Initial Patient Information

Patient Name: (Last Name, First Name) _____ _____

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

Email: _____ **Home Phone** #: _____

Work Phone #:_____ **Cell #**:_____ **Date of Birth** (Birth date)_____

Social Security #:_____ **Driver's License #**: _____

Ethnicity: ☐ Decline this information ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ Decline this information ☐American Indian/Alaska Native ☐Asian ☐ Black/African American ☐Native Hawaiian/ Other Pacific Islander ☐ White ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Subscriber Name: _____ **Health Plan**: _____

Subscriber ID #: _____ **Group #**: _____

Spouse's Name: _____ **Spouse's Phone** #:_____

Your Occupation: _____ Employer:_____

City: _____ State:_____ Zip:_____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

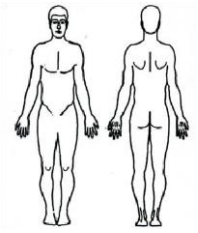
_____

Current Complaint – **How are you feeling TODAY??**

0 is no pain and 10 is unbearable pain:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Mark an X where your pain or symptoms



Date Problem Began: _____

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain ☐ Extremity/Other Pain_____

Is this Condition ☐ Work Related? ☐ Auto Related? ☐ Sports/Recreational Related? ☐ Other_____

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Can you perform your daily activities ☐ Yes ☐ No

Describe any current activity limitations _____

Have you had spinal ☐ **X-rays**, ☐ **MRI** ☐ **CT Scan**? ☐ Yes Date(s) taken: _____ ☐ No

If yes, what area(s) of your body? _____

Please check all of the following that apply to you **or** check here if ☐ none apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History or Recent Infection	☐	☐	Aortic Aneurysm
☐	☐	Recent Fever	☐	☐	Cancer/Tumor
☐	☐	HIV/AIDS	☐	☐	Osteoporosis
☐	☐	Diabetes	☐	☐	Recent Trauma
☐	☐	Corticosteroid Use	☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Take Birth Control Pills	☐	☐	Epilepsy/Seizures
☐	☐	Pregnancy, # of births_____	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid back pain
☐	☐	Stroke (date) _____	☐	☐	History of Neck pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Frequent Urination	☐	☐	Surgeries/Medications:_____
☐	☐	Prostate Problems			_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I, _____, certify that the above information is complete and accurate.

***If the health plan information is not accurate, or if I am not eligible to receive healthcare benefits through this provider, I agree that I am personally responsible for ALL charges for services rendered.** I **agree** to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

I understand and give permission to Dr. Brody or his employee(s) whom may communicate with my health plan/employees regarding information relating to my care or health plan coverage.

Patient Signature: _____ Date signed: _____

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1. Some patients may experience some stiffness or soreness following the first few days of treatment.

2. Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote; however you are being informed of the possibility regardless of the extremely remote chance.

3. I will make every effort to screen for any contraindications to care; however if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4. Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check during the history, examination and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by
Dr. Bruce K. Brody, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____

Patient name (printed) Patient Signature Date

_____

Witness Signature Date

HEALTH CARE PROVIDER-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the health care provider and his or her successors and assigns including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as back-up for the health care provider, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the health care provider, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that the provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this Arbitration Agreement including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2) and the right to have a judgement for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: **Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient.

Article 5: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial below.

Effective as of the date of first professional services.

_____
Patient's Initials

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____
Print Patient's Name

_____ _____
Health Care Provider's Signature (Date) Patient's Signature (Date)

By _____ _____
Health Care Provider's Duly Authorized Representative (Date) Patient's Agent's or Representative's Signature (Date)

_____ As: _____
Translated by (Date) Relationship to Patient

A **signed original, WHITE copy** is to be filed in Patient's file.
A **signed YELLOW copy** is to be kept in a separate Malpractice Arbitration Agreements file containing yellow copies for all patients.
A **signed PINK copy** is to be given to the patient.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. AProtected health information@ is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures or Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care to you, to pay your health care bills, to support the operation of the physician=s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician=s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. for example, we may disclose your protected health information to medical school students that see patients at our office. In addition we may use a sign-in sheet at the registration desk where you will be asked to sign you name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military, and National Security, Worker=s Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time. In writing, except to the extent that your physician or the physician=s practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact or your complaint. We will not retaliate against you for filling a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name:_____ Signature: _____ Date: _____