

TO THE

# New Patient

OUTLINE OF PROCEDURES FOR CARE



**STEP ONE:**

All new patients are requested to fill out this personal health history questionnaire.

**STEP TWO:**

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

**STEP THREE:**

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

**STEP FOUR:**

The doctor will advise you if additional laboratory tests or x-rays are needed.

**STEP FIVE:**

You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

**STEP SIX:**

If you are accepted as a patient, care will begin. Additional explanations will be given on the different types of treatments that are available in the office.

**STEP SEVEN:**

An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

**STEP EIGHT:**

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

**Date:** \_\_\_\_\_

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Initial: \_\_\_\_\_  
Nick Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone:(\_\_\_\_\_) \_\_\_\_\_  
Work Phone:(\_\_\_\_\_) \_\_\_\_\_  
Cell Phone:(\_\_\_\_\_) \_\_\_\_\_  
E-mail: \_\_\_\_\_ Sex: M F  
Occupation: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Drivers Lic. #: \_\_\_\_\_  
Height: \_\_\_\_\_ Wt: \_\_\_\_\_

**CLAIM INFORMATION**

**CARRIER (INSURANCE NAME):**

\_\_\_\_\_  
*(Please give insurance card to receptionist.)*

**RELATION OF PATIENT TO INSURED PERSON:**

Self ( ) Spouse ( ) Child ( ) Other ( ) \_\_\_\_\_

**MAIN SUBSCRIBER'S INFORMATION:** (If different from patient)

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Initial: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone:(\_\_\_\_\_) \_\_\_\_\_  
Birthdate: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Sex: M F  
Employer/School: \_\_\_\_\_

**RELATIONS AND CONTACTS**

**PATIENT'S EMPLOYER:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_

**SPOUSE:** None ( ) *(if none, move to next section)*

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Initial: \_\_\_\_\_  
Home Phone:(\_\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_  
SSN : \_\_\_\_\_ DOB: \_\_\_\_\_  
Occupation: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_

**REFERRAL:** *(Please be as specific as possible)*

How did you hear about our office?

**GENERAL INFORMATION**

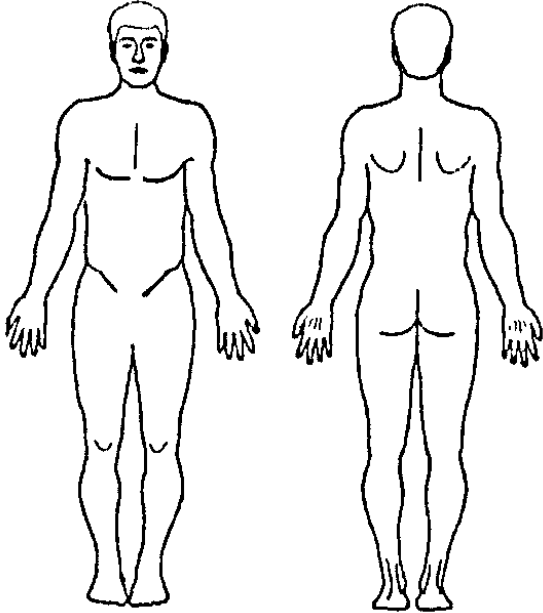
Injury Date: \_\_\_\_\_  
Injury Description (How did you get hurt?): \_\_\_\_\_  
\_\_\_\_\_  
Place of Injury: \_\_\_\_\_  
Complaint (Describe your pain...): \_\_\_\_\_  
\_\_\_\_\_  
Is The Injury New or old? (acute or chronic): \_\_\_\_\_  
Marital Status: Single ( ) Married ( ) Widowed ( ) Divorced ( )  
Employment status: Employed ( ) Unemployed ( ) \_\_\_\_\_  
Off Work Due to Injury? Y N Since When? \_\_\_\_\_  
Injury Is Related to: Work ( ) Auto Accident ( ) Other Accident ( )  
Other ( ) \_\_\_\_\_

\_\_\_\_\_  
*Signature of Patient or Guardian*

## Injury Detail

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

<p>Please mark the location of your symptoms on the figure below and describe.</p>	<p>Please mark where your current complaint is on this scale (how you feel today):</p> <p style="text-align: center;">0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10</p> <p>(0 = No Pain) (10 = Unbearable Pain)</p>
	<p>How often are your symptoms present?</p> <p style="text-align: center;"> <input type="checkbox"/> 0-25%    <input type="checkbox"/> 26-50%    <input type="checkbox"/> 51-75%    <input type="checkbox"/> 76-100%         </p> <p>Have you ever had these symptoms before? Y N</p> <p>(Explain): _____</p> <p>Can you perform your daily work? Y N</p> <p>(If no, you've been off work since when?) _____</p> <p>Have you had x-rays, MRI, CAT scan, or other? Y N</p> <p>(What area taken?): _____</p> <p>Have you ever seen a chiropractor before? Y N</p> <p>(When, and who?): _____</p>

Any past/current medical problems or conditions? Y N      Do you take any regular medications? Y N

(Explain): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<p>Any surgeries in the past? Y N</p> <p>(Explain): _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Any injuries in the past? Y N</p> <p>(Explain): _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Family History:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> High Blood Pressure</li> <li><input type="checkbox"/> Cardiovascular problems/stroke</li> <li><input type="checkbox"/> Back / Neck pain</li> <li><input type="checkbox"/> Other _____</li> </ul>
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**Female Patients-** I certify that I am not pregnant, nor is there a likely chance that I may be pregnant. I give my permission for any necessary x-rays to be taken today.

Patient Signature: \_\_\_\_\_      Date: \_\_\_\_\_

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health coverage in the future.

Patient Signature: \_\_\_\_\_      Date: \_\_\_\_\_

**Dr.'s Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Tulare Chiropractic

## Accident & Injury Center

Steven D. Mitchell, D.C.  
1098 E. Cross Ave.  
Tulare, CA 93274  
(559) 685-9391  
*Tularechiro.chiroweb.com*

### INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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 the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and 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 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 interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about it's 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.

To be completed by patient:

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Print Name of Patient's Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Patient's Representative

Name and Address of Clinic/Office:

Tulare Chiropractic Clinic  
1098 E. Cross Ave.  
Tulare, CA 93274

As: \_\_\_\_\_  
Relationship or Authority of Patient's Representative

\_\_\_\_\_  
Date Signed

Print name(s) of doctors treating this patient:

\_\_\_\_\_  
Steven D. Mitchell, D.C.

Witness to Patient's Signature:

\_\_\_\_\_

Date \_\_\_\_\_

Translated by:

\_\_\_\_\_

Date \_\_\_\_\_

**TULARE CHIROPRACTIC CLINIC  
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 IT CAREFULLY.

Tulare Chiropractic Clinic 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**

**Phone Calls to Patient**

We may call you at the phone numbers you have listed in case of emergency, missed appointment, or the need to reschedule an appointment. If there is a number you **do not** wish us to call, please, let the receptionist know.

**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 Tulare Chiropractic Clinic.*

*It is our policy to provide a substitute health care provider, authorized by Tulare Chiropractic Clinic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.*

**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 Tulare Chiropractic Clinic for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care 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 order 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, as described below:

*"You may be sent an informational newsletter periodically. No personal health information will be revealed in this newsletter.*

*"As a courtesy to our patients, we may call your home prior to your scheduled appointment to remind you of your appointment time, or call your home, work, or mobile number if you have missed an appointment. If you are not at home, we 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."*

*"It is our practice to participate 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 purpose of Tulare Chiropractic Clinic sponsored fund-raising events."*

**Change of Ownership.**

In the event that Tulare Chiropractic Clinic 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 Tulare Chiropractic Clinic 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 Tulare Chiropractic Clinic amend your protected health information. Please be advised, however, that Tulare Chiropractic Clinic 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 Tulare Chiropractic Clinic.
- 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**

Tulare Chiropractic Clinic 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, Tulare Chiropractic Clinic is required by law to comply with this Notice.

Tulare Chiropractic Clinic 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: Steven D. Mitchell, D.C. by calling this office at 559-685-9391. If Steven D. Mitchell, D.C. 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 Tulare Chiropractic Clinic has handled your health information should be directed to Steven D. Mitchell, D.C. by calling this office at 559-685-9391. If Steven D. Mitchell, D.C. 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

This notice is effective as of \_\_\_\_/\_\_\_\_/\_\_\_\_

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

By way of my signature, I provide Tulare Chiropractic Clinic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Patient's Signature \_\_\_\_\_ Date

\_\_\_\_\_  
Authorized Facility Signature \_\_\_\_\_ Date

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO  
DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH  
INSURANCE**

• I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check made out and mailed directly to:

**Tulare Chiropractic Clinic  
Dr. Steven D. Mitchell  
1098 E. Cross  
Tulare, CA 93274**

for the professional or chiropractic 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 service charges over and above this insurance payment.

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

- I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.
- I authorize Dr. Steven Mitchell to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I authorize Dr. Steven Mitchell to deposit checks received from insurance companies on my behalf when made out to me.

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of policyholder

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder

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**LETTER OF NO ACCIDENT OR INJURY**

\_\_\_\_\_ (pt. initials) I hereby state with my signature that I was not involved in any auto accident, slip and fall, or work injury. My treatment is in no way associated with any 3<sup>rd</sup> party, and no other party is responsible or liable for the cost of my treatment. Please process and pay all claims immediately.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## Financial Policy

We would like to take a moment to welcome you to Tulare Chiropractic Clinic and assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, we would first like to explain how your medical bills would be handled.

It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided. If this arrangement becomes inconvenient for you, please see our billing representative so that other arrangements can be made for you. These arrangements must be made in writing. Should you suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

If you have a primary insurance carrier who has chiropractic benefits, then we will bill the primary insurance for you. If the carrier does not pay the bill within the time allowed through the California Health and Safety codes (without a legitimate reason), then the balance will be due from the patient. **Our office does not bill secondary or 3<sup>rd</sup> party insurances.**

I have read and agree to the above.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Financially Responsible Person

\_\_\_\_\_  
Signature

*(if different than above)*

## ADVANCE BENEFICIARY NOTICE (ABN)

**NOTE: You need to make a choice about receiving these health care items or services.**

We expect that many health insurance companies may not pay for the item(s) or service(s) that are described below. Health insurance does not pay for **all** of your health care costs. Health insurance only pays for covered items and services listed in your particular contract. The fact that your health insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **your health insurance probably will not pay for:**

**Items/Services:** Spinal Decompression, Massage Therapy, Supplements, Durable Medical Equipment

**Reason:** Non-Covered Elective Services

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

Before you make any decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why your health insurance probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost :\$\_\_\_\_\_**), in case you have to pay for them yourself or through other insurance.

I understand that my insurance will not cover these services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or person acting on patient's behalf