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 ( )

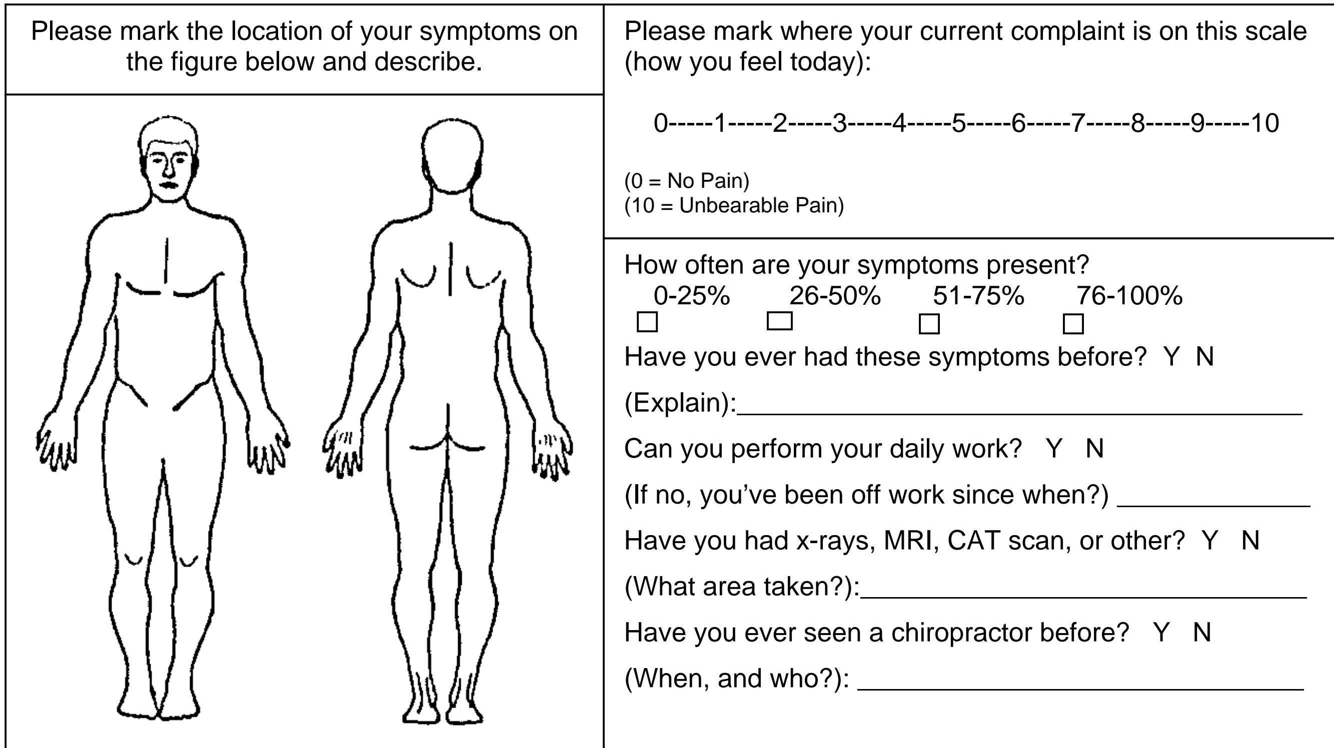
Other ( ) ______________________________

____
Signature of Patient or Guardian

Injury Detail

Patient Name: ___________________________ Date: ______________

Please mark the location of your symptoms on the figure below and describe.



Please mark where your current complaint is on this scale (how you feel today):

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

(0 = No Pain)
(10 = Unbearable Pain)

How often are your symptoms present?

- ☐ 0-25%
- ☐ 26-50%
- ☐ 51-75%
- ☐ 76-100%

Have you ever had these symptoms before? Y N

(Explain):_______________________________________

Can you perform your daily work? Y N

(If no, you've been off work since when?) _____________

Have you had x-rays, MRI, CAT scan, or other? Y N

(What area taken?):______________________________

Have you ever seen a chiropractor before? Y N

(When, and who?): ______________________________

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

(Explain):____

____

____

Any surgeries in the past? Y N

(Explain): ___________________

____

____

____

Any injuries in the past? Y N

(Explain): ________________

____

____

____

Family History:

- ❑ Cancer
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Cardiovascular problems/stroke
- ❑ Back / Neck pain
- ❑ Other ________________

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:

____
Print Patient's Name

____
Signature of Patient

____
Date Signed

Name and Address of Clinic/Office:

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

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

____
Print Name of Patient

____
Print Name of Patient's Representative

____
Signature of Patient's Representative

As: ______________________________
Relatationship 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 __________

AUTO INJURY QUESTIONS

Date: ___________________

Patient Name: __________________________ Date of Injury: ___________________

1. Please write out a general description of the accident: (eg; I was stopped when another car rear-ended mine)

2. Details:
   - Were you the Driver, or Passenger? ____________________________
     - If Passenger, where were you sitting? ___________________
   - Were there other people in the vehicle with you? Y N If "yes", state number: ___________ were they injured? Y N
   - What type of vehicle were you in? (eg: "1998 Ford Escort"): ___________________ Other Vehicle?______________
   - Were you wearing your seat belt? Y N Does the vehicle have an airbag? Y N
     - If "yes", did the air bag deploy? Y N
   - What position were you in at the time of impact? (eg; "head turned to the left", or "looking straight forward")

   - Was your car moving or stationary? ____________________________ If moving, how fast? ______________
   - Were you unprepared for the collision, or did you see it coming? _____________________________________
   - Was the car's break on?
   - How did your body move at impact? ____
   - Did any part of your body strike the vehicle's interior? Y N
     - If "yes", please describe: ____
   - How much damage was done to the vehicle you were in? (estimate) __________________________________

3. Misc. Information:
   - Did you ever have these symptoms before the accident? Y N
     - If "yes", please describe:____
   - Did the ambulance come to the scene of the accident? Y N
   - Did the Police come to the scene of the accident? Y N
     - If "yes", did the Police make a report? Y N *(If "yes", please let us copy for your records)*
   - Did you loose consciousness? Y N If "yes", for how long? _________________________
   - Was the vehicle drivable after the accident? Y N
     - If "no", was it towed away? Y N

- Did you go to the hospital? Y N If "yes", when ? ____________________________________
- Have you seen any other Healthcare Provider(s) as a result of this accident? Y N
  - If "yes": Name: ________________________________
    Address: ______________________________ City _________________ Zip ___________
  - What was done? ____
  - Results? ____

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

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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

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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
1098 E. Cross Ave.
Tulare, CA 93274

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

Steven D. Mitchell, D.C.
1098 E. Cross Ave.
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.

Dated at   this _________ day of ____________ 20__.

___________________________   ________________________________
Signature of policyholder   Signature of Claimant, if other than Policyholder

____
*With my signature above, the full deductible or co-payment would be a financial hardship on me.

Tulare Chiropractic
Accident & Injury Center
Steven D. Mitchell, D.C.
1098 E. Cross Ave.
Tulare, CA 93274
(559) 685-9391
Tularechiro.chiroweb.com

PERSONAL INJURY ACCEPTANCE POLICIES

Tulare Chiropractic Clinic will accept your Personal Injury Case when the following conditions are agreed to and kept. Tulare Chiropractic Clinic **will bill your auto-med pay and group insurance. You must assign your benefits for direct payment to** Tulare Chiropractic Clinic**. If represented by legal counsel, you must sign a Recession of Attorney Assignment Form which directs both your carrier and attorney that payment is to be paid directly to** Tulare Chiropractic Clinic**.**

In the event you are represented by acceptable legal counsel and you do not have the above referenced insurance, treatment will be rendered on a lien basis as long as the following conditions are agreed to and adhered to. In the event these conditions are not followed, full payment is immediately owed to Tulare Chiropractic Clinic. Please be advised that when treatment is rendered on a lien basis, **you are directly and fully responsible for any chiropractic bills owing. Payment is not contingent upon any settlement, judgment, or verdict.**

LIEN ACCEPTANCE POLICIES

1. That you are represented by an attorney specializing in personal injury law that meets with the approval of this office.

2. That a Doctor's Lien Form is signed by you and acknowledged in a timely manner by your attorney. This allows the Doctor's fees to be paid from the final settlement of your claim.

3. That the merits of your case are established by your attorney and communicated in a timely manner to Tulare Chiropractic Clinic.

4. That you **follow and complete the treatment program recommended by Dr. Mitchell or his associate.** Should you discontinue care or change doctors without approval of Dr. Mitchell or his associate, then payment becomes immediately due and payable.

5. ALL MEDICAL INSURANCE AND AUTO-MED PAYMENTS SHALL BE ASSIGNED TO TULARE CHIROPRACTIC CLINIC AND **NOT TO THE ATTORNEY.**

By my signature below, I agree to the above referenced policies.
Patient Signature:_______________________________ Date:__________________

NOTICE OF DOCTOR'S LIEN

Patient Name:____________________________

Patient DOB: ____________________

Date of Accident:____________________

I do hereby authorize **Steven D. Mitchell, D.C.** to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due the owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor.. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable. I further direct my attorney to pay said doctor one hundred percent of all chiropractic costs associated with my treatment. I understand all costs associated with my care and believe them to be necessary, reasonable and customary.

Dated ____________________ ____

Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated ____________________ ____

Attorney’s Printed Name

____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: Steven D. Mitchell, D.C.
1098 E. Cross
Tulare, CA 93274
(559) 685-9391

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 3rd 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 you 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**