CONFIDENTIAL PATIENT INFORMATION

Name: _____ Other Legal Name(s): _____

Hm Phone: _____ Wk/Cell Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ Marital Status: (circle one) M S D W Sex: F M Age _____

Social Security Number _____-_____-_____ E-mail Address _____

Occupation: _____ Employer: _____

Work Address: _____ City, St, Zip: _____

Spouse's Name: _____ # of Children: _____

Who may we thank for referring to our office: _____

Have you ever had Chiropractic care before? Yes □ No □ Date: _____

Is this injury/illness related to: Automobile Accident □

Date/Time: _____ Location: _____

Your Auto Insurance Co: _____ Phone: _____

Third Party Auto Insurance Co: _____ Phone: _____

Your Health Info

What brings you in today?

Is the pain (circle): Sharp Dull Achy Nagging Shooting Pressure Stabbing Throbbing

☐ neck pain	☐ low back pain	☐ headaches	☐ leg pain
☐ upper back pain	☐ numbness	☐ migraines	☐ carpal tunnel
☐ mid back pain	☐ sciatic pain	☐ hip pain	☐ other: _____

How long has this been going on (circle)? Days Weeks Months Years Decades

Does the pain stay in one spot or does it travel? Where?

What have you tried that makes it better?

☐ ice	☐ medication	☐ exercising	☐ chiropractic
☐ heat	☐ lying down	☐ stretching	☐ other: _____
☐ rest	☐ sitting	☐ massage	☐ other: _____

What makes the pain worse?

☐ sitting	☐ bending	☐ morning time	☐ sneezing
☐ standing	☐ twisting	☐ evening time	☐
☐ walking	☐ coughing	☐ seasonal	☐ other: _____

Are you pregnant? (Yes) (No) (Not Sure)

Notes: _____

Please list all current medications you are taking: _____

_____

_____

Please list all surgical procedures you have had: _____

_____

_____

Please explain any significant traumas you have had: _____

_____

_____

All charges are due when services are rendered...

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

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 program.

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

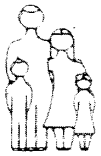
Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I authorize Joyce Family Chiropractic to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

THANK YOU FOR ALLOWING US TO SERVE YOU!



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joycechiro@sbcglobal.net
joycefamilychiro.com

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 the 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 knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily 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 of 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.

The chiropractic adjustment is the application of a precise movement and/or force into the pine 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 hand delivered by hand. Some may require the use of an instrument of 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 concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE JOYCE FAMILY CHIRPORACTIC TO PROCEEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED THIS_____ DAY OF _____, 20_____

_____ _____

PATIENT SIGNATURE DOCTOR'S SIGNATURE

Parental Consent for Minor Patient:

Patient Name: _____

Patient Age_____ DOB_____

Printed name of person legally authorized to sign _____

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 _____

Signature_____

Relationship to patient_____

Remarks:

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JOYCE FAMILY CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the entire form carefully.

Joyce Family Chiropractic is required, by law, to maintain the privacy and confidentially of your protected health information and to provide our patients with notice of our legal duties and practices with respect to your protected health information.

Disclosure of your health information

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. For example, on occasion it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Joyce Family Chiropractic. It is our policy to provide a substitute healthcare provider, authorized by Joyce Family Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situations.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. For example, as a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Joyce Family Chiropractic for health care services rendered. If you pay for your health care services personally, we will as a courtesy provide an itemized billing statement to your insurance carrier for the purpose or reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the healthcare services received.

Workers' 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: preventing or controlling 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 a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court or subpoena, and other law enforcement purposes.

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

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health 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 marketing purposes or fundraising purposes. For example, as a courtesy to our patients, we may call your home on the evening 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. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment. Also, or practice participates in charitable events to raise awareness, food donations, gifts, money, etc. During these times we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purposes of Joyce Family Chiropractic sponsored fundraising events.

Change of Ownership
In the event that Joyce Family Chiropractic is sold or merged with another organization, your health information/records will become 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 Joyce Family Chiropractic is not required to agree to the restrictions that you may request.
- 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 request.
- You have the right to inspect and copy your health information.
- You have the right to request that Joyce Family Chiropractic amend your protected health information. Please be advised, however, that Joyce Family Chiropractic is not required to agree to amend your protected health information. If your request to amend 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 the right to receive an accounting of disclosures of your protected health information made by Joyce Family Chiropractic.
- You have the right to a paper copy of this Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Joyce Family Chiropractic 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, Joyce Family Chiropractic is required by law to comply with this Notice.

Joyce Family Chiropractic 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: Mayra Ledezma by calling this office at (530)899-8500. If Mayra Ledezma is not available, you may make an appointment for a personal conference in person or by telephone within 2 business 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 Ave SW
Room 509F HHH Building
Washington DC 20201

This notice is effective as of _____/_____/_____

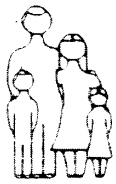
I have read the Privacy Notice and understand my rights contained in this Notice.

By way of my signature, I provide Joyce Family Chiropractic with my authorization and consent to use and disclose my protected healthcare information for the purpose of treatment, payment, and healthcare operations as described in the Privacy Notice.

_____
Patient's name (Printed)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date



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AUTHORIZATION TO RELEASE XRAYS & INFORMATION

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

□ X-rays □ History □ Records □ Diagnosis □ Treatment □ Reports □ Other: _____
Concerning: □ Accident □ Injury □ Illness □ Other: _____

To be released to : _____ of _____
(Physician's Clinic Name)

For the purpose of : _____
(Specify: Review, investigate or evaluate of an application, or the processing of any claim or any purpose reasonably related to the above)

Signed _____ Date: _____/_____/_____
□ Patient □ Spouse □ Parent □ Guardian

I understand that I have the right to receive a copy of this authorization upon my request.
Copy requested □ yes □ no

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

_____ **Medicare:** I am eligible for Medicare. I understand that Medicare could pay for manipulation of the spine, x-rays or exams if deemed a medical necessity. I also understand that Joyce Family Chiropractic will courtesy bill Medicare for me. I have read and signed the Medicare ABN and I am aware that I am responsible for paying for my services whether Medicare pays of denies my claims. It has been explained to me that Joyce Family Chiropractic does not accept assignment; therefore any services paid by Medicare will go directly to me, the patient, and not to Joyce Family 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 Joyce Family 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. Joyce Family Chiropractic can never determine of verify 100% of my anticipated coverage, therefore they will not offer any advice on my insurance benefits. Joyce Family 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 Joyce Family Chiropractic or help with insurance questions all I need to do is ask!

_____ **Automobile Accident:** I understand that Joyce Family Chiropractic does not hold open balances for automobile accidents with third party claims. I understand that you will bill my personal Auto Insurance for services rendered if med-pay is available. 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 for my case.

_____ **Personal Injury:** (Falling, slipping, etc.) I understand I am responsible for the total bill for services rendered. I am aware that Joyce Family 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. Joyce Family Chiropractic will courtesy bill for me and any payments will be sent to the policy holder. If I have an attorney, you will send any reports and billing to them with a signed lien.

I authorize Joyce Family Chiropractic to furnish full information and records concerning me to the Credit Bureau, for obtaining credit at Joyce Family 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!

******* A 1.5% monthly late charge will be applied on all unpaid balances over 60 days*******

Signature: _____ Date: _____

In the event I discontinue my Chiropractic Care, my bill is due in full immediately!

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 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 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 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. 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 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: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one processing. 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 California 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.

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 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. 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.

_____
Health Care Provider's Signature (Date)

By:_____
Health Care Provider's Duly Authorized Representative (Date)

_____
Translated by (Date)

_____
Print Patient's Name

_____
Signature of Patient or Patient's Agent, Representative, or Parent (Date)

As: _____
Relationship to Patient

A **signed original, WHITE copy** is to be filed in Patient's file.
A **signed YELLOW copy** is to be given to the patient.

1048-N
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