# 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

# 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_____

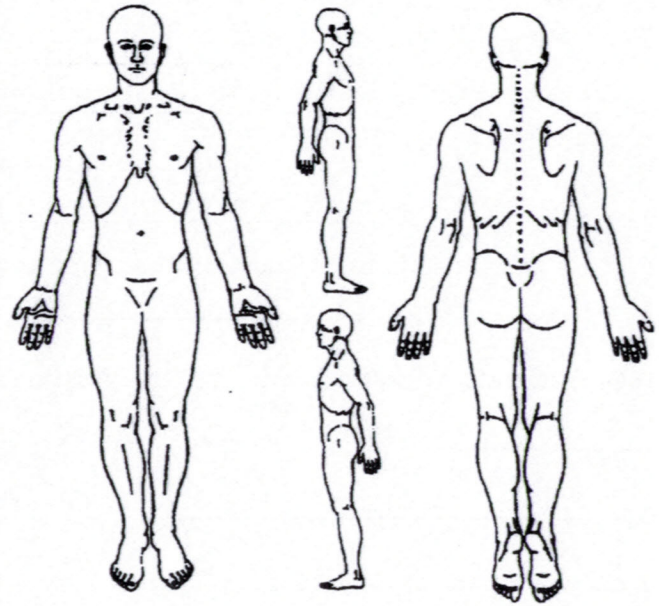
**When and what makes it better?** _____

_____

**When and what makes it worse?** _____

_____

Please mark on the diagram the location of the pain.



# 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**: _____

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