Roseville Disc & Pain Center
901 Sunrise Ave., Ste. B-3, Roseville, CA 95661
(916)786-3737, (916)786-3757 fax

Full Name: _____

Address: _____ **City/State:** _____ **Zip:**_____

Work Phone: _____ **Home:** _____ **Cell:** _____

Birthday: _____ **Email:** _____

Whom may we thank for referring you? _____

Marital Status: M S D W Spouse's Name/Occupation:_____

Your Employer: _____**Occupation:** _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____**Relationship:**_____

Work Phone: _____ **Home:** _____ **Cell:** _____

Favorite Hobbies/Interests: _____

Reason for visit? _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ( ) *Yes* ( ) *No* ( ) *Unknown*

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ( ) *Work* ( ) *Sleep* ( ) *Daily Routine* ( ) *Recreation* ?

Activities or movements that may be painful to perform:
( ) *Sitting* ( ) *Standing* ( ) *Walking* ( ) *Bending* ( ) *Lying Down*

Is your condition due to an ( ) *Auto Accident* or ( ) *Work Injury* ? ( ) *No* Date: _____

Do you have a pacemaker or a defibrillator? ( ) *Yes* ( ) *No*

If you have insurance, please write the name of the company: _____

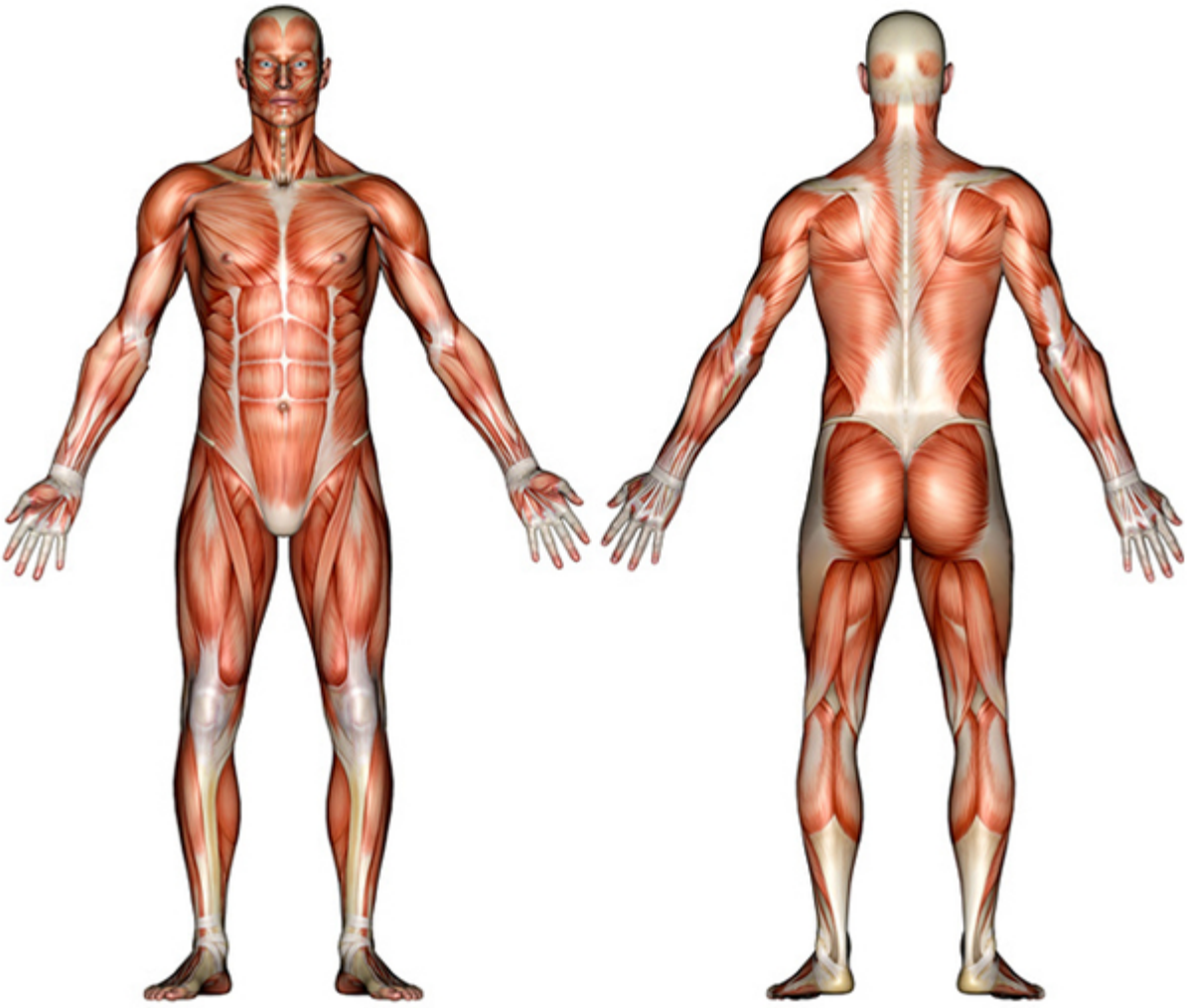
*** ***Please hand your insurance card to us before your treatment begins. Thank You!***

The above information is true and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____

Patient:_____ **Date:**_____

Please Mark The Areas On Your Body Below Where You Are Having Pain.
Use the 0 – 10 Scale Below. Also, Indicate The Percentage Of Time You Have It.



PAIN SCALE (0 – 10)

0-1 = Minimal = The pain is an annoyance but does not stop me from working.

2-3 = Slight = I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.

5 = Moderate = The pain causes a marked handicap in my ability to work but, I can continue.

7-8 = Moderate to Severe = The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.

10 = Severe = The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

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OFFICE POLICIES AND PROCEDURES:

- **Unplanned Emergencies:** I understand that emergencies occur and that on the rare occasion, I might miss one of my appointments. Roseville Disc & Pain Center (RDPC) **requires a 24-hour notice** so that they have the time to fill in that appointment time with another person in need. The 24-hour period is necessary to avoid a missed appointment fee.
- **Missed or Rescheduled Appointment:** By accepting care, I understand I am committing to getting well. The only way to get well is to make my appointments. If I miss a scheduled appointment for any reason, I agree to make up that missed appointment within 7 DAYS time. If I do not, I may be dismissed from care for non-compliance.
- **Missed Appointment Fee:** If I miss my appointment and do not provide 24-hour notice, I will be charged a **$50 no-show fee**. My time is valuable and so is the Doctor's time.
- **Health Insurance:** I agree that as an insured patient, I am expected to take care of my fees as services are rendered (co-payments and additional fees not covered by my insurance). RDPC will bill all of my insurance claims as a service to me. If RDPC has a problem collecting from any of my claims or is denied payment, I am responsible for the unpaid balance on my account. If I prefer, I may send in my own claims and RDPC will provide me with a statement and/or a superbill.
- **Personal Injury**: I understand that to obtain treatment from RDPC for a personal injury case, I must either have medical coverage payments from my auto insurance or have an attorney's signature on a doctor's lien.
- **Work Injury**: I understand that all work injuries must be reported to my employer. My employer will complete an accident report and I will complete all necessary paperwork, in order for RDPC to provide treatment as needed for my work injury. If authorization is not provided from the insurance carrier, I understand that I am financially responsible for all medical services rendered.

INCLUDED CARE AND ADDITIONAL CHARGES:

I understand that all programs include all needed chiropractic adjustments, physical therapy and progress examinations. I understand that any after-hour emergency visits, supports, orthotics, cervical pillows, or other similar products are not included and I will pay for them upon receipt.

TERMINATION/REFUND:

I understand that THERE ARE NO REFUNDS FOR SUPPLEMENTS. I understand that I can discontinue treatment at any time within the terms of this agreement. I may do so by putting my request in writing and delivering that request in person to the Doctor. I understand that I am fully responsible for the retroactive charges that would be incurred by the removal of any discounted rates. I understand that refunds will be provided and paid within 10 days of the written request after applying the funds to all outstanding balances in my account and in my family accounts.

SUBSEQUENT INJURIES:

If during the course of the care outlined above, I am injured in a separate incident for which insurance coverage is available, I understand that this care program will be suspended until such time as my subsequent injury has been resolved. I recognize that during this period, my insurance carrier may be billed for chiropractic services, if applicable. I understand that the care I receive under this Agreement has been determined based upon my original condition. I understand that if a new injury or condition arises, then a new fee arrangement may be required, at the discretion of the Doctor.

I HAVE FULLY READ THIS AGREEMENT AND AGREE TO ABIDE BY ALL OF THE TERMS.

_____ _____ _____

Patient Signature **RDPC Representative Signature** **Date**

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Informed Consent

Dear Patient:

Every type of health care is associated with some risk of potential problems. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means a portion of the brain does not receive enough oxygen from the blood stream. The results can be a temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. **This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.**

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment will aggravate the problems and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may cause a disc problem if the disc is in a weakened condition. **These problems occur so rarely that there are no available statistics to quantify their probability.**

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit jolting movement. Rarely a chiropractic adjustment, tractions, etc. may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. **These problems occur so rarely that there are no available statistics to quantify their probability.**

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, especially those having osteoporosis on their x-rays. **These problems occur so rarely that there are no available statistics to quantify their probability.**

(Over)

Physical Therapy: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in the skin pain and there may be some redness or blistering of the skin.

Soreness: It is common for chiropractic adjustment, traction, exercises, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and or explain them all in advance of treatment.

Chiropractic is a system of health care delivery and as with any health care delivery system, we cannot promise a cure of symptoms, disease, or condition as a result of treatment. Therefore, with your best interest in hand, we may refer you to another provider who we feel will assist you in your situation.

If you have any questions regarding the above, please ask your doctor. When you have a full understanding, please sign and date below.

Patient Name (Printed) Date

Patient's Signature Signature of Parent or Guardian for Minor

Consent Form

I acknowledge that Roseville Disc & Pain Center has disclosed information to me regarding my diagnosis, the nature and purpose of the proposed treatment, the risks involved in the proposed treatment, the probability of success of the proposed treatment, treatment alternatives, risks involved in the treatment alternatives and the prognosis if I remain untreated.

Patient Name (Printed) Date

Patient's Signature Signature of Parent or Guardian for Minor

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NOTICE OF PRIVACY PRACTICES

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

Roseville Disc & Pain Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment and payment of healthcare operations. For example, it may be necessary on occasion to seek consultation regarding your condition from other healthcare providers associated with Roseville Disc & Pain Center. In this case, it is our policy to provide access to these healthcare providers 24 hours a day, 7 days a week. Roseville Disc and Pain Center may provide a substitute healthcare assessment and/or treatment to our patients without advance notice, in the event that your primary provider is absent due to vacation, sickness or other emergency situations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations. For example, as part of our services to our patients, Roseville Disc & Pain Center submits itemized billing statements containing medical information, including diagnosis, date of injury or condition, and codes which describe the healthcare services provided.

Worker's Compensation
We may disclose your health information as necessary to comply with California State Worker's Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member or person responsible for your care, about your medical condition. This includes the event of emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities reporting for the purpose related to preventing or controlling disease, reporting injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medication, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your heath information to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an institutional review board.

(Over)

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner, and government benefits purpose.

Marketing
We may disclose your health progress for fundraising purposes with your consent. We may also utilize testimonials you provide in marketing Roseville Disc & Pain Center.

Change of Ownership
In the event that Roseville Disc & Pain Center is sold or merged with another organization, your health information/record will become the property of the new owner or organization.

Your Health Information Rights

- *You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Roseville Disc & Pain Center is not required to agree to the restriction that you request.*
- *You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.*
- *You have the right to inspect and copy your health information.*
- *You have the right to request that Roseville Disc & Pain Center amend your protected health information. Please be advised, however, that Roseville Disc & Pain Center is not required to amend your protected information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.*
- *You have the right to receive an accounting of disclosures of your protected health information made by Roseville Disc & Pain Center.*
- *You have the right to receive a paper copy of this Notice of Privacy Practices at any time upon request.*

Changes to this Notice of Privacy Practices
Roseville Disc & Pain Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for information that it maintains. Until such amendment is made, Roseville Disc & Pain Center is required by law to comply with this Notice.

Roseville Disc & Pain Center 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 Dr. Heather D. Rosenberg by calling our office at (916) 786-3737. If Dr. Rosenberg is not available, you may make an appointment for a personal conference with Dr. Rosenberg in person or by telephone within (2) working days.

Complaints
Complaints about your privacy rights or how Roseville Disc & Pain Center has handled your health information should be directed to Dr. Rosenberg by calling (916) 786-3737. If Dr. Rosenberg is not available, you may make an appointment for a personal conference with Dr. Rosenberg in person or by telephone within (2) 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 Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201

I have read the Notice of Privacy Practices and understand my rights contained in this notice. By way of my signature, I provide Roseville Disc & Pain Center with my authorization and consent to use any disclosed protected healthcare information for the purposes of treatment, payment and healthcare operations as described in this notice.

_____	_____	_____
Patient Name (please print)	Patient Signature	Date

_____
Roseville Disc & Pain Representative