Confidential Patient Data

PATIENT INFORMATION

Today's Date: _____

Name: _____ Sex:_____ DOB: _____ Age: ____

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

Home #:_____Cell #: _____ Preference: ❑Cell ❑Home

E-mail: _____ Social Security #:_____

❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____ # of Children: ____

Name of emergency contact: _____ Phone: _____

Your Occupation_____ Your Employer: _____

Referred to this Office by: ❑Friend/Family Member - Name? _____

❑ Online ❑ Doctor ❑Other_____

Have you ever had chiropractic care before? ❑Y ❑N When?:_____ Where?:_____

Payment for Services will be by: ❑Self-Pay ❑Health Insurance

❑Automobile Insurance ❑Worker's Compensation

Name of Insurance Co.: _____ Insured's Employer: _____

Insurance ID #:_____ Group #:_____ Provider Phone #:_____

Are you covered by more than one insurance company? ❑Yes ❑No, Name_____

Is your current condition due to an accident/injury? ❑Y ❑N Date of accident _____

if Yes, which one: ❑Auto ❑Work ❑Home ❑Other

Have you reported you accident to anyone else? ❑Y ❑N if

Yes, Whom?: _____

Were x-rays taken of the injured area? If yes when?_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

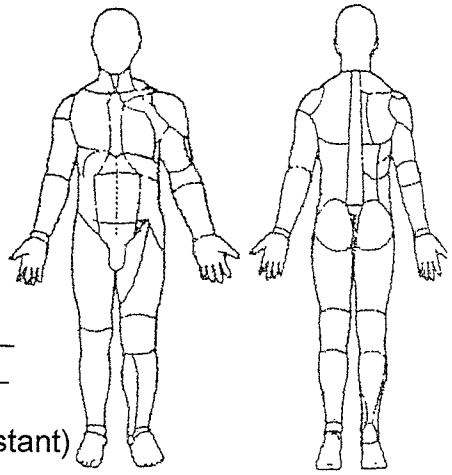
Please Rate your symptoms (1-10, with 1 being least serious), and please mark the area or areas with an X on the diagram to the right showing where you hurt.

1._____ _____

2._____ _____

3._____ _____

4._____ _____



When did your symptoms begin? _____

How did your problem begin?_____

Check below how often your symptoms are present.

(occasional) 0-25%___ 26-50%___ 51-75%___ 76-100%___ (constant)

In the past week how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores? Circle the number below.

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

____Excellent ____Very Good ____Good _____Fair ____Poor

Is your condition getting worse? ❑Y ❑N

Symptoms are worse in: ❑morning ❑afternoon ❑night

Does it travel from one place to another?: ❑Y ❑N

If yes, from where to where? _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking the appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	indigestion	❑	❑	❑	dislocated joints	❑	❑	❑	fibromyalgia
❑	❑	❑	arthritis	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	asthma	❑	❑	❑	bladder trouble	❑	❑	❑	numbness
❑	❑	❑	neck pain	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	mid back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	low back pain	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	muscular dystrophy	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	seizures	❑	❑	❑	menstrual cramps	❑	❑	❑	tuberculosis
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	osteoporosis

ARE YOU PREGNANT ❑NO ❑YES IF YES, WHEN ARE YOU DUE? _____

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____ Date of Last Physical Exam_____

Other conditions not listed above or any other information you feel the doctor should know about:

_____

_____

SOCIAL HISTORY:

Tobacco usage: None ❑ Light ❑ Moderate ❑ Heavy ❑

Alcohol usage: None ❑ Light ❑ Moderate ❑ Heavy ❑

Drug usage: None ❑ Light ❑ Moderate ❑ Heavy ❑

Exercise: Never ❑ Seldom ❑ Occasional ❑ regularly ❑

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. _____ Date:_____

❑Job ❑Auto ❑Other 2._____ Date:_____

❑Job ❑Auto ❑Other 3._____ Date:_____

SURGICAL HISTORY:

1._____ Date: _____

2._____ Date: _____

3._____ Date: _____

ARE YOU TAKING ANY MEDICATIONS/VITAMINES/HERBS/MINERALS ❑NO ❑YES WHAT KIND?

Name Dose amount # doses/day Reason for taking Prescribed by

_____

_____

_____

I certify that I have read and understood all of the above information, and the above questions have been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that I am financially responsible for all charges made by this office and for knowing my insurance benefits. All explanations of insurance benefits made by this office are estimates and are **not** a guarantee of payment.

Patient's Signature: _____ Date: _____

Reviewed By:_____ Date: _____

BELLWOOD CHIROPRACTIC
Activities that are affected by my current health problem

Name:_____ Date:_____
0= No affect
1= I am aware of my problem when I do this activity (mild)
2= I don't want to do this activity because of my problem (moderate)
3= I can't do this activity at all (severe)

_____ Bending
_____ Climbing Stairs
_____ Falling Asleep
_____ Kneeling
_____ Lifting
_____ Looking Over Shoulder
_____ Lying Down
_____ Rising Out of Chair
_____ Sitting
_____ Standing
_____ Staying Asleep
_____ Walking
_____ Caring for Infirm Family Member
_____ Child Care
_____ Computer Use (extended time)
_____ Computer Use (short time)
_____ Concentrating
_____ Driving
_____ Housework
_____ Lifting Children
_____ Lifting/Carrying Groceries
_____ Pet Care
_____ Reading
_____ Sexual Activity

_____ Yard Work
_____ Computer Work
_____ Desk Work
_____ Driving (at work)
_____ Lifting (at work)
_____ Using the Telephone
_____ Bathing
_____ Dressing
_____ Hair Care
_____ Shaving
_____ Cycling
_____ Drawing
_____ Exercise
_____ Golf
_____ Needle Work
_____ Piano
_____ Running
_____ Softball
_____ Swimming
_____ Tennis

Bellwood Chiropractic
Notice of Privacy Practices

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

Bellwood Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information, but there may be certain circumstances that allows us to disclose your information.

Disclosure of your health care information

Treatment- We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment- We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Worker's Compensation- If applicable, we may disclose your health information as necessary to comply with state Worker's Compensation laws.

Emergencies- We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health- As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; or reporting domestic violence.

Law Enforcement- We may disclose your health information to a law enforcement official for purpose such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons- We may disclose your health information to coroners or medical examiners.

Complaints- Complaints about your privacy rights or how Bellwood Chiropractic has handled your health information should be directed to Dr. Diane Bellwood. The office number is

(909)941-0633 and she will be happy to assist you. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HH Building
Washington, DC 20201

FOR ADDITIONAL INFORMATION ABOUT YOUR PRIVACY,
PLEASE VISIT:
www.hcfa.gov/medicaid/hippa

Bellwood Chiropractic
8645 Haven Avenue, Suite 700
Rancho Cucamonga, Ca. 91730
(909)941-0633

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____DOB_____

Signature_____

Date_____

Bellwood Chiropractic

Informed Consent To Chiropractic Adjustments And Care

I hereby request and consent to the performance of adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic or any doctor designated person now or in the future that treats me while employed by, working or associated with or serving as back-up for the doctor of chiropractic.

I understand I 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 I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

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.

Patient's signature:_____ Date:_____

Authorization for Release of Case Records and Authorization to Pay Doctor

I hereby authorize *Bellwood Chiropractic* to disclose to my insurance company any information which may be acquired by examination or other means of my physical condition and I hereby release *Bellwood Chiropractic* of any consequence thereof.

I hereby authorize my insurance company to pay by check made out and mailed directly to **Bellwood Chiropractic 8645 Haven Ave., Suite 700 Rancho Cucamonga, Ca. 91730** the expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Patient's signature:_____ Date:_____

Consent to Treat of Minor Child

I hereby authorize *Bellwood Chiropractic* and whomever they may designate as their assistant to administer chiropractic care as they deem necessary to my _____ (relationship to child). Child' Name:_____

Signed:_____ Date:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To Provider:_____

Address:_____

You are hereby requested to furnish the following information checked below regarding,
Patient_____DOB_____
X-rays Reports History Diagnosis Treatment Records
concerning my: Accident Injury Illness DOI/Illness_____

To: **BELLWOOD CHIROPRACTIC**
8645 HAVEN AVE., SUITE 700
RANCHO CUCAMONGA, CA 91730
PHONE# 909 941-0633 FAX# 909 945-5372

for the purpose of evaluation and treatment of my condition.

This authorization shall become effective immediately and remain in effect only as long as necessary for the Requester to complete the required activities undertaken.

I understand that I have a right to receive a copy of this authorization upon my request.
Copy requested Yes No

Signed_____Date_____
Patient Spouse Parent Guardian

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, including 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 state and federal law, and not by a lawsuit or resort to court process, except as state and federal 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: **All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, 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, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office 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 associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

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. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. 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 provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. 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: **General Provision:** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: **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 and all other disputes between the parties.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

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. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

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.

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE X