WELCOME!

Today's Date: ____/____/____

Your Name: ______________________________[ ] Male [ ] Female

What do you prefer to be called? (Nickname)___________________

Date of Birth: ___/___/____ Age: ________

Social Security Number: ____-____-____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Home Address: ____
City: ______________________State: _______Zip:____________________
Home Phone: (___) ______________Work Phone: (___) ______________
Mobile Phone: (____) _____________Email:________________________

Emergency Contact: _________________Phone: (___)_________________

Employer: ____
Employer's Address: ____
Employer's City: _________________State: ______Zip:_______________
Occupation: ____

Who can we thank for referring us to you? __________________________
Can we contact him/her? [ ] Yes [ ] No

Health Insurance: ____
Insured's Name: ____
Insured's Social Security #:_________________________________

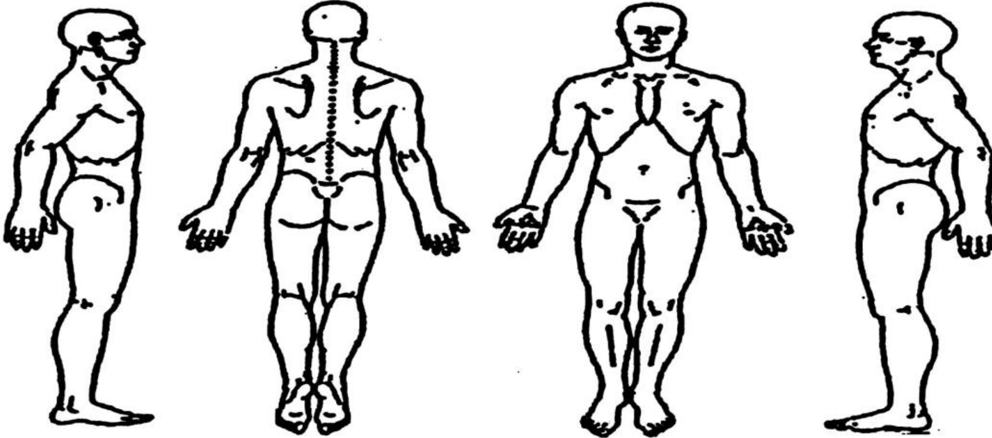
Please have front desk copy your insurance card and photo ID.

THANK YOU☺

Patient Name: ________________________________ Date: ________________

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:___________________

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____________
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? ___________

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: Height___________ **Weight** _____________ **Age** ___________

Occupation ____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis	□ Diabetes	□ Lupus
□ Heart Problems	□ Cancer	□ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:____________________________				

20. List all prescription medications you are currently taking:

____

21. List all of the over-the-counter medications you are currently taking:

____

22. List all surgical procedures you have had:

____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

____

25. Have you ever been hospitalized? □ No □ Yes

if yes, why ____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?____

Patient Signature___________________________________ **Date:**____________________

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act [HIPAA] provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information [PHI]. These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules if HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____Date_____________________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Dr. John Harman, D.C. (714)731-5433

1131 E. Main Street, Suite 106 Tustin, CA 92780

FINANCIAL POLICY

METHOD OF PAYMENT: Payment is due at the time or service. The amount due for services will depend on whether you have insurance, are self-pay, or are going through a Third Party Administrator. See below for further information regarding insurance, selfpay and Third Party Administrator. The accompanying adult to a minor patient is responsible for payment. For your convenience we accept Credit card, cash, and personal checks. .

CANCELLATION/NO SHOW FEE: While some cancellations are inevitable, cancellations with less than 24-hour notice or missed appointments (no-shows) have unfortunately become a great expense to our organization.

INSURANCE: Our services are rendered to you, not your insurance company. In most cases we will call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We will bill your insurance plan and will collect any copay, co-insurance, or deductible due by you at the time or service. Any noncovered service fees will also be collected at the time of service. If your health plan determines a service to be "not covered" or is not an eligible expense under your plan. You will be responsible for the complete charge or remaining balance of the non-covered service(s). Payment is due upon receipt of that statement from your insurance company. It is uncommon, but pre-authorization from your insurance company may be required for chiropractic care in order to receive full benefit coverage. If you are not sure pre-authorization is required for your plan, please contact our office or your insurance company to verify your plan benefits. If required, an authorization must be received by our office prior to your visit.

SELF PAY (No Insurance): Full payment is due at the time of service

PERSONAL INJURY/AUTO INJURY/WORKER'S COMP (THIRD PARTY ADMINISTRATOR)
Please advise our office on your first visit whenever you have one of the above claims. We will work with any insurance companies/attorneys involved, but please remember that you are ultimately responsible for your bill if payment cannot be obtained from another party. If you, your attorney or the insurance company does not cooperate in protecting the doctor's interest, we will not await payment and may declare the entire balance due and payable immediately.

BALANCE: Failure to pay any balance due may result in your account being turned over to an outside collection agency. This action with not compromise your care.

I have read and understand the financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice.

Patient Signature____Date_______________________