# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

## Patient Information

Name _____ Soc. Sec. # _____
*Last Name* *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

## Primary Insurance

Person Responsible for Account _____
*Last Name* *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ City _____

State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

## Reason for Visit

Have you ever seen a chiropractor? ❑ Yes ❑ No If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ❑ Worse ❑ Better ❑ Same ❑ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ❑ Sitting ❑ Walking ❑ Bending ❑ Lying down ❑ Lifting

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Aching ❑ Burning ❑ Tingling ❑ Numbness ❑ Cramping
❑ Stiffness ❑ Swelling ❑ Other _____

Is pain interfering with: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Please complete both sides.

# Health

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries you have had in the last 10 years:

| | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |
| Other Serious Injuries | | |

Women: Are you pregnant? ❑ Y ❑ N If so, how far along? _____ Nursing ❑ Y ❑ N

# Medical

Check ( ✓ ) yes or no whether you have had or currently have any of the following medical conditions?

❑ Y ❑ N Heart Attack/Stroke
❑ Y ❑ N Congenital Heart Defect
❑ Y ❑ N Alcohol/Drug Abuse
❑ Y ❑ N Fainting/ Seizures/Epilepsy
❑ Y ❑ N Shingles
❑ Y ❑ N Psychiatric Problems
❑ Y ❑ N Difficulty Breathing
❑ Y ❑ N Hepatitis
❑ Y ❑ N Anemia

❑ Y ❑ N Arthritis
❑ Y ❑ N Frequent Neck Pain
❑ Y ❑ N Jaw Pain
❑ Y ❑ N Wrist Pain
❑ Y ❑ N Shoulder Pain
❑ Y ❑ N Arm Pain
❑ Y ❑ N Leg Pain
❑ Y ❑ N Lower Back Problems
❑ Y ❑ N Severe/ Frequent Earaches

❑ Y ❑ N Ringing in Ears
❑ Y ❑ N Severe/ Frequent Headaches
❑ Y ❑ N Diabetes/Tuberculosis
❑ Y ❑ N Dizziness
❑ Y ❑ N Emphysema/Glaucoma
❑ Y ❑ N Kidney Problems
❑ Y ❑ N Artificial Bones/Joints
❑ Y ❑ N Cancer
❑ Y ❑ N HIV Positive/AIDS

❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Gout
❑ Y ❑ N Numbness, where?
_____
❑ Y ❑ N Tingling, where?
_____
❑ Y ❑ N Muscle Spasms, where? _____

# Personal

| | Heavy | Moderate | Light | None |
|---|---|---|---|---|
| Alcohol | ❑ | ❑ | ❑ | ❑ |
| Coffee | ❑ | ❑ | ❑ | ❑ |
| Tobacco | ❑ | ❑ | ❑ | ❑ |
| Drugs | ❑ | ❑ | ❑ | ❑ |
| Exercise | ❑ | ❑ | ❑ | ❑ |
| Sleep | ❑ | ❑ | ❑ | ❑ |
| Appetite | ❑ | ❑ | ❑ | ❑ |

# Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**

# Protecting Your Confidential Health Information is Important to Us

## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

### Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

### How Your HEALTH INFORMATION May be Used to

#### Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

#### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

#### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

#### In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

#### To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

## NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

### As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

### Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

### Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

### For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

### Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

### Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

### Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

### Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

### Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

### To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

**Dr. Nadia Emen, D.C.**
**www.evolutionchiropracticandwellness.com**

# Protecting Your Confidential Health Information is Important to Us

## To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

## For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

## In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

## Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

# PATIENT RIGHTS

You have the following rights related to your health information.

## Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

## Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

## Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

## Amend Your Health Information

*You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

## Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

## Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

## Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

## Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

## Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

## Patient Acknowledgment

Patient Name(s): _____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

# Evolution Chiropractic and Wellness

4601 Telephone Road, Suite 110, Ventura, CA 93003
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## INFORMED CONSENT TO CHIROPRACTIC CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure.

As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

# Evolution Chiropractic and Wellness

## FINANCIAL AGREEMENT CASH PAYMENT

Dr. Nadia Emen, D.C.
805-665-3545
4601 Telephone Road, Suite 110, Ventura, CA 93003
drnadia@evolutionchiropracticandwellness.com
www.evolutionchiropracticandwellness.com

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled.

**Payment Arrangements:**

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.

Financial arrangements will be provided on an as needed basis and must be clearly defined prior to receiving care.

**Voluntary Termination of Care:**

It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

We hope that this has answered any questions you might have regarding your financial arrangements. Once again, we would like to welcome you to our office. If, at any time, you have any questions about your case, please don't hesitate to ask.

**I have read and agree to the above.**

_____ _____

**Patient's Signature** **Date**

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# Evolution Chiropractic and Wellness

## APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your health care to Evolution Chiropractic and Wellness. When you schedule an appointment with Evolution Chiropractic and Wellness, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective immediately, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office **with at least a 24 hour notice** will be considered a No Show and charged a **$25.00** fee.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a **$50.00** fee.
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from Evolution Chiropractic and Wellness.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient and is **due at the time of the patient's next office visit.**
- As a courtesy, a reminder text and email are sent 3 days and 24 hours prior to the scheduled appointment. If you are not receiving any reminders via text and/or email, please alert Dr. Nadia so that you are set up to receive them.
- Please respect your appointment and **arrive on time**. Patients who show up at their scheduled time will be seen first. Patients who fail to arrive on time repeatedly will be rescheduled if it's the third tardy visit. Repeat offenders may be **dismissed** from Evolution Chiropractic and Wellness.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact Dr. Nadia.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

# Evolution Chiropractic and Wellness

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## HMO INSURANCE MEMBER BILLING ACKNOWLEDGEMENT FORM

Dear patients,

For those who have HMO Insurance with chiropractic care coverage, please note that your insurance **COVERS CHIROPRACTIC ADJUSTMENTS ONLY**. If you would like to receive non-covered services inclusive of manual therapy entailing stretches, use of Gua Sha tools, Leander table, or Intersegmental Traction table w/ice &/or hot packs in addition to your chiropractic adjustments, there is an additional **$20** charge besides your co-pay, if applicable.

**Please also note that cash monthly rates are steeply discounted for the services rendered**

In addition, HMO Insurance requires authorization for chiropractic visits. Please understand that more than likely, not all visits will be authorized and paid for. As such, it is your financial responsibility to pay for unauthorized or denied as medically necessary visits by your insurance carrier. Furthermore, HMO Insurance carriers typically DO NOT COVER chiropractic maintenance-type services.

I have read and understand the HMO Insurance Member Billing Acknowledgement Form and agree to its terms.

| | |
|---|---|
| _____ | _____ |
| Signature (Parent/Legal Guardian) | Relationship to Patient |
| _____ | _____ |
| Printed Name | Date |