Confidential Patient Information

North Valley Chiropractic
"We listen, we care, we get results!"

Section I: **Patient Demographics** **Date**_____

Name:_____Home Phone: _____Cell Phone: _____

Mailing Address:_____City:_____State:_____Zip:_____

Date of Birth:_____Age: _____Marital Status please circle: Single Married Widowed Divorced

E-mail Address:_____

Employer:_____Occupation: _____Work Phone: _____

Spouse's Name:_____#of Children:_____

Whom may we thank for referring you? _____

Do you wish to receive text reminders? Yes____ No ____ Do you wish to receive email reminders? Yes ____ No ____

If yes, who is your phone carrier? Please circle: Verizon ATT Sprint T-Mobile Other_____

Have you ever had Chiropractic before? Yes____ No_____ If yes, when and where _____

Section II **Insurance**

Do you have Medicare Part B? Yes ____ No____ If yes, what is your Medicare Number? _____Do you have Triwest? Yes ____ No _____ If yes, what is your Social Security Number? _____ If this is for a car accident, please get additional paperwork from front desk.

Section III **Treatment Authorization**

All charges are due when services are rendered.

Method of Payment: Cash ___ Check ____ Credit Card ____ Care Credit____ Other _____

Why Chiropractic?

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Your doctor will weigh your needs and desires when recommending your treatment. ***Please circle below the option you are most interested in today.***

RELIEF CARE

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

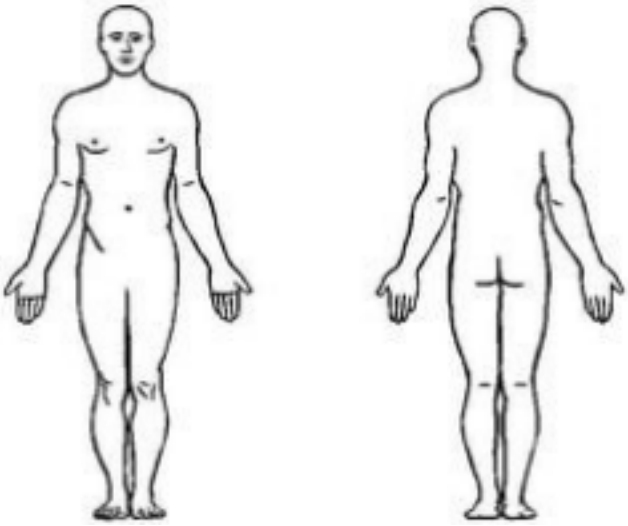
CORRECTIVE CARE

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length and time, but is more lasting

I authorize North Valley Chiropractic to render necessary services to me and I am responsible for all charges incurred. Patient Signature _____ Date _____
Guardian authorizing care_____

FLIP OVER →

PLEASE MARK AN **X** WHERE YOU HAVE PAIN



List your chief complaints in order of severity

1._____

2._____

3._____

How long have you had this problem?

_____

_____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

_____

_____

_____

Check any of the following you have had in the last six months:

- ☐ Headaches
- ☐ Sinus Congestion/Allergies
- ☐ Vision problems
- ☐ Ear Aches
- ☐ Dizziness
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Blood Pressure Problems
- ☐ Ankle Swelling
- ☐ Prostate/Sexual Dysfunction
- ☐ Menstrual Cycle Dysfunction
- ☐ Numbness
- ☐ Frequent
- ☐ Nausea/Vomiting
- ☐ Abdominal Cramps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Diabetes
- ☐ Cancer

Are you pregnant? Yes ____ No____ Not Sure____

North Valley Chiropractic

2062 Talbert Dr. Ste. 500
Chico, CA 95928
(530)809-1077 Fax (530)636-4471

We have prepared the following check list in order to help our patients determine their responsibility toward payment for chiropractic services. Please carefully read each statement and check the statement that applies to you and sign at the bottom.

_____ **MEDICARE**: I have Medicare Part B. I understand that Medicare could pay for manipulation of the spine, x-rays or exams if it is deemed a medical necessity. I also understand that North Valley Chiropractic will courtesy bill Medicare for me. I have read and signed the Medicare ABN and am aware that I am responsible for paying for my services whether Medicare pays or denies my claims. It has been explained to me that North Valley Chiropractic does not accept assignment, therefore any services paid by Medicare will go directly to me, the patient, and not to North Valley Chiropractic.

_____ **PRIVATE PAY**: As I have NO INSURANCE, or third party liable for my health care expense, I agree to assume all responsibility and to keep my account current to the financial arrangements made for payment that is suitable to all parties.

_____**INSURANCE COVERAGE***: I am aware that North Valley Chiropractic is not contracted with my insurance company and for that reason I have decided to pay in full for the amount of my care in their office.* ***North Valley Chiropractic can never determine or verify 100% of my anticipated coverage, therefore they will not offer any advice on my insurance benefits.*** North Valley Chiropractic will supply an itemized statement to me each month as a courtesy that I can send to my Personal Health Insurance and if the insurance deems necessary, they will reimburse me. If I ever need additional insurance statements from North Valley Chiropractic or help with insurance questions, all I need to do is ask.

_____ **AUTOMOBILE ACCIDENT:** I understand that you will bill my personal Auto Insurance for services rendered. If I have an attorney, you will send any reports and billing to them with a signed lien. ***I understand I am responsible for any unpaid balances due at the time I am released from my case.***

_____ **PERSONAL INJURY: (**falling, slipping, etc.) I understand I am responsible for the total bill for services rendered. I am aware that North Valley Chiropractic is not contracted with my insurance company and for that reason I have decided to pay in full the amount of my care in their office. North Valley Chiropractic will supply an itemized statement to me each month as a courtesy that I can send to my Personal Health Insurance and if the insurance deems necessary, they will reimburse me. If I have an attorney, you will send any reports and billing to them with a signed lien.

_____ **OTHER:** _____

I authorize **NORTH VALLEY CHIROPRACTIC** to furnish full information and records concerning me to the Credit Bureau, for obtaining credit at North Valley Chiropractic. We believe the clear definition of our financial policy will allow us to all concentrate upon the most important issue of your HEALTH and WELL-BEING!!!

SIGNATURE: _____ **Date** _____

In the event I discontinue my Chiropractic Care, my bill is **DUE IN FULL IMMEDIATELY!!**

North Valley Chiropractic

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process, you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebrae in the spine is misaligned and/or does not move properly, causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

A chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness and/or musculoskeletal sprain/strain.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

FLIP OVER →

I HAVE READ THE PARAGRAPH ON THE PREVIOUS PAGE. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE NORTH VALLEY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATE _____

_____ _____

Patient Signature Doctor's Signature

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for patient:

_____

Signature:_____

Relationship to Patient:_____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for patient:

_____

Signature:_____

Relationship to Patient:_____

Remarks:

****I hereby acknowledge that I have been offered a copy of North Valley Chiropractic "NOTICE OF PRIVACY PRACTICES," as required by the HIPAA privacy regulations. I am aware that there is a copy posted in the office.**

_____

****Patient Signature**

PHYSICIAN-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 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 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 shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associations, corporations, partnerships, employees, agents, clinics and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. Filing by Physician of any action in any court by the physician 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 Physician, 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 by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed and the remainder of the Agreement will be enforced in accordance with California law.

I understand that I have the right to receive a copy of this 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.

Signed: _____ Date: _____
Printed Name: _____
Relationship to patient: _____ Patient _____ Guardian

North Valley Chiropractic

Steven Seegrist, D.C.
2062 Talbert Dr. Ste. 500
Chico, CA 95928
(530)809-1077 Fax (530)636-4471

AUTHORIZATION TO RELEASE X-RAYS & INFORMATION

I, _____ request the following information:
(Patient's name)

_____ X-rays _____ History _____ Records _____ Diagnosis _____ Treatment
_____ Reports _____ Other_____

Patient date of birth: _____

To be released to:

☐ Steve Seegrist D.C.
North Valley Chiropractic
2062 Talbert Dr. Suite 500
Chico, CA 95928

OR

☐ _____ of _____
(Physicians name) (Physicians clinic name)

_____
(Clinic address)

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original

Signed: _____ Date: _____
Printed Name: _____
Relationship to patient
_____ Patient _____ Guardian

I understand that I have the right to receive a copy of this authorization upon my request
Copy requested (please circle) yes ____ No

This form is for future care. For the ease of this office, this release will only be valid after verbal authorization is also obtained.