

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____
First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____

Relationship to Patient _____

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

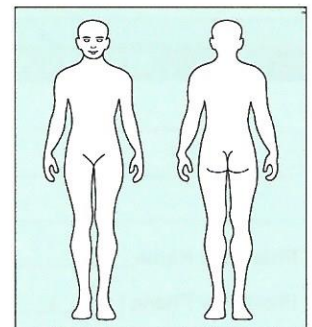
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

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 are painful to perform Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | | | | | |
|---------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|----------------------|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy Shots | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fractures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Miscarriage | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anorexia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Suicide Attempt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Appendicitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gonorrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumors, Growths | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Breast Lump | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson's Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Typhoid Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pinched Nerve | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bulimia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herniated Disk | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vaginal Infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Polio | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prostate Problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ | | |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Chicken Pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| | | | | | | Rheumatoid Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

<p>EXERCISE</p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p>WORK ACTIVITY</p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p>HABITS</p> <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Drinks Cups/Day _____ <input type="checkbox"/> High Stress Level Reason _____
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Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

JACKSON CHIROPRACTIC

Dr. Stacy Jackson, D.C. and Dr. Gil Jackson, D.C.

3249 Mount Diablo Court, Suite 102, Lafayette, CA 94549

❖ Notice of Health Information Practices of Jackson Chiropractic

Protecting the privacy of your personal health information is important to us. In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 2003, this notice describes how information about you may be used and disclosed and how you can get access to this information at Jackson Chiropractic. Please review it carefully.

Understanding Your Health Record/Information

- Every time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:
- Basis for planning your care and treatment among health care providers
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- A tool in educating health professionals such as in medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning, marketing, and improvement of care.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524 for an administrative fee of \$35.
- Amend your health record as provided in 45 CFR 164.528. We require the request be made in writing, explaining why the information should be amended. Your request may be denied under certain circumstances.
- Obtain an account of disclosures of your health information as provided in 45 CFR 164.528 for up to 6 years prior to the date of your request but not prior to April 14th, 2003. Your request must be made in writing to our Privacy Officer. This accounting does not include disclosures made to carry out treatment, payment and health care operations, disclosures made to you, disclosures to individuals involved with your care, disclosures made for national security or intelligence purposes, and disclosures made prior to the compliance date of the HIPAA Privacy Rule.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We at Jackson Chiropractic are required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction you have made.
- Accommodate reasonable requests you may have to communicate health information by alternative means or by alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail you a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. Any additional authorizations must be written and signed by you or the parent/legal guardian of a minor in the presence of the staff of Jackson Chiropractic.

Examples of Disclosures for Treatment, Payment and Health Operations

1. *We will use your health information for treatment.* For example: Information obtained by our staff will be recorded and used to determine the course of treatment that best suits your needs.
2. *We will use your health information for payment.* For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
3. *We will use your health information for regular health operations.* For example: We may use your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Uses and Disclosures

1. *Business Associates:* There are some services provided in our organization through contacts with business associates. Examples include physician services with radiologists, diagnostic imaging Centers, laboratory test centers, and other specialists. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associates to appropriately safeguard your information.
2. *Law Enforcement/Judicial and Administrative Proceedings:* We may disclose protected health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.
3. *Notification:* In cases of emergency, we may use or disclose information to notify or assist in notifying a family member, personal representative, or person responsible for your care, your location and general condition. In nonemergency situations, however, we will not disclose your information to others, not even family members. If you are a minor, however, by law we may disclose your health information to your legal guardian or parent.
4. *Research:* We may disclose information to researchers when their research has been approved by an Institutional review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
5. *Marketing:* We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest and benefit to you. They may be left on voicemail, postcards, or letters.
6. *Worker's Compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
7. *Public Health:* As required by law, we may disclose your health information to public health or legal authorities responsible for preventing and controlling disease, injury, or disability.

My signature below indicates that I have been provided with a copy of the notice of privacy practices and I have read, understood, and agreed to the privacy policies of Jackson Chiropractic.

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Date Signed

Name (Printed)

JACKSON CHIROPRACTIC

Stacy Jackson, D.C. and Gil Jackson, D.C.

3249 Mount Diablo Court, Suite 102, Lafayette, CA 94549

❖ INFORMED CONSENT ❖ ASSIGNMENT OF BENEFITS ❖ FINANCIAL AGREEMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or serving as back-up for the doctors named above, including those working at the clinic or office listed above or any other office or clinic.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his or her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he or she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases. I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have had an opportunity to discuss with the doctors named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, sprains, fractures, disc injuries, strokes and dislocations. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctors to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided or forward a copy via e-mail at my request. I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an 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.

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Date Signed

Name (Printed)

I hereby instruct _____ Insurance Company to issue payment directly to Jackson Chiropractic for professional or medical expense benefits allowable. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to Jackson Chiropractic and I agree to pay any balance incurred for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Date Signed

Name (Printed)