# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

## 2 INSURANCE INFORMATION

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr.______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient

## 3 PHONE NUMBERS

Cell Phone (____) ______ Home Phone (____) ______

Best time and place to reach you ______

**IN CASE OF EMERGENCY, CONTACT**

Name ______ Relationship ______

Home Phone (____) ______ Work Phone (____) ______

## 4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date ______

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______

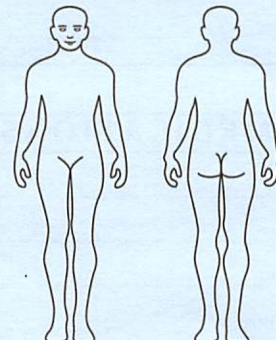
## 5 PATIENT CONDITION

Reason for Visit ______

When did your symptoms appear? ______

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ______

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ______

Is it constant or does it come and go? ______

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down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## 6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ____________________

Name and address of other doctor(s) who have treated you for your condition ____________________

Date of Last: Physical Exam __________ Spinal X-Ray __________ Blood Test __________

Spinal Exam __________ Chest X-Ray __________ Urine Test __________

Dental X-Ray __________ MRI, CT-Scan, Bone Scan __________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | Diabetes | ☐ Yes | ☐ No | Liver Disease | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No |
| Alcoholism | ☐ Yes | ☐ No | Emphysema | ☐ Yes | ☐ No | Measles | ☐ Yes | ☐ No | Scarlet Fever | ☐ Yes | ☐ No |
| Allergy Shots | ☐ Yes | ☐ No | Epilepsy | ☐ Yes | ☐ No | Migraine Headaches | ☐ Yes | ☐ No | Sexually Transmitted Disease | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No | Fractures | ☐ Yes | ☐ No | Miscarriage | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Anorexia | ☐ Yes | ☐ No | Glaucoma | ☐ Yes | ☐ No | Mononucleosis | ☐ Yes | ☐ No | Suicide Attempt | ☐ Yes | ☐ No |
| Appendicitis | ☐ Yes | ☐ No | Goiter | ☐ Yes | ☐ No | Multiple Sclerosis | ☐ Yes | ☐ No | Thyroid Problems | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | Gonorrhea | ☐ Yes | ☐ No | Mumps | ☐ Yes | ☐ No | Tonsillitis | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Gout | ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Bleeding Disorders | ☐ Yes | ☐ No | Heart Disease | ☐ Yes | ☐ No | Pacemaker | ☐ Yes | ☐ No | Tumors, Growths | ☐ Yes | ☐ No |
| Breast Lump | ☐ Yes | ☐ No | Hepatitis | ☐ Yes | ☐ No | Parkinson's Disease | ☐ Yes | ☐ No | Typhoid Fever | ☐ Yes | ☐ No |
| Bronchitis | ☐ Yes | ☐ No | Hernia | ☐ Yes | ☐ No | Pinched Nerve | ☐ Yes | ☐ No | Ulcers | ☐ Yes | ☐ No |
| Bulimia | ☐ Yes | ☐ No | Herniated Disk | ☐ Yes | ☐ No | Pneumonia | ☐ Yes | ☐ No | Vaginal Infections | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | Herpes | ☐ Yes | ☐ No | Polio | ☐ Yes | ☐ No | Whooping Cough | ☐ Yes | ☐ No |
| Cataracts | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | Prostate Problem | ☐ Yes | ☐ No | Other __________ | | |
| Chemical Dependency | ☐ Yes | ☐ No | High Cholesterol | ☐ Yes | ☐ No | Prosthesis | ☐ Yes | ☐ No | | | |
| Chicken Pox | ☐ Yes | ☐ No | Kidney Disease | ☐ Yes | ☐ No | Psychiatric Care | ☐ Yes | ☐ No | | | |
| | | | | | | Rheumatoid Arthritis | ☐ Yes | ☐ No | | | |

### EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

### WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

### HABITS

☐ Smoking Packs/Day __________
☐ Alcohol Drinks/Week __________
☐ Coffee/Caffeine Drinks Cups/Day __________
☐ High Stress Level Reason __________

Are you pregnant? ☐ Yes ☐ No Due Date __________

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |

## 7 MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS

| MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS |
|---|---|---|
| | | |
| | | |
| | | |
| Pharmacy Name __________ | | |
| Pharmacy Phone (____) __________ | | |

JOHNSON RANCH
CHIROPRACTIC
Charles Boley II, D.C.
WELLNESS & INJURY CENTER

Johnson Ranch Chiropractic
Charles Boley, II, D.C.
1891 East Roseville Pkwy, Suite 130
Roseville, CA 95661
Ph. 916-771-3999 - Fax 916-474-5321

# INFORMED CONSENT TO CHIROPRACTIC CARE

**Patient: Please discuss any questions or concerns with the doctor before signing this consent.**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment:

**Spinal Adjustment, Spinal Examination, Exercise, Stretching, X-Ray, UltraSound, Decompression Therapy, Laser, Hot/Cold Packs, and Massage.**_________________

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_________________________________ Date ___________________

Signature of Parent/Guardian__________________________ Date ___________________
(If patient is a minor)

Witness Signature___________________________________ Date ___________________

Doctor's Signature___________________________________ Date ___________________

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# PAYMENT POLICIES

***We believe that a clear definition of our policies will allow us both to concentrate on the big issue of regaining and maintaining your health...***

**APPOINTMENT POLICY**

***In order to serve all our patients we ask that you call if you are unable to make your appointment. If you find yourself running late, please stop by the office and notify the receptionist and we will get you in for your visit as soon as possible. When you fail to notify our office, this leaves a time slot open that could otherwise be used to help someone else. Please help us help others. Thank you.***

## *PAYMENT SCHEDULE*

*THE FIRST DAY'S CHARGES ARE EXPECTED ON YOUR INITIAL VISIT.*
*WE ACCEPT CASH, CHECK OR CREDIT CARD.*

*INSURANCE*

Please present your insurance card today. We will call your insurance company for you to verify your coverage. If you have chiropractic care coverage on your insurance plan, our office will submit claims for you. **In some cases misinformation is given to us by the insurance company in regards to chiropractic coverage (such as where to submit claims, authorizations needed, co-pay's/co-insurance amounts, deductibles, etc...). We will do our best to handle this for you, however, please be advised you are responsible for payment of all services provided to you should your insurance not cover or deny treatment. (initial________)**

*CASH*

Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. **(initial________)**

*PERSONAL INJURY*

You need to provide us with the accident report, your auto insurance, health insurance, and attorney if applicable. If the claim is a possible third party liability, please provide us with the other parties' insurance carrier information. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care on a cash basis. Patients with approved personal injury claims are not required to pay for care as it is rendered. Patients who are covered by third party insurance only will need to check with the insurance department to make payment arrangements. **(initial________)**

*WORKER'S COMPENSATION*

You need to report your accident to your employer, bring in necessary insurance information. Complete and sign a required Accident Report in our office. Until the necessary information is provided OR if the claim is denied you will be required to pay for your care on a cash basis. Approved worker's compensation claims are not required to pay for care as it is rendered. Transfer of Care claims will be verified with the claims manager. Reopening of claims closed past 90 days will require patient to make personal arrangements and will be reimbursed if claim is allowed.
**(initial________)**

*SERVICE CHARGES*

A late fee of $25.00 will be added to any account that is 10 days or more past due agreed due date. A 1.5% service charge will accrue each month on any account 30 days or more past due.

**Patient's Signature or Guardian** ______________________ **Date:** ______________________

**CA initials:**________

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# *HIPAA LAW #101-191 CONSENT FORM*

The information you provide us is kept to the strictest of confidence, while protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health care information.

1. It may be necessary to use or disclose your private health information to another health care provider or hospital, if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health information.
2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes including:

    A. Your individual Travel Sheet will be placed on the counter for you to sign in on with each visit.
    B. Files are stored in plain site behind and around front desk
    C. Appointment reminders at home, cell, work or by text
    D. Leaving messages on voice mail or answering machines
    E. Testimonials of your improvement in written or verbal form used in office and on website
    F. X-rays/x-ray jackets with names may be stored in adjusting rooms and x-ray room.
    G. Per your consent X-Rays may be sent out for further review.
    H. Doctor's report or record of care may be discussed in adjusting rooms with no door closure. Conversations may be heard by other patients
    I. Travel Sheets are carried through the office with your personal information
    J. Travel Sheets may be placed in clear boxes at the door of each adjusting room
    K. Sending you marketing materials
    L. Information about alternative treatments
    M. Other health related information that may be of interest to you
    N. "Thank you", Birthday Card's", Newsletters, etc… may be sent to you
    O. Your name may be placed on our referral board located in the front waiting room.

4. A closed consultation room may be used in discussing in detail your current health issues as well as making financial arrangements. You may request this room at anytime.

***PATIENT RIGHTS UNDER HIPAA LAW #101-191***

1. You have the right to request that we do not disclose your private health information to specific individuals, companies or organizations under the following circumstances.
    A. all requests must be in writing
    B. by law we are not required to agree with your restriction, however, if we do agree with your restrictions, the restrictions is binding on us.
2. You have the right to REVOKE your Authorization under certain conditions:
    A. IT MUST BE IN WRITING
    B. The request will not be honored if we have already released your private health information before we received your authorization as a condition of obtaining insurance, the insurance may have then the right to your private health information. Should they decide to contest any of your claims, information that we use or disclose based on the authorization your are giving us may be subject to re-disclosure by anyone that has access to the remainder of other information and may no longer be protected by the federal privacy rules.
    C. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for services rendered to you.

Patient Signature:______________________________________ Date:____________________