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?

_____

_____

_____

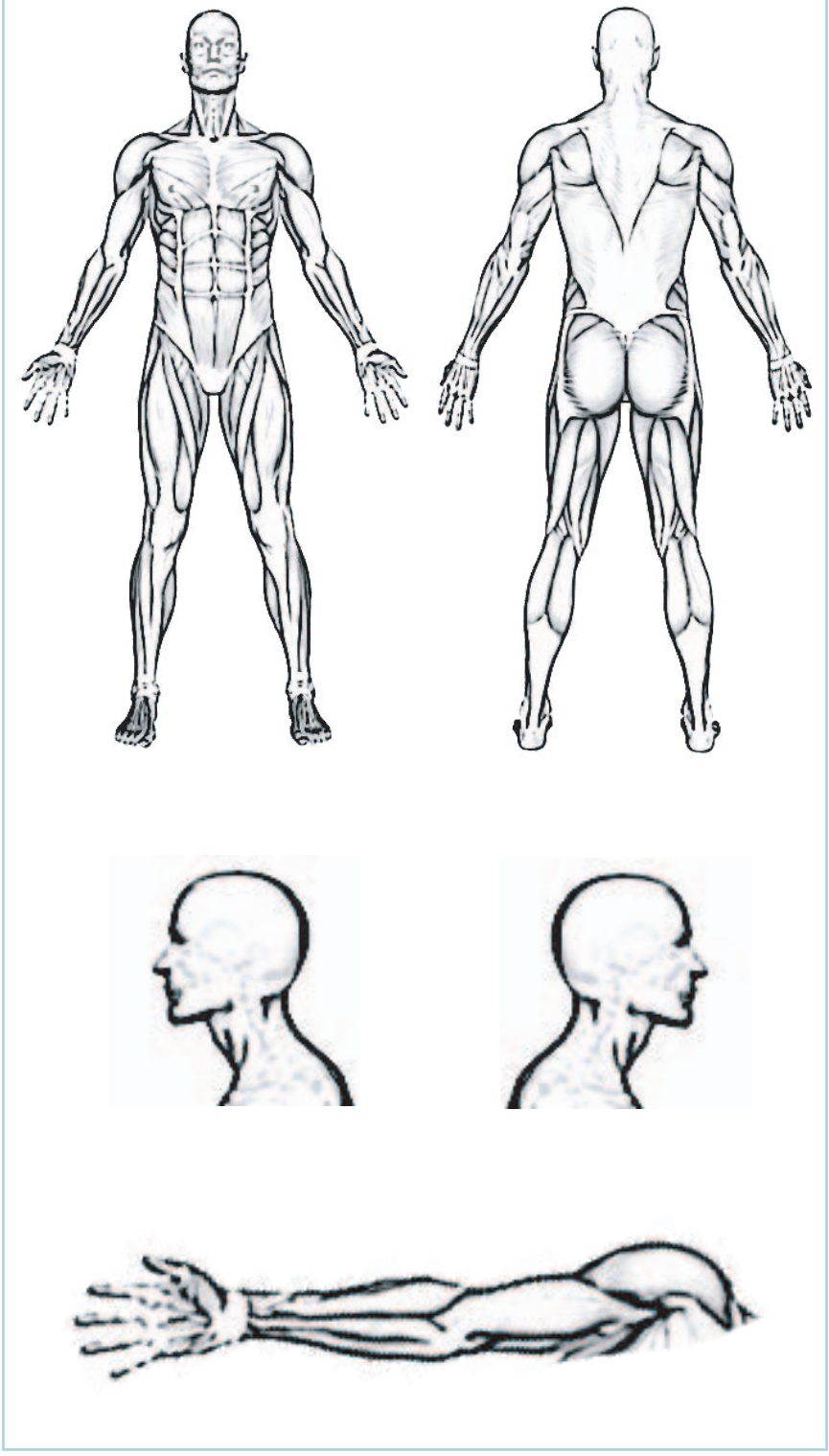
Have you ever suffered from:

- 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

_____ _____

Patient's Name Medicare Claim Number

Advanced Notice of Non-covered Services

Physician Notice:
In accordance with the Medicare Act, Section 1842 (I), this letter is to advice you that Medicare will only pay for services that determines to be "reasonable and necessary" under Section 1862 (a)(i) of the Medicare Act. If Medicare determines that a particular service, although it would be otherwise covered, is not "reasonable and necessary", under Medicare program standards, Medicare will deny payment for that service. I believed that in your case, Medicare is likely to deny payment for:

Procedure description: Any procedures done other than chiropractic adjustments including but not limited to myofascial release, examinations, re-examinations, orthopedic supplies, rehabilitative services, x-rays, Surface EMG, neuromuscular re-education.

Treatment plan (or dates of service): Any visits over 12 per year.

The reason for this denial is: Medicare pays only for chiropractic adjustments. They don't pay for exams, x-rays, or any other office procedures.

Beneficiary Agreement

I have been notified by my physician, that he or she believes that, in my case, Medicare is likely to deny payment for the service(s) identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ _____

Patient/Beneficiary's Signature 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

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).

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

BLUE SHIELD SUBSCRIBERS

Blue Shield is making it increasingly more difficult for their subscribers to utilize out-of-network doctors. The latest is that they no longer honor the assignment-of-benefit agreement signed by our patients that implicitly instruct Blue Shield to mail all payments and statements to Bayside Chiropractic. In order to continue to offer excellent chiropractic services at a minimum out-of-pocket cost for you and your family we will need your help.

Bayside Chiropractic will continue to prepare all billings for services rendered and mail them to your insurance company as a service to our patients. Please be aware that all statements will be mailed to your home address and all checks will be made out in your name. It will be your responsibility to bring in all statements and checks related to your care at Bayside Chiropractic to the office. All checks related to your care at Bayside Chiropractic needs to be signed over to Bayside Chiropractic.

Even if you receive a statement without a check attached please bring it in so that we may properly follow-up with Blue Shield regarding any denied billings and ensure that your benefits are being protected. If you receive anything from your insurance company that you're not sure what to do with or how to respond to please bring it into the office and we will be glad to assist you. Often questionnaires, short forms and requests are mailed out to the patient. Without the proper response to these inquiries all future bills will be held up and go unpaid.

Any payments received from Blue Shield are in addition to the co-payment and deductible amounts you and your family make in the office. Without the checks from your insurance company we would not be able to offer you chiropractic services at such a low out-of-pocket expense for you and your family.

If you prefer you may pay for all services at the time they are rendered and then submit a statement to your insurance company for reimbursements.

Please initial your preferred option below:

_____ I understand and agree that I am responsible for bringing in all correspondence from Blue Shield pertaining to Bayside Chiropractic for me and my family. I agree to continue making co-payments and deductible payments to Bayside Chiropractic.

_____ I understand and agree that I am responsible for full payments of services rendered for me and my family. I agree to mail in statements for reimbursement from Blue Shield on my own.

Name: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____