Chiropractic Sports Medicine

NEW PATIENT REGISTRATION FORM

(Please Print)

Today's date:						**PCP:**		
PATIENT INFORMATION								
Patient's last name:		**First:**	**Middle:**	❑ **Mr.** ❑ **Mrs.**	❑ **Miss** ❑ **Ms.**	**Marital status (circle one)** **Sin / Mar / Div / Sep / Wid**		
Is this your legal name? ❑ **Yes** ❑ **No**	**If not, what is your legal name?**		**(Former name):**		**Birth date:** / /	**Age:**	**Sex:** ❑ **M** ❑ **F**	
Street address:			**Social Security no.:**			**Home phone no.:** ( )		
P.O. box:	**City:**			**State:**		**ZIP Code:**		
Occupation:	**Employer:**					**Employer phone no.:** ( )		
Chose clinic/Referred to clinic by (please check one box):			❑ **Dr.**			❑ **Insurance Plan**	❑ **Hospital**	
❑ **Family**	❑ **Friend**	❑ **Close to home/work**	❑ **Yellow Pages**	❑ **Other**				
Other family members seen here:								

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

PATIENT HISTORY AND INFORMATION

Purpose for this appointment: ____

Present Complaints (please circle the appropriate ones)

Headache	Upper back pain	Constipation
Migraines	Upper back stiff	Feet/Hands cold
Ears ringing/buzzing	Midback pain/stiffness	Sciatica
Dizziness	Pins and needles in R/L arm	Pins and needles in R/L hand
Unbalanced	Chest pain	Double vision
Shortness of breath	Pins and needles in R/L leg	Pins and needles in R/L foot
Neck pain/stiffness	Rib pain	Low back pain/stiffness
Pain radiating in R/L arm	Pain radiating in R/L leg	Pain radiating into neck
Pain radiating into skull	Pain radiating into ribs	Pain radiates in shoulder

Do you have difficulty with: Standing Sitting Bending Twisting Walking

Cannot lift: Light Moderate Heavy Repetitive

When and how did these symptoms appear? ____

Have you ever had the same or similar condition: Yes or No

Please rate your symptoms on a scale of 1-10, where 10 is the worst pain:
1 2 3 4 5 6 7 8 9 10

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing

How frequent is this condition? Constant Daily Intermittent Night only

What makes the pain or symptoms better? ____

What makes the pain or symptoms worse? ______________________________

List any doctors/specialists that you have seen for this complaint: ______________________________

Relevant medical history: (Please circle conditions you have or have had previously)

Arthritis	Epilepsy	Muscular Dystrophy
Asthma	Fibromyalgia	Neck pain or spasm
Anemia	Hand or wrist pain	Neuritis
Back pain or spasm	Headaches	Numbness
Cancer	Heart problems	Osteoporosis
Concussion	Hepatitis	Rheumatic Fever
Convulsion	High blood pressure	Sinus Trouble
Diabetes	HIV	Sciatica
Digestion problems	Measles	Tuberculosis
Dizziness	Multiple Sclerosis	Venereal Disease

List any operations that you've had and approximate dates: ______________________________

Have you had any broken bones: ______________________________

List any major accidents other than those above: ______________________________

Are you allergic to any medication(s): ______________________________

Are you taking any medication: ______________________________

Do you: Drink Alcohol Exercise Smoke

WOMEN ONLY:
Are you pregnant: Yes or No For how long? ______________________________

Fees are payable at the time X-rays, examinations, and treatments are rendered, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Authorization and Release:

I hereby instruct the above named Insurance Company to pay by check made out to and mailed directly to:

Chiropractic Sports Medicine
24741 Alicia Parkway Suite D
Laguna Hills, CA 92653
(949) 951 - 1160

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

Chiropractic Sports Medicine
24741 Alicia Parkway Suite D
Laguna Hills, CA 92653
(949) 951 - 1160

For professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

If there is anyone you do not want to receive your medical records, please inform our office.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Chiropractic Sports Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature: ______________________________ **Date:** ________/____________/*20*________

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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

I understand that, as with any health care procedures, that there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strains, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulations 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 reply 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 the opportunity to discuss with the doctor named below and/or with the office personnel the nature, 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 adjustment and related treatment. By signing the 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.

CHIROPRACTIC SPORTS MEDICINE
24741 Alicia Parkway, Suite D
Laguna Hills, CA 92653
(949) 951 -1160

Print Name(s) of Doctor Treating this Patient

Steve J. Costales, DC, MS, ATC

____

Patricia K. McHone, DC

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DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

______________________________ ______________________
Printed Name of Patient Date

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Signature of Patient's Guardian Date

Notice of Privacy Practices

Chiropractic Sports Medicine
24742 Alicia Parkway Suite D
Laguna Hills CA 92653
(949) 951 - 1160

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.

Chiropractic Sports Medicine is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health 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. “On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Chiropractic Sports Medicine.” “It is our policy to provide a substitute health care provider, authorized by Chiropractic Sports Medicine to provide assessment and or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence, or by assignment. “We utilize an open filing system for patients charts located in a secure area. Only staff members are allowed in secure areas.
Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. “As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Chiropractic Sports Medicine for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to you upon request. This billing may contain medical information, possibly including diagnosis, date of injury or condition, and codes which describe the health care services received.
Worker’s Compensation: We may disclose your health information as necessary to comply with State Workers’ 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 prevention or control of disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.
Law Enforcement: We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness, missing person or to comply with a court order/subpoena, and/or other law enforcement purposes.
Deceased Persons: We may disclose your health information to coroners or medical examiners.
Research: We may disclose your heath information to researchers conducting research that has been approved by an Institutional Review Board.
Public Safety: It may be necessary to disclose your heath information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
Specialized Government Agencies: We may disclose your health information for military, national security, prisoner, and government benefits purposes.
Marketing: We may contact you for scheduling purposes. We may call your home prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we may leave a reminder message on your answering machine, or with the person answering the phone. You may opt-in to be sent newsletters via mail or electronic means. We utilize a sign-in sheet which confirms a patient’s appearance on a specific day/date.
Change of Ownership: In the event that Chiropractic Sports Medicine is sold or merged with another organization, your health information/record will become the property of the new owner.
Your Health Information Rights: You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Chiropractic Sports Medicine is not required to agree to the restriction that you requested. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to inspect and copy your health information. You have a right to request that Chiropractic Sports Medicine amend your protected health information. Please be advised, however, that Chiropractic Sports Medicine is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by Chiropractic Sports Medicine. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.
Changes to this Notice of Privacy Practices: Chiropractic Sports Medicine reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Chiropractic Sports Medicine is required by law to comply with this Notice. Chiropractic Sports Medicine is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact: Steve Costales by calling this office at (949) 951-1160. If Steve Costales is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
Complaints: Complaints about your Privacy rights, or how Chiropractic Sports Medicine has handled your health information should be directed to Steve Costales by calling this office at (949) 951-1160. If Steve Costales is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. 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 HHH Building Washington DC 20201.

I have read and understand the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Chiropractic Sports Medicine with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patients Name (print)____Signature ______________________________Date _____________________

Authorized Facility Signature ____Date ______________________

Chiropractic Sports Medicine

24741 Alicia Parkway, Suite D
Laguna Hills, CA 92653

Payment Policy

It is the policy of Chiropractic Sports Medicine to receive payment in full at the time services are rendered unless other arrangements have been made in advance.

If you wish our office to bill an insurance company, a copy of the insurance card and/or complete billing information is required and must be presented before services are rendered.

Enrollment in an insurance plan is not a guarantee of payment.

Deductibles, co-payments and patient responsibility amounts are due at the time of service.

Chiropractic Sports Medicine does not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan *before* services are rendered. This also applies to any facility or provider that your doctor may refer you to.

Any portion of the balance not paid by the insurance company due to patient co-pays or deductible amount, non-covered services, services deemed by the insurance company as not medically necessary, doctor non-participation in a plan or any other reason for non-payment or reduced payment is the responsibility of the patient or responsible party.

HMO's and other insurance plans that require authorization for treatment from the Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self referrals and services provided by out of network providers are usually not covered. Authorization does not guarantee payment by the insurance company.

A statement of charges will be sent to the patient or responsible party each month showing the portion billed to the insurance company and the patient due balance. Patient due balances over sixty days old will be subject to late fees. Delinquent balances may be referred to an outside agency for collection.

I have read the above policy, and understand that I am financially responsible for all medical services rendered.

___________________________________ ___________________________

Signature of Patient or Responsible Party Date

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Print Name