.

Respectfully,

Dr. Selena Cermeño D.C.

PATIENT INTAKE

Patient Name:_____ Birth Date: _____ Sex: M / F
Address:_____ City:_____
State:_____ Zip:_____ Phone: (_____)_____ Cell Phone: (_____)_____
Primary Language:_____ **If telephone correspondence is needed is it okay to leave a message with either a person/machine in regards to your treatment (please check yes or no).** ☐ **YES** ☐ **NO**
Occupation:_____ Employer:_____
Work ph:_____
Address:_____ City:_____ State:_____ Zip:_____
Email:_____
In an Emergency, Please Contact: _____
Phone:(____)_____ Relation:_____
Please fill out insurance info., if applicable and hand insurance card to the front desk to copy.
Insured Name:_____Health Plan Name:_____
Insured ID#:_____ Group #:_____
Primary Care Physician Name:_____PCP Phone:_____
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
☐ Headache ☐ Neck Pain ☐ Mid-back pain ☐ Low Back Pain ☐Other:_____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began: _____How Problem Began:_____
How often are your symptoms present?
(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐76-100% (Constant) ☐ Other_____
In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores)?
(No Interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry on any activities)
HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCANS FOR YOUR AREA(S) OF COMPLAINT:
☐ No ☐ Yes
Dates(s) taken:_____What areas were taken?:_____
Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date): _____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) _____
_____
☐ Osteoporosis
☐ Other Health Problems (explain) _____
_____

☐ Prostate Problems
☐Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks _____
☐ Abnormal Weight ☐Gain ☐ Loss
☐ Marked Morning Pain/ Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries
☐ Epilepsy/Seizures
☐ Medication

Family History: ☐Cancer ☐Diabetes ☐Heart Problems/Stroke ☐Rheumatoid Arthritis ☐High Blood Pressure

I certify to the best of my knowledge, the above information is complete and accurate. I understand that I am liable for all charges for services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future. If I suspend or terminate my care and treatment, fees for services rendered to me will be immediately due and payable. All cancellations must be made 24 hours in advance. "No Show" and late cancellations will be assessed a $25 fee.

Patient Signature_____ Date_____

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of Back and Body Chiropractic) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of any updated/current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Back and Body Chiropractic
Dr. Selena Cermeño, D.C.
2858 Stevens Creek Blvd. Suite 209
San Jose, CA 95128
(408) 482-7775

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may

be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

1. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
2. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
3. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
4. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
5. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct

- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

I have received or reviewed the privacy practice notice for Back and Body Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially initiated care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Print Patient Name

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing or your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

FULL SERVICE OFFICE POLICY
(Please read this agreement before signing)

1. First Visit **We ask that your first visit be paid in full at the time of service.** All paperwork must be completed for verification of insurance coverage. Upon verification of insurance benefits, all applicable copays and deductible will be reconciled accordingly. The initial visit can range from $125-$180 depending on complexity.

2. Insurance Benefits Your insurance company is contracted to you; we bill your insurance as a courtesy for you. The balance is ultimately the patient's responsibility. Our policy is to verify your specific chiropractic benefits. We ask that you assign the benefits to be paid directly to the doctor. We will resubmit a claim only one time. We will not enter into dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company.

Group insurance is required by law to make payments within thirty (30) days of service billing. Understand that if your insurance company has not paid the claim within forty-five (45) days a copy of that unpaid claim will be given to you and you will be responsible to follow up on the status of payment. If payment has not been made within sixty (60) days of service then you will be required to pay for the service(s) and to seek reimbursement on your own.

Any checks received by you from an insurance company (or attorney) for services rendered, must be signed over for payment on any outstanding balance.

3. UCR Fees Our fees are generally considered Usual, Customary and Reasonable (UCR) for this area.

4. Non-Covered Services When services are paid according to preferred provider agreement (PPO) between the doctor and insurance company, a write off of the appropriate amount will be made. With some PPO and some non-PPO companies, some services will not be covered. These services may be the patient's responsibility.

5. Account Financing Our office does provide financial plans available for you.

6. Accidents If you were involved in a personal injury accident you will be required to read and sign the DOCTOR-PATIENT IRREVOCABLE ASSIGNMENT, AGREEMENT, LIEN AND POWER OF ATTORNEY" form. As soon as you have an attorney, you will be required to have him or her sign the "A Notice to Attorney of Doctor's Lien."

7. Workman's Compensation If your injury was the result of an accident at work you must report the injury to your employer. You must also provide employer and insurance information or you may be required to pay for services yourself and seek reimbursement on your own.

8. Delayed Payment Charge Each billing statement except for the first one will be charged a $10.00 billing charge on the next balance due statement to cover the cost of the new billing. If this charge is not paid it will accrue to the outstanding balance.

9. Discontinuing Care If the patient fails to follow the prescribed treatment for any reason other than discharge by the doctor, a final bill of any current outstanding balance due will be sent directly to the patient.

10. Credit Balance If at the end of your treatment you have a credit balance, it will be made available to you 30 days after your final visit or last insurance payment. This also can be sent directly to the patient.

11. Returned Checks There will be a $40.00 charge for all returned checks. A NSF (bounced) check can result in prosecution.

12. Collection Costs If we, unfortunately, have to send this account to collections, the responsible party will pay all collections fees, attorney's fees or any other fees related to collecting on this account.

I have read this agreement and agree to abide by it in full.

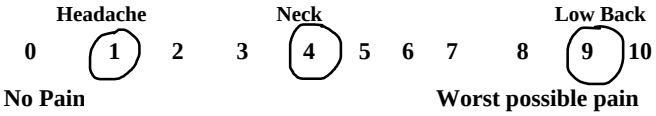
Patient Name	Patient Signature	Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read instructions carefully:
Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and circle the number for each complaint.
Example:

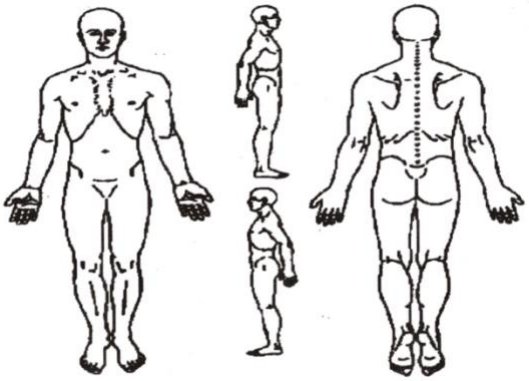


What is your pain RIGHT NOW?
0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible pain

What is your TYPICAL or AVERAGE pain
0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible pain

What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?
0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible pain

What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?
0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Possible pain



Please circle all pain area (s)