CHEELEY CHIROPRACTIC INC.

NEW PATIENT PAPERWORK FOR ACUPUNCTURE

1095 North D Street, Suite 100 ■ San Bernardino, CA 92410 ■ (909) 888-7649 ■ Fax (909) 888-1955
29099 Hospital Road, Suite 204C ■ Lake Arrowhead, CA 92352 ■ (909) 336-3724
cheeleychiro@cheeleycares.com

remove obstacles • restore function • improve performance • maximize potential

Welcome to Our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

These privacy practices are effective: _____

For further information please contact: _____

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

_____
patient or guardian signature

_____
date

Cheeley Chiropractic, Inc.

Patient Information

Last Name:_____ First Name:_____ M.I.___

Sex:_____ DOB:_____ Age:_____ Marital Status:_____

Address:_____ City:_____ Zip Code:_____

Home Phone #:_____ Cell #:_____

Work Phone #:_____ Job Title:_____

Drivers License#:_____ State:____

Person Responsible for This Account:_____

Referred by:_____

Insurance Information (If Applicable)

Please circle one of the following:

Work Related Injury Auto Accident Slip & Fall Personal Insurance Other:_____

Name of Insurance Company:_____ ID#:_____

Policy #:_____ Group #:_____ WC Claim#:_____

Name of Primary Insured:_____ Primary DOB:_____

Relationship:_____

Attorney Information (If Applicable)

Attorney Name:_____

Address:_____ City:_____ Zip Code:_____

Phone #:_____

Complaints:

Did your symptoms begin as a result of injury? Yes / No

If Yes, Date of Injury:_____

If Yes, please describe in detail:

_____

_____

_____

If No, please describe the onset of your current symptoms, including when they began and what you feel may be the cause:

_____

_____

_____

Past Medical History:

Are you pregnant? Yes / No

Have you ever had any similar symptoms in the past? If Yes, please describe in detail:

_____

_____

_____

Have you had any prior job related injuries, auto accidents, or any other injuries? If Yes, please describe:

_____

_____

_____

Have you ever been hospitalized and/or had any surgeries? If Yes, please provide date and list procedure:

_____

_____

_____

Do you have any allergies to any substances? If Yes, please list:

_____

_____

Do you have any medical illnesses? If Yes, please describe in detail:

_____

_____

_____

Do you smoke? Yes / No If Yes, how much a day?_____

Do you drink alcohol? Yes / No If Yes, how much a day?_____

Are you currently taking any medications? If Yes, please list each with dosage (mg) and frequency:

_____

_____

_____

Are you taking any illegal drugs? If Yes, please list:

_____

_____

If there is any additional information, please provide below:

_____

_____

_____

INITIAL HEALTH STATUS

Acupuncture

Patient Name_____ Birthdate_____ Primary Language_____ Sex M / F
Last First

Address_____ City_____ State____ Zip_____ Primary Phone_____

Employer_____ Occupation_____ Other Phone_____

Subscriber Name_____ Subscriber ID #_____ Group #_____

Primary Health Plan_____ Patient/Member ID #_____

2nd Health Plan_____ Primary Care Physician (PCP)_____ PCP Phone #_____
(Required) (Required)

Are you under the care of a physician? ☐ **No** ☐ **Yes, for what conditions?**_____

Please describe your current health problem(s)_____

How and When it began_____ Is this work related? Y / N

What treatment have you received for the above condition(s)? ☐ Surgery ☐ Medications ☐ Physical Therapy

☐ Injections ☐ Chiropractic ☐ Massage ☐ Other_____

Please describe your progress: ☐ Worse ☐ No Change ☐ 25% Better ☐ 50% Better ☐ 75% Better or_____

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other_____ _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Describe your current health condition: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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Please check all of the following that apply to you and list any medication(s) you are taking:

☐ Alcohol/Drug Dependence
☐ Abnormal Menstruation
☐ Allergies
☐ Angina
☐ Arthritis/ Rheumatoid Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disorder
☐ Breast Lumps
☐ Cancer/Tumor
☐ Convulsions/Seizures
☐ Diabetes
☐ Diarrhea/Constipation
☐ Excessive Thirst
☐ Fainting or Dizziness
☐ Fatigue
☐ Fever
☐ Frequent Urination
☐ Headache
☐ Heart Attack
☐ Heartburn or Indigestion
☐ High Blood Pressure
☐ Hospitalizations/Surgical Procedures_____
☐ Kidney Disease
☐ Liver Problems
☐ Osteoporosis
☐ Pacemaker
☐ Palpitation/Arrhythmia
☐ Peptic Ulcer
☐ Pregnant, # Weeks_____
☐ Prostate Problems
☐ Weight Gain/Loss
☐ Sinusitis
☐ Stroke
☐ Tobacco Use - Type_____ Frequency_____/Day
☐ Thyroid Disease
☐ Other_____
☐ **Medications**_____

If a family member has had any of the following, please mark the appropriate box and explain the relationship:

☐ Cancer_____
☐ Heart Disease_____
☐ Hypertension_____
☐ Lupus_____
☐ Other_____

Comments_____

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient signature_____ **Date**_____

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

Patient: _____

Employer: _____

Claim/Group#: _____

SS#/ID#: _____

I hereby instruct and direct the _____ Insurance Company to pay by check, made out and mailed directly to:

CHEELEY CHIROPRACTIC
1095 North D Street
San Bernardino, CA 92410

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:

C/o CHEELEY CHIROPARACTIC
1095 North D Street
San Bernardino, CA 92410

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services. 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 Witness

_____
Signature of claimant, of other than Policyholder

Authorization to Use or Disclose Protected Health Information

Cheeley Chiropractic, Inc.
1095 N. "D" Street
San Bernardino, CA 92410
Phone: (909) 888-7649 Fax: (909) 888-1955

Patient Name:_____

Address:_____

Date of Birth:_____ **Date Requested:**_____

As required by the Privacy regulations, Cheeley Chiropractic, Inc., may not use or disclose your protected health information except as provided in or Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

_____

Patient Health Information authorized to be disclosed:

_____

For specific purpose of (describe in detail):

_____

Effective dates for this authorization: _____ through_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and previous reliance on the used or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization
3. Inspect a copy of Patient Health Information being used or disclosed under Federal Law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not affect my condition, my treatment, payment, enrollment in a health plan, or eligibility for benefits, whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patient's Authorized Representative **Date**

_____ _____
Authorized Signature of Facility **Date**