INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

Name and address of office:
Contreras Chiropractic
4200 East Ave. Suite #102
Livermore, CA 94550

Doctor treating this patient:
Dr. Gerardo D. Contreras, D.C.

Patient's Name: _____

You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I hereby request and consent to the performance of procedures which are within the scope of practice of chiropractic including, but not limited, to chiropractic adjustments, various modes of physical therapy and diagnostic x-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above 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 above, including those working at the office listed above or any other office, whether signatories to this form or not.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop", and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment he/she determines is most appropriate for your condition.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. I understand an undesirable result does not necessarily indicate an error in judgment. I understand that results are not guaranteed, and there are risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment.

I understand and I am informed that there are some risks to chiropractic treatment, including but limited to; fractures, disc injuries, dislocations, sprains/strains, burns or frostbite (physical therapy), worsening/aggravation of spinal conditions, increased symptoms and pain, no improvement of symptoms or pain, and bruising.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

Permission for Physical Contact: I understand that, in the course of various chiropractic examination procedures and treatment methods, the doctor of chiropractic or other clinical staff may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment, and is prohibited. Nevertheless, I also realized that some chiropractic procedures may require that the doctor or clinician contact me in some physically sensitive areas. I understand, however, that before any sensitive contact or procedure occurs the doctor or other clinical staff will explain to me; what is to be done, how it will be performed, why it will be performed, that I may refuse that particular test or procedure, or alternatively that I may request that another member of the staff be present for my safety and protection, and finally, that I will be given the oppurtunity to signal the doctor or clinician when I am ready to continue the test or procedure. I also agree that if I ever have any questions, doubts, or misgivings about the appropriateness of such contact I can discuss my concerns with the doctor, or other office or clinicial staff member. Finally, it is my understanding that I may revoke this permission at any time by a mutual exchange of written acknowledgments indicating that permission for any further physical contact by the doctor or other staff member with my person is prohibited.
I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused my pain in the past.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

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Initial Health Status

Patient Name: _____ Birth date: __/____/____ Age: _____ Sex: M / F

Address:_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Marital Status: S M D W Spouse: _____

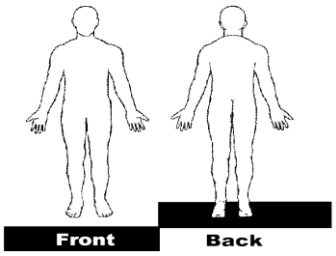
Social Security #: _____Driver's License #: _____Referred By: _____

Good News! We offer appointment reminders via text or email. Choose from one of the following options:

Email: _____ or Cell Phone:_____

Phone Carrier (*ex. T mobile, AT&T*): _____

MARK AN X ON THE PICTURE WHERE YOU
HAVE BEEN HAVING PAIN OR OTHER SYMPTOMS



Describe your current problem and how it began:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Arm pain ☐ Shoulder pain
☐ Hand pain ☐ Low back pain ☐ Leg pain ☐ Foot pain ☐ Other: _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date problem began; _____

How problem began; _____

_____

In general would you say your overall health right now is;

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

In the past week, how much has your pain interfered with your daily activities?

(e.g., work, social activities, or household chores)

0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No interference **Unable to carry on any activities**

How do you feel today? (Mark an X on the line)

Best ◄——————————► Worst

Pain Scale

0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐1

No Pain **Unbearable Pain**

On a daily basis, how often are your symptoms present?

☐0-25% ☐26-50% ☐51-75% ☐76-100%

Can you perform your daily activities? ☐Yes ☐No If no, please describe: _____

Have you seen another: M.D. _____ D.C. _____ ☐Other:_____

Have you had: ☐X-Rays ☐MRI ☐CT Scan Date Of: _____ Where: _____

What areas were taken? _____

Please check all of the following that apply to you: ☐ **None apply**

No	Yes	Condition	No	Yes	Condition
__☐	__☐	History of recent infection	__☐	__☐	Prostate problems
__☐	__☐	Recent fever	__☐	__☐	Frequent urination
__☐	__☐	HIV/AIDS	__☐	__☐	Pregnancy/ # of births: _____
__☐	__☐	Diabetes	__☐	__☐	Abnormal weight ☐ gain ☐ loss
__☐	__☐	Corticosteroid use	__☐	__☐	Epilepsy / Seizures
__☐	__☐	Recent trauma	__☐	__☐	Cancer/Tumor; type: _____
__☐	__☐	Birth control pills	__☐	__☐	Marked morning pain/stiffness
__☐	__☐	Menstrual problems	__☐	__☐	Pain at night
__☐	__☐	Visual disturbances	__☐	__☐	Pain unrelieved by position or rest
__☐	__☐	High blood pressure	__☐	__☐	History of low/mid back pain
__☐	__	Stroke / Date: _____	__☐	__☐	History of neck pain
__☐	__☐	Dizziness/Fainting	__☐	__☐	History of headaches or migraines
__☐	__☐	Numbness in groin/buttocks	__☐	__☐	Arthritis
__☐	__☐	Urinary retention	__☐	__☐	History of alcohol use
__☐	__☐	Bowel /Bladder problems	__☐	__☐	History of tobacco use
__☐	__☐	Osteoporosis/osteopenia	__☐	__☐	Other health problems (explain) _____
__☐	__☐	Aortic aneurysm	_____		

Family History:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular problems/Strokes ☐ Rheumatoid Arthritis

Please list/provide your past surgeries:

_____

_____

Please list/provide your current medications:

_____

_____

- I agree to pay in full for all services rendered at the time of visit, unless other arrangements have been made and agreed to. If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for the legal fees, collection agency fees, and any other expenses incurred in collecting my account balance.
- I authorize the staff to perform any necessary services needed during treatment.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand that I am liable for all charges for services rendered.
- I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.
- We reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.
- **The missed appointment fee is $20.00.**

_____	_____	_____
Print Patient Name	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

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IN THE EVENT OF AN EMERGENCY

Who should we contact? _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Who is your medical doctor? _____ Phone #: _____

Nearest relative not living with you: _____

Relationship to you? _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

ACCOUNT INFORMATION

Person ultimately responsible for this account

Name: _____ Relation: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Driver's License #: _____ Phone #: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my insurance/financial status.

☐ Adult Patient ☐ Parent/Guardian ☐ Spouse _____ Date: _____

Signature

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for us both to be working towards the same objectives.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine and or extremities.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral and/or extremity subluxation.

I,_____ have read and fully understand the above statement.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____

(Signature) (Date)

HIPAA GUIDELINES PRIVACY NOTICE

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

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

*Your protected 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 company, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.

*Your name, address, telephone number, e-mail address and health records may be used to contact you, regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

This office utilizes an "open-treatment" environment for ongoing patient care. "Open-treatment" involves several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing routine details or care, are discussed within earshot of other patients and staff. The use of sign in sheets and treatment cards may reveal your name to other patient's incidental to being treated in the office.

You have the right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have the right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted, and may be required to use or disclose your health information without your authorization in these following circumstances:

*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 judgment, we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of such disclosures made by the office.

Any use of disclosure of your protected health information, other than as outlines above, will only be made upon your written authorization. If you provide an authorization for release of information, you have the right to revoke that authorization at a later date.

(SEE REVERSE SIDE)

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

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a specific form, please advise us in writing as to your preference.

We reserve the right by state and federal law to maintain the privacy of your patient file and health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by 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.

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: Dr. Contreras.

If you would like further information about our privacy policies and practices please contact: Dr. Contreras.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office of with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created.

_____ _____ _____

Printed Name Signature Date

If you are a minor, or if you are being represented by your parent or guardian:

_____ _____ _____

Printed Name Signature Date