Better Health CHIROPRACTIC

PATIENT APPLICATION FORM

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. We may not accept your child as a patient until we are absolutely certain we know what's causing their condition, perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

_____

PATIENT NAME

_____

DATE COMPLETED

4700 Rocklin Road · Rocklin, CA 95677 · (916) 632-2676
www.bhchiro.com

Patient Information

Name: _____ (Age)_____ Gender: M F

Home Address: _____ Birth Date: _____/_____/_____

City, State, Zip: _____ Cell Phone: ( ) _____

Name of Mother/Guardian: _____ Home Phone: ( ) _____

Birth Date: _____/_____/_____ (Age) _____ Marital Status: S M D W Work Phone: ( ) _____

Home Address (If Different): _____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

Name of Father/Guardian: _____ Home Phone: ( ) _____

Birth Date: _____/_____/_____ (Age) _____ Marital Status: S M D W Work Phone: ( ) _____

Home Address (If Different): _____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? ❑ Yes ❑ No If yes, when: ____/____/____

If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe incident or reason for onset of symptoms: _____

_____

Please use the General Symptoms Chart on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? ____/____/____ Are they: ❑ Constant ❑ Intermittent ❑ Activity-related

Are they getting worse? ❑ Yes ❑ No Do they interfere with: ❑ School ❑ Sleep ❑ Hobbies/Play ❑ Daily Routine

Explain: _____

_____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ❑ Yes ❑ No If yes, explain: _____

Has your child experienced these symptoms before (if not accident/injury related)? ❑ Yes ❑ No

If yes, explain: _____

_____

Has your child been treated for this? ❑ Yes ❑ No When was the last treatment? ____/____/____

Name of treating practitioner/facility? _____

What treatment(s) was performed? _____

_____

How did your child respond? _____

_____

General Pain Disability Index

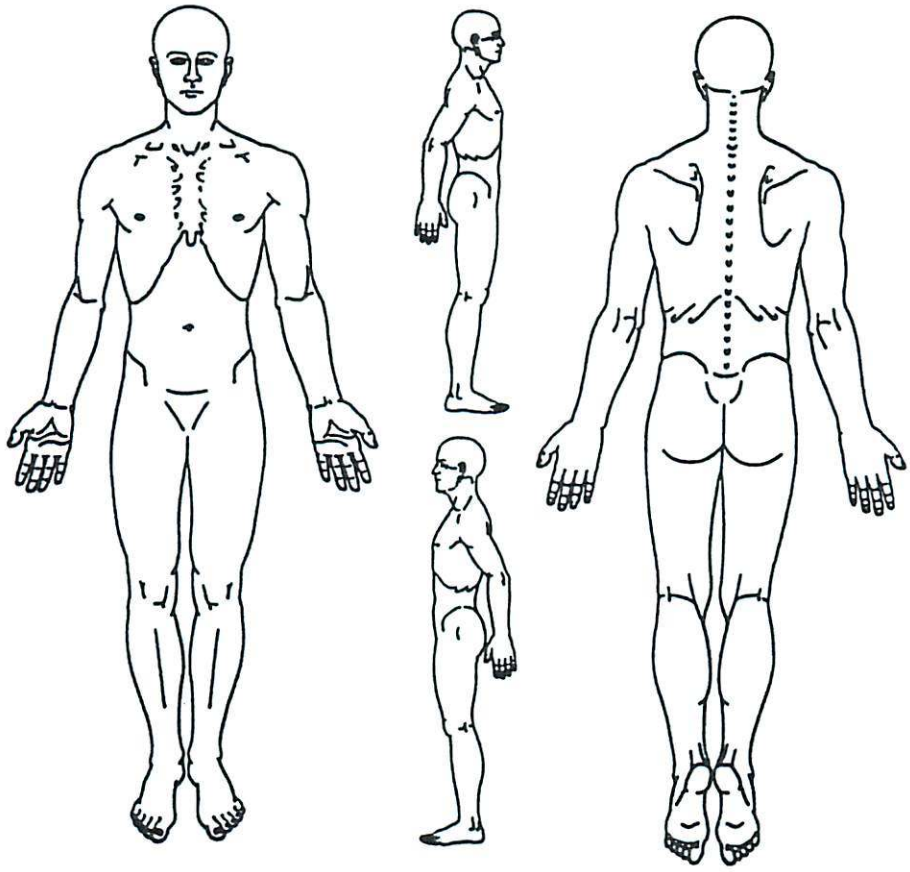
How long have you had this pain?___Years___Months___Weeks

Is this your first episode of this pain? ❑ Yes ❑ No

Use the letters below to indicate the type and location of your sensations right now

KEY: A = Ache B= Burning N = Numbness

P = Pins & Needles S = Stabbing O = Other



Please rate your pain level by placing an X on the scale below:

Pain level TODAY:

|----------|

Absent Extreme

Average Pain level over the PAST WEEK:

|----------|

Absent Extreme

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.1 Please answer the following questions accurately so we may determine the full extent of your child's condition.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such *(if you check an item with an asterisk, please offer a detailed explanation)*:

____ Fell from a height of two (2) feet or more as an infant
____ Experienced a fall that left a bruise or lump on their head or other resulting trauma*
____ Rough shaking as an infant
____ Were involved in a car accident ***(if you check this item, please ask the front desk person for the corresponding form)***
____ Experience broken bones or debilitating injuries*
____ Difficult Birth (see below)

Explanation of (*) item(s):_____

_____

BIRTH EXPERIENCE:

How long was labor?_____

Describe any complications:_____

_____

Type of delivery: ❑ Vaginal ❑ C-Section ❑ Vacuum Extraction ❑ Forceps Assistance

VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received:_____
2. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received:_____
3. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received:_____
4. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received:_____
5. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received:_____

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

____ Swelling, redness, heat/hardness of site
____ High-pitched screaming
____ Breathing problems (asthma, etc.)
____ Excessive diarrhea or chronic constipation
____ Chronic ear or respiratory Infections
____ Crossing of eyes
____ Body rash or hives
____ Extreme sleepiness or unresponsiveness
____ Excessive bleeding or anemia
____ Loss of memory/foggy state
____ Vision or hearing disturbances
____ Seizures
____ High fever (over 103 degrees)
____ Body twitching or paralysis
____ Head banging
____ Muscle weakness
____ Joint pain
____ Other (please explain)

Explanation(s):_____

_____

_____

_____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

Health Conditions *continued...*

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Colic
____ Sore throats
____ Auto-Immune Diseases
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Ear Infections
____ Learning disabilities
____ Other (please explain)
____ Sinusitis
____ Allergies/Hay fever
____ Recurrent colds/Flu
____ Low Energy/Fatigue
____ TMJ/Pain/Clicking
____ Flu/Stomach disorders
____ Hyperactivity/ADD

Explanation(s):_____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations
____ Shingles
____ Upper Back Pain
____ Recurrent Lung Infections/Bronchitis/Pneumonia
____ Heart Murmurs
____ Shortness Of Breath
____ Pain On Deep Inspiration/Expiration
____ Asthma/Wheezing
____ Tachycardia (fast heart beat)
____ Other (please explain)

Explanation(s):_____

_____

_____

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn
____ Liver problems
____ Tired/Irritable after eating or when not having eaten for a while
____ Nausea
____ Ulcers/Gastritis
____ Reflux
____ Spleen problems
____ Diabetes
____ Hypoglycemia
____ Other (please explain)

Explanation(s):_____

_____

_____

Health Conditions *continued...*

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet
____ Numbness/tingling in legs/feet
____ Frequent/difficulty urinating
____ Menstrual irregularities/cramping (females)
____ Weakness/injuries in hips/knees/ankles
____ Recurrent bladder infections
____ Muscle cramps in legs/feet
____ Low back pain
____ Coldness in legs/feet
____ Constipation/Diarrhea
____Other (please explain)

Explanation(s):_____

_____

_____

OTHER

Please list any health conditions not mentioned:_____

_____

Please list any medications (include name, dose, for what condition, and how long your child has been taking it):_____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed):_____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following? ***If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation).:***

____ ADD
____ Arthritis
____ Broken bones/fractures
____ Circulatory problems
____ Ear Infections
____ Fetal drug exposure
____ Heart disease
____ High blood pressure
____ Kidney Disease
____ Measles
____ Neurological problems
____ Pneumonia/Bronchitis
____ Scoliosis
____ Spinal Bifida
____ Tuberculosis
____ Allergies/Hay fever*
____ Asthma
____ Cancer
____ Crohn's/Colitis
____ Eczema
____ Food allergies*
____ Heart murmur
____ HIV
____ Liver disease
____ Metal implants
____ Osteoporosis
____ Polio
____ Seizure disorder
____ Stroke
____ Varicose veins
____ Anemia
____ Bed wetting
____ Cerebral Palsy
____ Depression
____ Eczema/Psoriasis
____ Gall bladder
____ Hepatitis
____ Infectious disease
____ Lumbago
____ Migraine headaches
____ Paralysis
____ Rash
____ Sickle cell anemia
____ Thyroid problems
____ Whooping cough
____ Appendectomy
____ Blood sugar problems
____ Chicken pox/shingles
____ Diabetes
____ Epilepsy/seizures
____ Headaches
____ Hernia
____ Influenza
____ Lung disease
____ Mumps
____ Pleurisy
____ Rheumatic fever
____ Small Pox
____ Tonsillectomy
____ Other*

Explanation of (*) item(s):_____

_____

Experience with Chiropractic

Has your child seen a Chiropractor before? ❑ Yes ❑ No Who?_____

Reason for visit(s):_____

Did your previous chiropractor take 'before' and 'after' x-rays? ❑ Yes ❑ No What was the diagnosis?_____

Did he or she recommend a specific course of treatment? ❑ Yes ❑ No

Did they recommend a Home Health Care program? ❑ Yes ❑ No

If yes, what?_____

How long was your child treated?_____ Last treatment:____/____/____

How did your child respond?_____

Are you aware of any poor posture habits in your child? ❑ Yes ❑ No

Is there any history of spinal problems in your family? ❑ Yes ❑ No

If yes, explain:_____

_____

_____

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my child's spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if my child/charge does not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or staff for all services rendered.

Parent/Guardian Signature _____ Date_____ /_____ /_____

Parent/Guardian Name Printed_____

If patient is not your biological child, but a legal charge requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded_____County, State of Guardianship_____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date_____ /_____ /_____

In Case of Emergency

Name_____ Relationship_____

Work Phone ( ) _____

Home Phone ( )_____

Cell Phone ( )_____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to Better Health Chiropractic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to Better Health Chiropractic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. Better Health Chiropractic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Better Health Chiropractic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically due and payable.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? ❑ Yes ❑ No

Signature of Person Authorizing Care:

_____ Date_____/_____/_____

Relationship to Insured _____ Date of Birth_____/_____/_____

Employer_____

Primary Insurance Company_____ Policy#_____

Address_____ Phone # ( ) _____

Insured's Name_____ Insured's Social Security #:_____-_____-_____

Secondary Insurance Company_____ Policy#_____

Address_____ Phone # ( ) _____

Insured's Name_____ Insured's Social Security #:_____-_____-_____

Informed Consent to Chiropractic Adjustments and Care

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

I have had an opportunity to discuss with the Doctor of Chiropractic named below 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, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based up on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. 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.

To be completed by patient:

_____

Print Patient's Name

_____

Parent/Guardian Signature

_____

Date Signed

To be completed by doctor or staff:

Name and address of clinic/office:

Better Health Chiropractic
4700 Rocklin Rd
Rocklin, CA 95677
916-632-2676

_____

Witness to Patient's Signature

_____

Translated By

HIPPA Happenings at Better Health Chiropractic

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise to You, Our Valued Patient...

We want to assure you that we take the new Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now ?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of electronic technology in the health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review how your information is used within our computers, internet, phones, fax machines, and any device used to copy or transfer that data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal health information will be shared only as required for the purpose of administering your care. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we promise our adherence to those laws. We also want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice in order to collect payment for the services provided to you in this office. We may do this with insurance forms filed for you electronically or by mail. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations to our staff. Some of the best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during insurance company audits or by government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy, which is to partner with our patients to see they receive the best chiropractic care we can provide. This may include postcards, newsletters, flyers, and telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).

Public Health and National Security

We may be required to disclose necessary health information to Federal officials or military authorities in order to complete investigations related to public health and or national security.

For Law Enforcement

As permitted or required by State and Federal law, we may disclose your health information under certain circumstances to proper authorities for the purpose of law enforcement. This may take place if you are a victim of a crime, or in order to report a suspected crime.

Family, Friends and Care Givers

We may share your health information with those that assist you with your home hygiene, care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable communicate your wishes, we will use our very best judgement when sharing your health information with anyone participating in your care.

Medical Research
Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories will transpire only under the ethical guidance, requirements, and approval of an Institution Review Board.

Authorization to Use or Disclose Heath Information
Other than the information stated above, or information that Federal, State, and Local laws require, we will not disclose your health information without your written authorization. You may revoke that authorization in writing at any time.

Patient Rights
This law is careful to describe that you have rights related to you health Information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications
You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately, with or without other family members present, or through sealed mail communications. We will make all reasonable efforts to honor your request.

Inspect and Copy Your Health **Information**
You have the right to read, review, and copy your health information. This Includes your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested, sealed, and or delivered to any authority for review.

Documentation of Health **Information**
You have the right to request a description of how our office used your health information for reasons other than treatment, payment, or health care operations. Our documentation procedure will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We greatly appreciate your limited request for no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of This Notice
You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. We are required by law to maintain privacy of our health information and provide to you or your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients will be notified of any such changes. You have the right to express concerns or complaints to any staff member of Better Health Chiropractic, or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Patient Acknowledgment

Patient Name(s):

_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, please let us know. If not, we would appreciate your acknowledgments that you have received, thoroughly reviewed, and understand this policy by signing on the line below. Thank you.

_____ _____

Parent/Guardian Signature Date


Better Health
CHIROPRACTIC