elite chiropractic & wellness center

Patient Name_____ Birthdate_____ Gender: M / F

Address_____ City_____

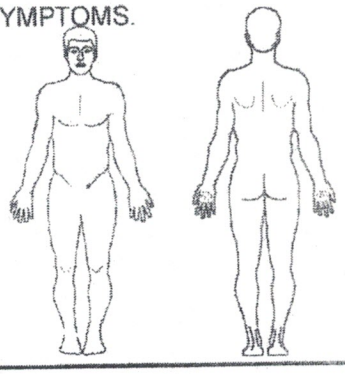
State_____ Zip_____ Phone (____)_____ Patient Height_____ Weight _____

E-mail_____ Where did you hear about us/Referred by?_____

Occupation_____ Employer_____ Work Phone_____

Primary Care Physician Name_____

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_____

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

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

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
☐ Exercise routine_____

☐ Medications/Supplements
_____
_____

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**_____

Automobile Accident Questionnaire / Report

Please answer all questions completely

Patient Name: _____ Date: _____

Have you retained an attorney? Yes _____ No _____ Not Yet _____ if so complete the following

Name of Law Office: _____
Phone# _____ ext. _____ Fax# _____
Date of accident _____ Time of accident _____:_____ AM _____ PM _____
Were the police notified? Yes _____ No _____
Were you a: driver _____ Passenger (front) _____ Passenger (rear/back seat) _____ Pedestrian _____
Were you wearing seatbelts? Yes _____ NO _____ did the airbags deploy? Yes _____ No _____

Your vehicle is a: Auto _____ Truck _____ Van _____ Motorcycle _____ Motor home _____
Bicycle _____ Other _____ Year _____ Model _____
What was the approximate damage done to the car you were in? $ _____
Was it drivable? Yes _____ No _____ did your head strike windshield/object? Yes _____ No _____
Were you rendered unconscious? Y _____ N _____ if so for how long? _____
Other vehicle: Auto _____ Truck _____ Van _____ Motorcycle _____ Motor home ____ Bicycle ____
Other _____ Year _____ Model _____ was it drivable? Yes _____ No ____

Was your vehicle hit: front __ rear __ Rt side __ Lt side __ Rt front __ Lt front __ Rt rear ___ Lt rear ___
Other vehicle contact: front __ rear __ Rt side __ Lt side __ Rt front __ Lt front __ Rt rear ___ Lt rear ___

In your own words please briefly describe the accident: _____
_____
_____
_____
_____
_____
_____
_____
_____.

What was your head position at the time of impact?
Head turned: right ____ left ____ looking back ____ straight ahead ____
Did your body strike any part of the interior vehicle: _____
_____
_____

Did you bleed or get cuts and bruises? Yes ___ No ___ if yes, bleeding _____ cuts/bruises _____
Were you taken by ambulance to the hospital? Yes ___ No ___ if yes, which one? _____
Did you receive medical attention at the scene? Yes __ No __ If yes, what type? _____

Any abnormal symptoms since the accident? _____
_____
_____

Are there any activities that have become difficult or impossible since the accident? Yes__ No__ if yes, please describe: _____
_____
_____

Have you lost any time for work as a result of this accident? Yes ___ No ___ if yes, explain below:
a. Last day worked: _____
b. Type of employment: _____
c. Are you being compensated for time from lost work? Yes _____ No _____

Did you have any physical complaints before the accident? Yes ___ No ___ if yes, please describe: _____
_____
_____
_____
_____
_____
_____.

_____ _____
Patient's / Guardian's Signature Date

CHIROPRACTIC INFORMED CONSENT / SHARED DECISION MAKING

Please read this entire document prior to signing it, It is very important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: Your chiropractic doctor or intern may use his hands or a device to manipulate the area being treated. You may feel or hear a "click" or "pop" and you may feel stimulation or other types of therapy. Your chiropractic doctor will recommend treatment that is most appropriate for your condition.

Possible risks: Chiropractic treatment is safe and the majority of patients experience improvement. Approximately 30% of patients experience slight pain in the treated area, possibly due to the next few days. Temporary minor pain may also occur with exercise, heat, cold and electrical therapy but are rare. Some soft tissue treatments may produce local discomfort, reddening of the skin, and superficial tissue bruising/soreness during and post treatment. Many factors can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illnesses., diseases or conditions.
When complicating factors are present, chiropractic treatment may be associated with serious adverse events such as fracture, dislocation, or aggravation of existing injuries. Your chiropractic doctor is aware with neck adjustments is exceedingly rare (1 in 1 to 5 million) and while current research does not refute a causal relationship, it strongly suggests associated strokes are already in progress at the start of the medications you are taking, including blood thinners, any surgeries you have had, and any other medical conditions, including osteoporosis, heart disease, numbness, cancer, stroke, fracture, or previous severe injury.

I agree to have a physical examination. I understand some testing may provoke existing symptoms but that these test are necessary to arrive to a diagnosis:

_____ _____

Patient Signature (Guardian if Minor) Date

NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Accident: _____

I do hereby Authorize Elite Chiropractic & Wellness Center to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said corporation such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due to the office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said corporation. And I hereby
further give a Lien on my case to said corporation 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 corporation for all medical bills submitted by them for service rendered me and that this agreement is made solely for said corporation 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 corporation 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 such substituted 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 corporation's interest, the corporation will not await payment and may declare the entire balances due and payable.

_____ _____

DATE 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, judgement or verdict, as maybe necessary to adequately protect and fully compensate said corporation above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____

DATE ATTORNEY SIGNATURE

_____ _____

DATE ATTORNEY'S / LAW OFFICE NAME

8620 Wilshire Blvd. Suite 610, Beverly Hills, CA 90211 Tel: (310) 880-1695 Fax: (866) 509-1539
Email: elitechirowellness@gmail.com

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please note that by signing below you are only acknowledging that you have received a copy of our Notice of Privacy Practices.

Signature **Date**

elite chiropractic
—& wellness center—

Appointment No Show and Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. **We hold a credit card on file to reserve future appointments**. We charge your credit card on file if you do not call and cancel your appointment within the timeframe below.

The doctor wants to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Circumstances have caused us to enforce a policy of charging for no show appointments, and those appointments not cancelled within 24 hours. **There is a fee of $100.00 if we do not receive a call, voicemail message or email to cancel an appointment within the 24 hours.**

Thank you for being a valued patient and for understanding and your cooperation as we enforce this policy.

_____ _____ _____

Credit Card Number Exp. Date Zip Code

Print name as it appears on credit card: _____

_____ _____

Patients Signature DATE