MAGNOLIA CHIROPRACTIC OF PETALUMA

Tino Abon Chiropractic Inc.

Today's Date:_____ ***Referred by:*** _____

Name:_____

Cell Phone: _____ Home Phone: _____ Office Phone:_____

E-mail Address:_____

Address: _____ City:_____ State: _____ Zip: _____

Age:_____ Birth Date: _____ Marital Status: M S W D No. of Children _____

Please Check Type of Payment: Cash/Debit Check Credit

Name of Spouse or Parent: _____ Birth Date:_____

Occupation: _____ Years on Job: _____

Describe The Major Complaints That Bring You To Our Office:

_____

_____

Is Your Condition Due To An Accident? ❑ Yes ❑ No Date of Accident:_____

Type of Accident? ❑ Auto ❑ Work/Job ❑ At Home ❑

Other:_____

Please note:

At this time we are **Not Accepting** any type of medical insurance for chiropractic care. However, we can provide you with a super receipt that you can personally submit to your insurance provider to be reimbursed. Reminder that there is no guarantee that your insurance provider will cover the bill. We will do our best to supply you with proper codes so that your chances of being reimbursed are greater.

Would you be interested in Appointment Reminders? ❑ Text (SMS Service if checked_____) ❑ Email ❑ No Thanks

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ ***Date:*** _____

Guardian's Signature (For Minors):_____ ***Date:*** _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Health History

List All Current Health Problems:

_____
_____
_____

List Any Other Doctors/Practitioners/Therapists seen for the above problems:

_____
_____
_____

List Current Primary Physician:

_____
_____

List All Surgeries And Their Dates:

_____
_____
_____

List Any Medications and/or Supplements You Are Taking:

_____
_____
_____

List Any Traumas And Their Dates:

_____
_____
_____

Please list any DIAGNOSED CONDITIONS that you have or have had: _____
_____
_____

Please check all PRESENT SYMPTOMS:
Cardiovascular:
( )Swelling in arms/legs
( )Irregular heart beat
( )Cold hands/feet
( )Chest pain

Vertebrobasilar:
( )Vision problems
( )Memory problems
( )High blood pressure
( )Dizziness
( )Previous head/neck trauma

Head:
( )Headaches
( )Migraines
( )Vertigo
( )Loss of Hearing
( )Ringing in ears
( )Loss of balance
( )Loss of taste
( )TMJ/Jaw clicking/pain

Neck:
( )Neck pain
( )Limited neck movement
( )Neck stiffness

Mid-Back:
( )Mid-back pain
( )Muscle spasms

Low Back:
( )Low back pain
( )Low back stiffness
( )Muscle spasms

Shoulders:
( )Pain in shoulder(s)
( )Pain between shoulder blades

Arms & Hands:
( )Pain in arms/hands
( )Tingling/numbness in arms/hands
( )Swelling in arms/hands

Hips, Legs & Feet:
( )Pain in hips, legs or feet
( )Tingling/Numbness in hips, legs or feet
( )Swelling in feet

Please check all present symptoms with:
( )Skin, hair, nails
( )Eyes/Vision
( )Ears/Hearing
( )Nose/Sinuses
( )Mouth/Throat
( )Respiratory/Breathing
( )Digestion/Elimination
( )Urination
( )Allergies
( )Nervousness
( )Irritability
( )Fatigue
( )Depression
( )Panic attacks
( )Problems sleeping
( )Generally feel run-down

Women Only:
( )Painful/Irregular periods
( )Taking birth control medication
# of pregnancies _____
# of deliveries_____

Social History:
( )Smoking
( )Other tobacco use
( )Alcohol use
( )Coffee or tea

Diet is:
( )Balanced
( )Not balanced

Sleep is:
( )Sufficient
( )Not sufficient
I average _____ hours of sleep per night

Exercise/Recreation is:
( )Sufficient
( )Not sufficient
Please list type and frequency of current exercise:_____

General stress is:
( )Severe
( )High
( )Moderate
( )Minimal
( )None

Favorite Hobby:
***Health Goals**:*

Financial Office Policy

1. All patients are on a **cash only** payment plan (Debit/Credit Ok).

2. Our office is out of network with all insurance providers and will gladly supply you with a super receipt.

3. This office does not warrant or guarantee that your insurance will reimburse for services provided. Nor does this office promise that an insurance company will or should pay the fees supplied on the super receipt. Insurance policies are an arrangement between an insurance carrier and a patient or insured.

4. As a patient, it is your responsibility to take care of the payment and any other services on a visit to visit or monthly basis if you're on a monthly payment plan. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings visit. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.

5. This office will submit a super receipt to the patient as needed. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims may be discussed between the patient and the doctor, but it is the sole responsibility of the patient to remedy the situation between the insurance carrier and or insured.

6. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only AFTER YOUR BALANCE IS COMPLETELY CLEARED WITH THIS OFFICE.

7. If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.

8. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any claims submitted.

9. If you change employers, address, phone number, and or debit/credit card then you agree to provide this office with current information immediately.

10. This office accepts all major credit cards, debit cards, and cash/checks.

11. If you have questions concerning this or any other matter, please speak with the receptionist *prior to seeing the Doctor.*

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient Signature Date

Patient Consent for Use & Disclosure of Protected Health Information

With my consent, Tino Abon Chiropractic Inc. may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO).

With my consent, Tino Abon Chiropractic Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care.

With my consent, Tino Abon Chiropractic Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I give my consent for the Doctor to contact other co-managing healthcare providers and inform them of relevant information regarding care, pending verbal authorization by me.

By signing this form, I am consenting to Tino Abon Chiropractic Inc. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Tino Abon Chiropractic Inc. may decline to provide treatment to me.

_____ _____

Signature Print Name

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

_____ _____

Signature Date

Authorization to Pay/Release Is Granted to: Tino Abon Chiropractic Inc.

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with the chiropractic adjustment is extremely remote.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

Patient Name (printed) _____ Date_____

Patient Signature (or Guardian) _____ Relationship to patient _____

Witness Signature (office staff)_____ Date _____

Privacy, Rules and Confidentiality Statement

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.

Disclosure of information has been provided on the *Patient Consent for Use & Disclosure of Protected Health Information page. Please refer back to that if any questions or concerns arise.*

Missed appointment

It is our policy to call your home, cell, or office when an appointment is missed. If you are not available, we will leave a message on your answering service or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternate contact number, please inform us of the number you would prefer to use.

Please note that we require a 24 hour notice to cancel or reschedule a visit. **We allow one missed appointment free of charge, this excludes the 2nd visit (Doctors Report of Findings). You will be charged the full price of the 2nd visit if a 24 hour notice is not given. After the first missed regular appointment we charge $35.00 (half the price of a single visit) for each additional missed appointment. If this is a recurring issue then it will be up to the discretion of the doctor to terminate any further care and will provide you with a list of other local chiropractors that utilize a drop in method.**

Reimbursement

If you signed the care plan agreement, but are not satisfied with the care you're receiving then you are legally qualified for reimbursement. Please **NOTE** that you will only be reimbursed for the remaining number of visits that have not been used.

Facility Set-Up

Our office offers a semi-private adjusting floor plan meaning there is a large partitioned wall between the adjusting area and waiting area. The staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need to discuss please inform the receptionist upon arrival so the doctor can clear the adjusting area or you may request that the doctor call you at his/her earliest convenience. **We suggest you call ahead of time to discuss any private information or schedule a call with the doctor at his or her earliest convenience.**

Your rights

- Send us a written request to see or procure a copy of the information that we have about or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer to the source of the information, such as other doctors or hospitals.
- Request additional restrictions on the uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.
- Requests that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
- Receive an accounting disclosure of your medical information, except when those disclosures are made for treatment, payment or healthcare operation, or the law otherwise restricts the accounting.
- You have the right to impact and have a copy of your health information. **There will be a fee of $25.00 for this service.**
- You have a right to amend your information. Please note we have the right to disagree with your amendments. If there is a disagreement, you will be provided with information about our denial of your amendment and how you may appeal the denial of the amendment.
- You have the right to a copy of this notice upon request.

Complaints
Complaints about your privacy rights or how your privacy is handled at this office can be directed to Dr. Abon by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to either one of the following:

- California State Board of Chiropractic Examiners at www.chiro.ca.gov/consumers/complaint.shtml
- DHHS (office of Civil Rights), 200 Independence Ave SW, Room 509F HHH Building, Washington, DC 20201

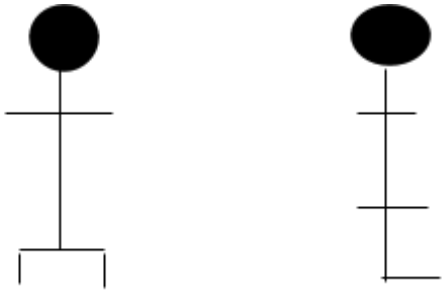
I have read this privacy notice and understand my rights contained in this notice. By signing this form, I provide authorization and consent to use and disclose my protected health information as noted above.

Patient Name:_____

Patient Signature:_____ Date:_____ / _____ / _____

Exam (For Doctor Use Only)

Posture:



CROM:

LR /80
RR /80
LLF /45
RLF /45
FL /55
EXT /75

O/N:

SLC:
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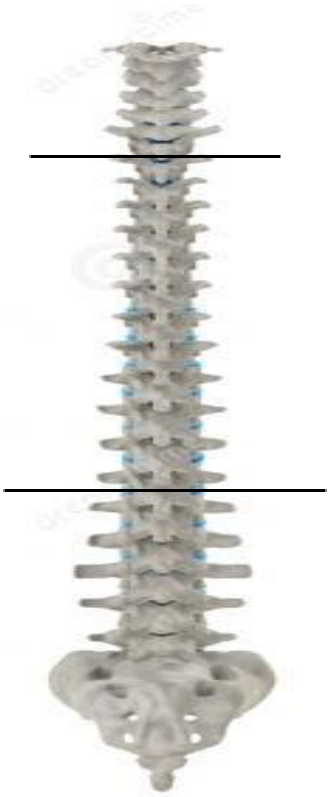

BP: