Patient Name _____

File # _____

Date _____

Patient Information

Name_____ Address_____

DOB _____ SSN_____ City, State, Zip _____

Home Phone_____ Cell Phone_____

Male ☐ Female ☐ / Single ☐ Married ☐ Divorced ☐ Age _____ # of Children _____

Name of Spouse (or Parent if under 18) _____

How did you hear about our office? _____

Employer_____ Occupation_____

Address_____ Work Phone_____

City, State, Zip_____

Name of family physician_____ Location (city) _____

Have you ever had Chiropractic care before? _____ If yes, doctor name _____

Date of last visit _____ How many visits this year? _____

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

	Yes	No
Currently or in the past have you ever experienced any of these complaints while working?	☐	☐
If yes, please explain_____		
Are there any activities or incidents outside of work that may have caused these complaints?	☐	☐
If yes, please explain_____		
Have you at any time in the past ever suffered a work injury?	☐	☐
If yes, what is the date of injury? _____		
Do you have an attorney representing you for this work injury?	☐	☐
If yes, who is your attorney? _____		
Have you been involved in an auto accident in the last 12 months?	☐	☐
If yes, what is the date of the auto accident? _____		
Have you ever had any surgeries of hospitalizations?	☐	☐
If yes, please list _____		

Please list any current or past injuries and illnesses not listed above _____

Please check all medications (over the counter and/or prescribed) you are currently taking:

☐ Aspirin/Tylenol ☐ Pain Killers ☐ Muscle Relaxers ☐ Insulin ☐ Birth Control Pills
☐ Sleeping Pills ☐ Anti-Depressants ☐ Others _____

Health Insurance Co. Name _____ Policyholder _____

Spouse's Health Insurance (if applicable) _____ Policyholder _____

Spouse's SSN (if applicable) _____ Spouse's Date of Birth _____

Patient Name _____

File # _____

Date _____

The rating scale below is designed to measure the degree to which several aspects of you life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). We would like to know how much your health condition is preventing you from doing what you would normally do, or from doing it as well as you normally would.

Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

Family/Home Responsibilities

Activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, driving children to school, etc.)

0 1 2 3 4 5 6 7 8 9 10

Completely Able to Function — **Totally Unable to Function**

Recreation

Hobbies, sports, and other similar leisure time activities

0 1 2 3 4 5 6 7 8 9 10

Completely Able to Function — **Totally Unable to Function**

Social Activity

Activities which involve participation with friends and acquaintances (parties, theater, concerts, dining out, etc.)

0 1 2 3 4 5 6 7 8 9 10

Completely Able to Function — **Totally Unable to Function**

Occupation

Activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker

0 1 2 3 4 5 6 7 8 9 10

Completely Able to Function — **Totally Unable to Function**

Self Care

Activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)

0 1 2 3 4 5 6 7 8 9 10

Completely Able to Function — **Totally Unable to Function**

Life Support Activity

Basic life supporting behaviors (eating, sleeping, breathing, etc.)

0 1 2 3 4 5 6 7 8 9 10

Completely Able to Function — **Totally Unable to Function**

Patient Name _____

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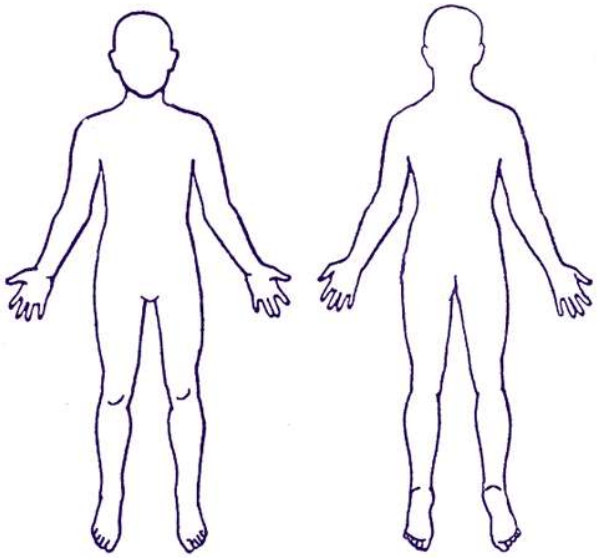
Date _____

If you are experiencing any health problems:

- Please mark the exact location of your pain on the diagram below.
- Describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS



Front Back

Patient Name _____

File # _____

Date _____

Consent to Treatment

I wish to receive examinations and treatment at Elite Chiropractic. The diagnoses and methods of treatment have been explained to me.

I understand that individuals respond differently to treatment and there are no guarantees of the result of any treatment. I understand the examination and treatment involves certain risks and those risks have been explained or provided to me.

I therefore authorize examination and treatment to be performed by the staff at Elite Chiropractic.

Patient Name _____

Patient Signature _____ **Date** _____

Witness Signature _____

The patient is unable to consent for the following reason(s):

☐ Under 18 years of age

☐ Other: _____

I therefore give consent on the patient's behalf:

Parent or Guardian Name _____

Parent or Guardian Signature _____ **Date** _____

elite CHIROPRACTIC

Dr. Carlos Reyes, D.C.

2612 F Street
Bakersfield, CA 93301
Tel: (661) 873-4151
Fax: (661) 873-4164

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

2. We are required to abide by the terms of this Notice currently in effect.

3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

1. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

3. You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

4. All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

PRIVACY OFFICER, 2612 F Street, Bakersfield, CA 93301.

elite CHIROPRACTIC

Dr. Carlos Reyes, D.C.

2612 F Street
Bakersfield, CA 93301
Tel: (661) 873-4151
Fax: (661) 873-4164

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Elite Chiropractic:

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have rights prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 2612 F Street, Bakersfield, CA 93312. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Date of Signing

_____ _____

Printed Name of Patient | Description of Personal Representative's Authority