



NEW PATIENT PAPERWORK FOR MEDICARE

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

We may use your health information for:

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

You have the right to:

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

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

PATIENT INFORMATION FORM

(Office use only)

1) New patient _____

Previous Patient (New Case) _____

Patient Code# _____ 2) Date: ____/____/____ 3) Time : ____ m 4) Claim# _____

5) First Name: _____ M.I. ____ Last Name: _____ 6) Sex: 1) Male 2) Female

7) Birthdate ____/____/____ Age ____ Marital Status (S M W D) Spouse's Name _____

8) Social Security # ____/____/____ 9) Home Phone () ____ - ____ Cell Phone () ____ - ____

10) Address _____ City _____ State _____ Zip _____

11) Employer _____ 12) Job Title _____ Work Phone () ____ - ____

Driver's License No. _____ State: _____

Person Responsible for this account _____

Referred By _____

Primary Insurance: (Group ____ Work/Comp ____ Automobile ____ Other ____) 13) Policy # _____

Insurance Co. _____ 14) Group# _____

Address _____ City _____ State _____ Zip _____ Phone () ____ - ____

15) Primary name of Insured: _____ DOB: ____/____/____ Relationship to Patient _____ SS# _____

16) Employer _____ Employee # _____ Work Phone () ____ - ____

Work Address _____ City _____ State: _____ Zip _____

Secondary Insurance: (Group ____ Work/Comp ____ Automobile ____ Other ____) Policy # _____

Insurance Co. _____ Group# _____

Address _____ City _____ State _____ Zip _____ Phone () ____ - ____

Primary name of Insured: _____ DOB: ____/____/____ Relationship to Patient _____ SS# _____

Employer _____ Employee # _____ Work Phone () ____ - ____

Work Address _____ City _____ State: _____ Zip _____

Other Insurance: (Group ____ Work/Comp ____ Automobile ____ Other ____) Policy # _____

Insurance Co. _____ Group# _____

Address _____ City _____ State _____ Zip _____ Phone () ____ - ____

Primary name of Insured: _____ DOB: ____/____/____ Relationship to Patient _____ SS# _____

Employer _____ Employee # _____ Work Phone () ____ - ____

Work Address _____ City _____ State: _____ Zip _____

Are you or do you think you might be pregnant? 1) Yes 2) No

17) Cause of complaint: (circle) 1) Auto Accident 2) Work Injury 3) Other Accident 4) Illness 5) Congenital 6) Unknown

I Understand and agree that health and accident insurances polices are an arrangement between an insurance carrier and me. I authorize payment for my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney's fees as may be required to effect collection.

Patient Signature _____ Date ____/____/____

PATIENT HEALTH HISTORY

Name: _____ Family Physician: _____

1) FAMILY HISTORY: (Circle as many as apply)

MOTHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

FATHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

SIBLINGS: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

2) SOCIAL HISTORY:

MARITAL STATUS: 1) Single 2) Married 3) Divorced 4) Widowed
NUMBER OF CHILDREN: (1) (2) (3) (4) (5) (6) (7) (8) (None)
DO YOU: 1) Exercise regularly 2) Eat a balanced diet 3) Obtain sufficient rest
DO YOU SMOKE? 1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (packs / day)
DO YOU DRINK COFFEE/TEA? 1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (cups / day)
DO YOU DRINK ALCOHOL? 1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (drinks / day)

3) MEDICAL HISTORY:

CHILDHOOD ILLNESSES: 1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes

LIST ANY SERIOUS CHILDHOOD ILLNESSES NOT RECORDED ABOVE.

Age: []

Age: []

Age: []

LIST ANY BIRTH DEFECTS:

HOSPITALIZATIONS & SURGERIES: If you have ever been hospitalized, list reason and dates.

M/D/Y ____/____/____

M/D/Y ____/____/____

M/D/Y ____/____/____

ADULT ILLNESSES/INJURIES: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.

M/D/Y ____/____/____

M/D/Y ____/____/____

M/D/Y ____/____/____

4) MEDICATIONS:

List all medications that you are currently taking or have taken on a regular basis in the last 6 months (include home remedies).

A) _____ B) _____

C) _____ D) _____

MEDICATIONS IN WHICH YOU ARE ALLERGIC:

A) _____ B) _____

C) _____ D) _____

INITIAL HEALTH STATUS
Chiropractic

Patient Name _____ Birthdate _____ Sex: M / F
Address _____ City _____
State _____ Zip _____ Phone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Headache Neck Pain Mid-Back Pain Low Back Pain

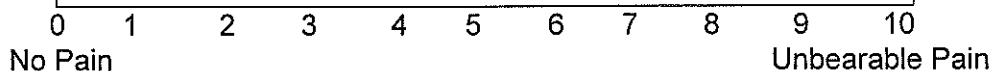
Other _____

Is this? Work Related Auto Related N/A

Date Problem Began _____

How Problem Began

Current complaint (how you feel today):



How often are your symptoms present?

(Occasional) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?)

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

In general would you say your overall health right now is:

Excellent Very Good Good Fair Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken _____ What areas were taken? _____

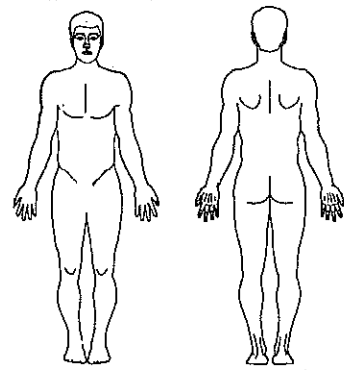
Please check all of the following that apply to you:

- Alcohol/Drug Dependence
- Recent Fever
- Diabetes
- High Blood Pressure
- Stroke (Date) _____
- Corticosteroid Use (Cortisone, Prednisone, etc.)
- Taking Birth Control Pills
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Cancer/Tumor (Explain) _____
- Prostate Problems
- Menstrual Problems
- Urinary Problems
- Currently Pregnant, # Weeks _____
- Abnormal Weight Gain Loss
- Marked Morning Pain/Stiffness
- Pain Unrelieved by Position or Rest
- Pain at Night
- Visual Disturbances
- Surgeries _____
- Osteoporosis
- Epilepsy/Seizures
- Other Health Problems (Explain) _____
- Tobacco Use - Type _____
- Frequency _____ /Day
- Medications _____

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, 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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ Date _____



Authorization to Use or Disclose Protected Health Information

Cheeley Chiropractic, Inc.
900 East Washington St., Ste 300
Colton, CA 92324
Phone: (909) 533-4591 Fax: (909) 533-4597

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 Cheeley Chiropractic, Inc. and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), and/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 the control of Cheeley Chiropractic, Inc.

I understand I have the right to:

1. Revoke this authorization by sending written notice to Cheeley Chiropractic, Inc. 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

**Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance**

Patient Name: _____

Name of Employer: _____

Claim/Group #: _____

SS#/ID#: _____

I hereby instruct and direct the _____ insurance Company
to issue check made out and mailed directly to:

Cheeley Chiropractic, Inc.

**900 East Washington St., Ste 300
Colton, CA 92324**

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

C/O Cheeley Chiropractic, Inc.

**900 East Washington St., Ste 300
Colton, CA 92324**

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 and any balance of said professional service charges over and above the 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 Patient or Patient's Authorized Representative

Date

Authorized Signature of Facility

Date