CORE HEALTH SPINE & SPORTS CARE

ABOUT YOU

Date:_____

First Name:_____ MI:_____ Last Name:_____

Date of Birth:_____ (please circle) Female Male

Marital Status (please circle): M S D W DP Spouses Name:_____

Address:_____City/State_____Zip Code_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Which Phone Number do you prefer to be contacted at (please circle): Home Cell Work

Email (please print legibly):_____

**we will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice

Occupation:_____ Employer Name:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Who can we thank for referring you to our office?_____

INSURANCE INFORMATION: We will make a copy of your insurance card(s)

ASSIGNMENT AND RELEASE

- I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the carrier and that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt.
- As a courtesy to you we will verify your health care benefits for this office. We cannot guarantee or be liable for any misquoted benefits. You will then be responsible for any co pay and deductibles.
- Your health insurance is a contract between you and the insurance carrier. In the rare event that your insurance company is in "bad faith" and after our office makes every attempt to have all claims paid, we will have you, the patient, be responsible for contacting your insurance carrier to have the claims paid.
- If your insurance company has not paid within 120 days of billing, then you will be responsible to pay the balance due.
- If collection efforts become necessary to enforce payment, the patient agrees to pay all collection costs, attorney's fees, and other costs associated with collecting this balance.

Patients's Signature:_____ Doctor's Signature:_____

CORE HEALTH
SPINE & SPORTS CARE
3784 CLAIREMONT DR., SAN DIEGO, CA 92117
858.272.0074 P 858.272.7574 F
WWW.COREHEALTHSD.COM

FINANCIAL POLICY

MISSED APPOINTMENTS: If unable to keep your appointment kindly give 24 hour notice. If we are not notified within the appropriate time we reserve the right to charge $25.00 for the missed appointment.

COPAYMENTS: Co-pays are due at the time of service. Our office accepts cash, personal checks, and credit cards

INSURANCE POLICIES: As a courtesy, we will bill your primary and secondary insurance policies. However, you are ultimately responsible for payment of services not covered by your insurance plan.

INSURANCE DEDUCTIBLES: If you have not met your deductible for your plan year, you are required to pay it at your appointment time.

INSURANCE CARDS: Your insurance card and complete insurance information is required at your initial visit, each benefit year and any insurance change.

By signing below, you agree that you understand and will abide by the above described financial policy. Thank you.

Print Name	Signature	Date

NOTICE OF PRIVACY PRACTICES

As your health care provider, we are 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.

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of consultation, treatment, payment or healthcare operations.

Payment
We may disclose your health information to your insurance provider(s), billing and insurance personnel, or a medical billing clearinghouse for the purpose of payment of your health care services.

Workers' Compensation
We may disclose your health information as necessary to comply with state Work Comp 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.

Other
As required by law, we may disclose your health information to the following persons or entities:

- Public Health Authorities
- Law Enforcement Officials
- Medical Examiners or Coroners
- Approved Medical Research or Review Board
- Public Safety Officers
- Specialized Government Agencies

Your Health Information Rights

- You have the right to request restriction on certain uses and disclosures of your health information. Please be advised, however, that we are 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 we amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of your denial reason(s) and information about how you can disagree with the denial.
- 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
We reserve 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.

We are required by law to maintain the privacy of your health information and to provide you with notice of your legal duties and privacy practices with respect to your health information. If your have questions about any part of this notice or if you want more information about your privacy rights, please contact our office manager.

Complaints
Complaints about your Privacy Rights or how our office handles the use or disclosure of your health information should be directed to our Privacy Officer

This notice is effective as of _____/_____/_____

Patient Signature _____

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 on 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 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 that have been associated with treatment, including, but not limited to, fractures, disc injuries, strokes, TIAs, cardiac arrest, dislocations and sprains. It should be noted that the more severe risks are extremely remote. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I 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 understand and am informed that possible alternatives to chiropractic treatment include, but are not necessarily limited to rest, physical therapy, acupuncture, massage, over the counter medication, and osteopathic/medical care involving prescription drugs and/or surgery.

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

Signature of Patient

_____

Print Patient's Name

_____

Date Signed _____

Signature of patient's representative, if necessary, (e.g., if patient is a minor or physically/legally incapacitated)

_____

Print Name of Patient's Representative

_____

Date Signed _____

Translated by (if applicable)

_____

Date Signed _____

--- Below is for Office Use Only ---

This form was verbally explained to the patient or to his/her representative by _____

on _____. Initial here as evidence of having personally performed this duty: _____

Adapted from the CCA's Fact Sheet #800 on Informed Consent

Core Health Spine & Sports Care

PATIENT NAME:_____ DATE:_____

REASON FOR VISIT

What is your primary reason for seeking care?

_____

_____

The pain is a result of: _____ When did the pain begin?_____

Are your symptoms getting worse? Y N Does anything relieve the pain? _____

Does anything make the pain worse? _____

Have you had this or similar conditions in the past? Y N If yes, explain_____

_____

Please list any other doctor (s) seen for this condition:_____ Date seen_____

Please state types of treatment received:_____ Did it help? Y / N

Name of your family physician:_____ Family physician's number:_____

Have you ever been treated by a chiropractor before? Y N Are you familiar with Active Release Techniques? Y N

The intensity of your pain ranges from? (please circle the range of intensity that you have)

Least 1 2 3 4 5 6 7 8 9 10 Most

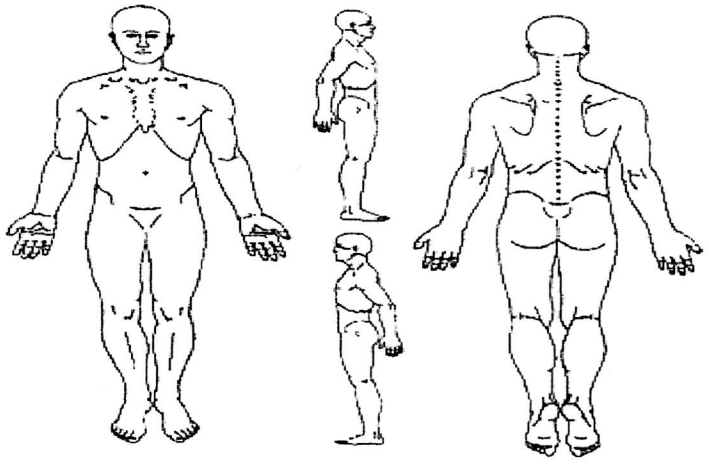
Please circle your type of pain

Dull	Aching	Sharp	Shooting	Deep	Stiffness
Burning	Throbbing	Numbness	Tingling	Nagging	Other_____

How frequent is the pain? (please circle the appropriate percentage)

0-25% 25-50% 50-75% 75-100%

Please indicate on the diagram your areas of pain by shading in those specific locations



HEALTH HISTORY

PATIENT NAME _____

Please check all that apply

	Yes	No
Diabetes		
Cancer		
High Blood Pressure		
Heart Attack		
Heart Problems		
Stroke		
Neurologic disease/injury		
Bleeding Disorder		
Infectious Diseases		
Tuberculosis		
Psychiatric problems		
Difficulty breathing		
Severe/frequent headaches		
Fainting/seizures/epilepsy		
Thyroid Disorder		
Tobacco		
Alcohol		
Caffeine		
Other _____		

Please check the appropriate box for the following test that you have had within the last year

Tests	Yes	No	Results, if known
X Ray			
CT Scan			
MRI			
Other			

Are you pregnant? Y N

Please list any surgeries

_____ Date _____

_____ Date _____

Please list all medications that you are currently taking

_____ Dosage _____

_____ Dosage _____

Please list any drug allergies

_____ Reaction _____

_____ Reaction _____

Patient's Signature _____ Physician's Signature _____