New Patient Health History Form

In order to provide you the best possible chiropractic wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name ______________ Date ________ Email ______________
Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

Mailing address

Address ______________ City ________ State _____ Zip _____
Telephone (work) ________ (home) ________ Referred By ______________
Age _____ Birth date ________ Social Security # ________ Number of children _____
Occupation ______________ Employer ______________
Marital Status ________ Spouse's name ________ Spouse's Occupation ________
Spouse's employer ______________ Spouse's health status ______________
Emergency contact ______________ Phone ______________

Current Complaints

Nature of injury: Automobile* ☐ Work ☐ Other ☐
Please describe ______________

____
Date of injury ________ Date symptoms appeared ________
Have you ever had same condition? ☐ No ☐ Yes If yes, when? ______________
List other practioners seen for this injury/condition ______________
Have you ever been under chiropractic care? ☐ No ☐ Yes
If yes, please describe ______________

Insurance Information

Name of party responsible for payment ______________ Phone ______________
Do you have health insurance? ☐ No ☐ Yes Name of company ______________
** If an auto accident please provide:*
Insurance company name ______________ Contact person ______________
Phone ______________ Claim # ______________

Billing Address

Name of the insured ______________

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature ______________ Date ______________

Spouse's or guardian's signature ______________ Date ______________

Medical History

Have you been treated for any conditions in the last year? ☐ No ☐ Yes

If yes, please describe ____

Date of last physical exam __________ Is there a chance that you are pregnant? ☐ No ☐ Yes

Have you had X-rays taken? ☐ No ☐ Yes If yes, where? ______________________________

What medications are you taking and for what conditions (Please list dosage and amounts, etc). __________

____

____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

____

____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	☐	☐	______________
Been hospitalized?	☐	☐	______________
Been in an auto accident?	☐	☐	______________
Had Sprains/Strains?	☐	☐	______________
Been struck unconscious?	☐	☐	______________
Had surgery?	☐	☐	______________

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your symptoms?

____

____

____

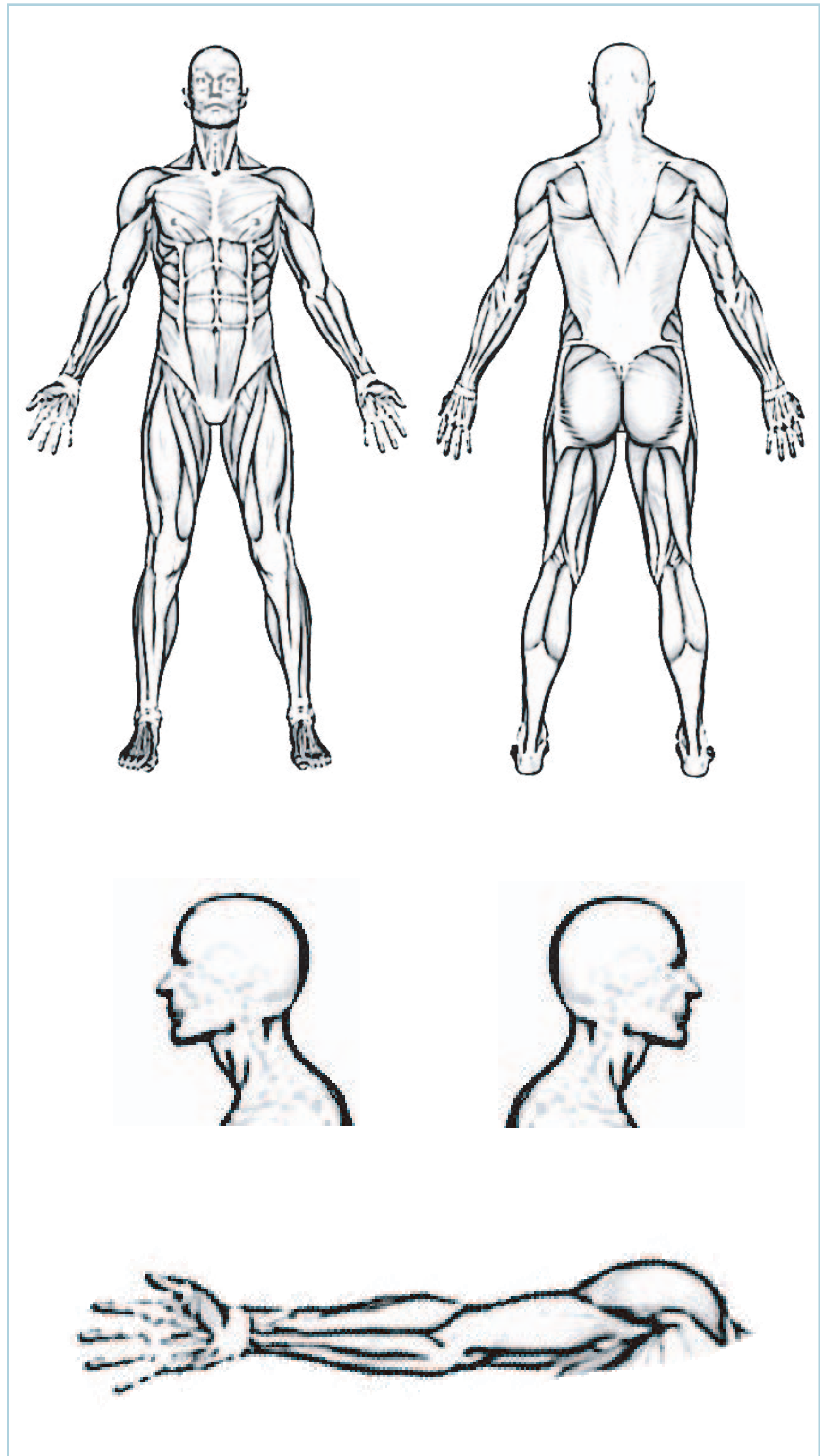
Have you ever suffered from:

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Breast lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chest Pain/Conditions
- [ ] Cold extremities
- [ ] Constipation
- [ ] Cramps
- [ ] Depression
- [ ] Diabetes
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Ears Ring
- [ ] Excessive Menstruation
- [ ] Eye Pain/Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Loss of memory
- [ ] Loss of balance
- [ ] Loss of smell
- [ ] Loss of taste
- [ ] Lumps In Breast
- [ ] Neck Pain or Stiffness
- [ ] Nervousness
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Sciatica
- [ ] Shortness of breath
- [ ] Sinus Infection
- [ ] Sleep problems/insomnia
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other:

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing



BAYSIDE CHIROPRACTIC CENTER

1200 Brittan Avenue, San Carlos, CA. 94070

NOTICE OF PRIVACY PRACTICE AND CONSENT FORM

Patients Name: ______________________________

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THESE RIGHTS ARE GIVEN TO YOU UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Bayside Chiropractic Center, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, your employer (if they are or may be responsible for the payment of your bills), or your attorney (if they are or may be responsible for the payment of your bills)
- Your name, address, phone numbers, and your health care records may be used by this office to contact you by the following means and regarding the following information:

  By Mail

  (If you would like to receive the following information at an address other than your home address, please advise us in writing)
  - Welcome and Thank You letters to the patients from the Doctor and the Team
  - Discharge and non compliance letters to the patient, from the Doctor and Team
  - Office visit reminder post cards
  - Missed office visit reminder post cards
  - Birthday cards with an offer for a free adjustment
  - Monthly billing statements and reminder letters, if appropriate
  - Newsletters with relevant information and special offers
  - Postcards or flyers regarding special events and / or discounts

  By Email
  - Newsletters and notices sent by Bayside Chiropractic Center with relevant health information and special events or offers sent to your email address
  - Information requested by you, the patient, and sent by Bayside Chiropractic Center

  By Telephone
  - Reminder calls to your home, office or cell phone from the Doctor or the team where we may leave a message on your answering machine
  - Progress / evaluations calls to your home, office or cell phone from the Doctor or team to inquire about your reaction to treatment and / or your state of health; a message may be left on your answering machine.
  - Inquiry calls may be made to your home, office or cell phone from the Doctor or team regarding billing and accident information, and any other category of information needed to enhance the billing and report process; a message may be left on your answering machine.
  - If you do not wish to be contacted at your work, please advise us in writing

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances;

- If we are providing health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care
- If we are ordered by the courts or anther appropriate agency

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

You have the right to inspect and / or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are further required by state and federal law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to who we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint to:

Bayside Chiropractic
1200 Brittan Avenue
San Carlos, CA. 94070

This notice is effective as of ______________________________. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My Signature acknowledges that I have read, understand and received a copy of this notice.

______________________	______________________	____________
Name (please print)	Signature	Date

If you are a minor, or if you are represented by another party

______________________	______________________	____________
Personal Representative (please print)	Personal Representative Signature	Date

____

Description of Authority to Act on Behalf of the Patient

BAYSIDE CHIROPRACTIC

We have prepared this easy to use check off list for your convenience. The first part is information you need to bring into the office in order for us to determine the best way to assist you with your case and to minimize your out of pocket expense. Many times your medical costs will be 100% covered by your or the other party's insurance. Please put N/A next to any of the items on the list that you don't have access to.

The second part of the list is action steps for you to take in order to report and document your case properly.

If you have any questions or concerns don't hesitate to call the office at 650.591.1002 for clarification.

Please bring these items to your next visit:

__ Police Report
__ Your auto insurance policy.
__ Your health insurance card.
__ Other party's auto insurance information.

Please take the following action steps before your next visit:

__ Call your auto insurance to report your accident.
__ Inform your auto insurance that you have suffered a bodily injury.
__ Ask for a claim number for your bodily injury claim.
__ Ask if you have Med Pay on your auto insurance policy and if yes, how much.

Insurance Policies and Guidelines

We would like to take this moment to inform you how our office will utilize your insurance benefits. We do this to ensure that all of us have a common understanding of how our office does insurance billing for the services provided to you and your family.

We ITEMIZE all of our services. The reason for this is to let your insurance company know exactly what was done on each and every visit. In reporting to your insurance company, we are responsible to them on your behalf, to accurately inform them of your health condition, progress, complications, exacerbations, unusual circumstances and we also have to let them know how long we anticipate your need for our care and at what frequency. All of this involves a tremendous amount of administrative assistance, professional time and expense. We do this as a service to you and your family.

Below is a current list of our services and charges as they will be billed to your insurance company. All fees are based on our professional association's guidelines for our specific geographical area (fees are reviewed each year for accuracy).

Service	Charge
Doctor-Patient Consultation	$110
New Patient Examination	$54-334
Re-Examinations/Report of Findings	$54-163
Chiropractic Spinal Adjustment	$54-67
Chiropractic Extra-Spinal Adjustment	$47
Neuromuscular Re-education	$57
Therapeutic Exercises	$54
Manual Therapy	$51
Chiropractic X-ray Studies	$73-230

Because we itemize all our services rather than just describe what is being done as an 'office visit', the charges per visit can vary from $50-250 per visit depending on what kind of services were performed on that specific visit. We KNOW that there are many charges that WILL NOT be paid by your insurance company for various reasons written into your policy agreement.

For example, many plans have a maximum dollar amount paid out per year, limits of service to be paid per visit, maximum dollar amount paid out per visit, and there may be limits to number of exams paid per year, just to name a few. These specific policy limitations vary greatly from insurance company to insurance company. Your benefits available under your policy may also change without notice. This is why we take the time to verify your insurance benefits when you first begin care and again at the beginning of each year.

We expect to receive denials on claims as that is the nature of the insurance industry. However, we are still going to bill for everything that we do, whether we get paid or not, as to adequately communicate with the insurance companies exactly what was done on each visit.

Our experience shows that an insurance company that receives billings which describe your visit to an office as an 'adjustment' have no understanding of what is being done and why. Some have taken the position that billings sent in this way imply that you are haphazardly receiving adjustments without any diagnostic criteria to objectively determine if an adjustment was even

needed on that visit. They look on this practice of reporting the same way they would if an MD were to just randomly give out shots or pills to every patient without FIRST determining whether or not that patient actually needed anything done during that visit. It just isn't good practice.

Some companies pay 100%, some 90%, some 80%, etc. Some pay for x-rays but not exams and visa versa, some pay for an adjustment and some pay for everything BUT the adjustment. Medicare pays for approximately 12-24 visits a year, demanding physical exams be performed but not paying for them. The list goes on and on. We only state this so that you are aware of the practices that exist within the insurance industry.

We also want you to know that you are at least responsible for your deductible and any co-pay that your policy says that you must pay. If you have an 80% / 20% policy, then the amount you are responsible for is 20%. You are also responsible to pay for your yearly deductible as per the policy agreement you have with your insurance company. Once we have received statements back from your insurance company showing the exact amount that was applied to your deductible, we will present it to you and ask for payment. This ensures that you do not over pay for your deductible.

Any payments made and sent to you by an insurance company or paying party in regard to services you have received in our office needs to be brought in to our office to be applied to your account. Payments not brought in to our office will be considered outstanding and payment for these past due bills will be your responsibility.

We request that you bring in any insurance correspondence that you may receive so that we may accurately follow up with your insurance company on your behalf. Many times you will receive information that is vital to processing a claim that was never sent to our office.

We hope the above information explains how the insurance industry works.

Please sign your name below to indicate that you have read and understand the above information. Thank You!

____ ____________________

Patient's Signature Date

BAYSIDE CHIROPRACTIC

FINANCIAL AGREEMENT
CAR ACCIDENT

We would like to take this opportunity to welcome you to the office and assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, we would like to explain how your medical bills will be handled.

Responsibility for Accident

If you were involved in an auto accident, that you were responsible for, in your own vehicle, we will bill your Med Pay portion of your car insurance policy (if available) for services rendered in our office.

If you were a passenger in another vehicle, the car insurance company that insures that vehicle may be billed for the charges of your medical services.

If another vehicle, other than the vehicle you traveled in, caused the accident, we will first bill your car insurance Med Pay portion for medical services rendered. If your car insurance policy does not include a Med Pay portion, we will require that you sign a lien and obtain an attorney. By signing the lien we agree, as a courtesy to you, to defer payment of your medical bills until your settlement is received. If care is discontinued before your treatment plan is complete, payment of your account is due immediately. This office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Responsibility for Payment

As a courtesy to you, we will provide your insurance company and attorney with all the information they might need to negotiate and provide payment for any charges you occur in our office. However, all charges for services rendered in our office are charged directly to you and ultimately you are personally responsible for payment of these charges.

We hope this has answered any questions that you might have about our financial agreements. If at any time you have further questions regarding your financial agreement please do not hesitate to ask us anything that’s on your mind.

I have read, understand and agree to the above financial agreement.

____________________________________ ________________

Patient’s Signature Date

____

Patient’s Name

____________________________________ ________________

Witness Date

BAYSIDE CHIROPRACTIC

ASSIGNMENT OF BENEFITS

Patient: ____________________________________ Date: ______________________
Employer: _____________________________________
Claim Group: __________________________________
ID Number: ___________________________________

I hereby instruct and direct ______________________________________ Insurance Company to pay by check made out and mailed to:

Bayside Chiropractic
1200 Brittan Ave.
San Carlos, CA 94070

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

C/O Bayside Chiropractic
1200 Brittan Ave.
San Carlos, CA 94070

For the professional and medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. 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, any balances of said professional service charges over and above this 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.

I authorize the doctor to initiate a complaint to the Insurance commissioner for any reason on my behalf.

Date: ________________________________

________________________________ ________________________________
Signature of Policyholder Witness

____
Signature of Claimant, if other than Policyholder

____ ____________________
Sign here if payment of the full deductible and co-payment amount would be a financial hardship on me and my family. Date

BAYSIDE CHIROPRACTIC
1200 BRITTAN AVE.
SAN CARLOS, CA 94070
PH: 650.591.1002 FX:650.596.9406

MEDICAL LIEN

Patient: ____
Claim Nr: ____
Date of Injury: ____

I hereby authorize Bayside Chiropractic to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to Dr. Joseph Bayside such sums as may be due and owing him for chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges injured for the injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

____________________ ______________________________
Date Patient's Signature

The undersigned attorney does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

____________________ ______________________________
Date Attorney's Signature

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENTS THAT: the undersigned has made, constituted and appointed Bayside Chiropractic and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful Attorney. If fact for and in the undersigned's name, place and stead to endorse any and all checks, drafts and/or money orders which are made payable to the undersigned alone or to the undersigned and Bayside Chiropractic to pay for Chiropractic services or the like at the request or within the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto the said office of Bayside Chiropractic the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of aid check, draft or money order are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the office of Bayside Chiropractic as Attorney In Fact, in accordance with this special power of attorney and shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands this ______________ day of _______________, 20________.

______________________________________	_____________________________________
Patient's Full Name (typed)	Witness's Full Name
______________________________________	_____________________________________
Signature of Patient	Signature of Witness