Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name ______________________________ Soc. Sec.# ______________
Last Name First Name Initial

Address ______________________________

City ______________ State ______ Zip ______ Home Phone ______________

Cell Phone ______________ Email ______________

Sex ☐ M ☐ F Age ______ Birth Date ______ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by ______________ Occupation ______________

Business Address ______________________________

Business Phone ______________ Business Email ______________

Notify in case of emergency ______________ Home Phone ______________ Work Phone ______________

Cell Phone ______________ Email ______________

Whom may we thank for referring you? ______________________________

Primary Insurance

Person Responsible for Account ______________________________
Last Name First Name Initial

Relation to Patient ______________ Birth Date ______________ Soc. Sec.# ______________

Address (if different from patient) ______________ Home Phone ______________

City ______________ State ______ Zip ______

Cell Phone ______________ Email ______________

Person responsible employed by ______________ Occupation ______________

Business Address ______________________________

Business Phone ______________ Business Email ______________

Insurance Company ______________________________

Phone ______________ Email ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Name of other dependents under this plan ______________________________

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? ______________

Your reason for *this* visit: ______________________________

Please describe your current pain and its location: ______________________________

When did symptoms begin (date)? ______________ Have you had similar conditions in the past? ______________

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? ______________

Have you been treated by a medical physician for this condition? ______________

If so, when and where? ______________________________

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other ______________

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: ____________________

____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? ____________ Nursing? ☐ Y ☐ N

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Fainting/Seizures/Epilepsy
- ☐ Shingles
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Frequent Neck Pain
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Lower Back Problems
- ☐ Severe/Frequent Earaches
- ☐ Ringing in Ears
- ☐ Severe/Frequent Headaches
- ☐ Diabetes/Tuberculosis
- ☐ Dizziness
- ☐ Emphysema/Glaucoma
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cancer
- ☐ HIV Positive/AIDS
- ☐ Ulcer/Colitis
- ☐ Gout
- ☐ Numbness, where? ____________
- ☐ Tingling, where? ____________
- ☐ Muscle Spasms, where? ____________

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____________________ Date ____________

Payment is due in full at time of treatment unless prior arrangements have been approved.

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X______________________________ I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of ______________________.
(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X______________________________________ ________________________
Signature of Patient/Guardian Date

X______________________________________ ________________________
Witness (Office Staff) Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures including examination teses, diagnostic x-rays and physical therapy techniques, on me (of on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licenses doctors of Chiropractic who now, or in the future, render treatment to me while employed by, working for, or associated with, or serving as back up for the doctor of Chiropractic named below.

I understand that as with any health care procedures, there are certain complications which may arise during Chiropractic adjustment. Those complications include, but are not limited to; fractures, disk injuries or dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then, known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the natural purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the Chiropractic adjustments and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Name(s) of Doctor(s) Treating Patient: James Baranski, D.C.
Advanced Spine & Sport Chiropractic
4601 Telephone Rd., Suite 110
Ventura, CA 93003
(805) 642-4061

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

______________________________ ________________
Printed Name of Patient Date

______________________________ ________________
Signature of Patient Date

______________________________ ________________
Witness to Patient's Signature Date

______________________________ ________________
Translated By Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay ______________________ as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of ________________ 20 ____.

X______________________________
(patient signature)

____
(please print patient name)

X______________________________
(signature of Guardian if applicable)

MISSED APPOINTMENT AND CANCELLATION POLICY

Advanced Spine and Sport Chiropractic has implemented such a policy our of respect for emergency patients, patients who are waiting for appointments, and for the doctor or massage therapist who is treating you. Please contact Advanced Spine and Sport Chiropractic 24 hours before your scheduled chiropractic or massage appointment to prevent a missed appointment charge. Advanced Spine and Sport Chiropractic reserves the right to bill for appointments not cancelled within 24 hours.

It is in my best interest to attend all appointments. I understand that failure to attend appointments without sufficient notice will result in missed appointment charges of $50 per missed appointment.

I fully understand the cancellation policy enforced by Advanced Spine and Sport Chiropractic.

Signature______________________________ Date_____________________

Privacy Practices Acknowledgement

I have been given the opportunity to review the Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide Advanced Spine & Sport Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

____

Printed Name of Patient

____ ____________________

Patient Signature Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: ____________________________ **Last Name**: _______________________________

Email Address: ____

Preferred method of communication for patient reminders (Circle one): Email / Call / Text

DOB: ___________ **Gender (Circle one)**: M / F **Preferred Language**: __________________

Smoking Status: ___ Everyday ___Occasional ___Former ___Never

Smoking State Date (Optional): _______________

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

_______ **I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: ____ **Date**: ________________

Patient Pain/Function Evaluation Form

PATIENT NAME: ______________________________ **DATE:** ______________

Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

- Current pain: ___/10 0 1 2 3 4 5 6 7 8 9 10
- Average pain: ___/10 0 1 2 3 4 5 6 7 8 9 10

PAIN LEVEL DURING:

- Activities of Daily Living: ___/10 0 1 2 3 4 5 6 7 8 9 10
- Work: ___/10 0 1 2 3 4 5 6 7 8 9 10
- Sports/Recreation: ___/10 0 1 2 3 4 5 6 7 8 9 10

Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

- ☐ Aching ☐ Shooting ☐ Other, describe it: ______________
- ☐ Burning ☐ Stabbing ______________
- ☐ Cramps ☐ Stiffness ______________
- ☐ Dull ☐ Swelling
- ☐ Numbness ☐ Throbbing
- ☐ Sharp ☐ Tingling

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ None ☐ Other______________

When and what makes it better? ______________________________

____

When and what makes it worse? ______________________________

____

Please mark on the diagram the location of the pain.

Roberta Ashley Ekholm, D.O.
James Baranski, D.C.
Nadia Emen, D.C.
Lauren Evans, N.P.

THIRD PARTY MEDICAL LIEN

Patient's Name:____

Social Security Number:__________________________________

Date of Injury:____

I hereby authorize direct_________________________Insurance Company, to pay Advanced Spine & Sport Medical Rehabilitation Center Inc. such sums as may be due and owing him for chiropractic/medical services rendered me by reason of the accident and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further request that payment be made DIRECTLY to say doctor which would be paid by myself, as the result of treatment charges incurred for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and that this agreement tis made solely for said doctor's protection and in consideration of this awaiting payment. I further understand that such payment is not contingent on my settlement, judgement or verdict by which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning this to the doctor's office. I have been advice if you not wish to cooperate in protecting the doctor's interest; the doctor will not await payment but may declare the entire balance due and payable to me.

Patient Signature:__________________________________Date:_________________

The undersigned insurance company does hereby agree to observe all the terms of the above and agrees to withhold sums from any settlement, judgement or verdict, as may necessary to adequately protect and fully compensate said Doctor above-name and make payment directly to said doctor.

Please date, sign and return the original to the Doctor's office. Also keep one copy for your records.

Date: __________________________

____

Signature of Insurance Company Representative

____

Insurance Company Name

Roberta Ashley Ekholm, D.O.
James Baranski, D.C.
Nadia Emen, D.C.
Heather Veitch, P.A.C.-M.P.H.

FINANCIAL AGREEMENT
PERSONAL INJURY

We would like to take a moment to welcome you to our office and to assure you that you will receive the best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

PARTY RESPONSIBILITY:
If you were involved in an auto accident in your own vehicle, we will bill the medical portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

MED PAY:
If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.

PIP:
If you were a passenger in another vehicle , and you own a car which as PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.

3RD PARTY: If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP policy coverage PRIOR to submitting a claim to the insurance carrier of the party at fault.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be funded to you.

ATTORNEY LIENS:
If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

RESPONSIBILITY FOR PAYMENT:
As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial agreement, if, at any time, you have further questions about your care, please do not hesitate to ask

I have read and agree to the above

______________________________ ____________________
Patients Signature **Date**

NOTICE OF DOCTOR'S LIEN

(Under California State Insurance Code #10133)

ADVANCED SPINE AND SPORT CHIROPRACTIC
4601 TELEPHONE RD. SUITE 110
VENTURA, CA 93003
Phone: (805) 642-4062 Fax: (805) 642-7295

Patient: ____________________________ **Date of Accident:**____________________________

I do hereby authorize James Baranski, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to James Baranski, D.C. such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are die his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate James Baranski, D.C. And I hereby further give a lien on my case to James Baranski, D.C. against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to James Baranski, D.C. for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify James Baranski, D.C. of any change or addition of attorney(s) used by in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

____________________________ ____

Dated **Patient's Signature**

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

____________________________ ____

Dated **Attorney's Signature**

**This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to James Baranski, D.C. for payment.