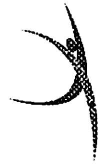


Conscious Chiropractic & Acupuncture

Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information.

Date_______________ Patient Name____ Patient #__________________

SSN_______________________ ☐ Male ☐ Female Birthdate______________ Home phone__________________

Work phone___________________ Cell phone____________________ Email address______________________________

Address____ City______________________ State_____ Zip___________

Check appropriate box: ☐ Minor ☐ Single ☐ Married/Significant other

Employer____ Occupation________________________________

Business address_______________________________ City______________________ State_____ Zip___________

Spouse or parent's name____ Employer_____________________________

Work phone___________________________ Occupation____

Whom may we thank for referring you?____

Please provide us the names of any healthcare providers whom you trust and think we should include in our list for referrals. ____

Person to contact in case of emergency____ Phone____________________

Do you have Medpay as part of your auto insurance policy? ☐ Yes ☐ No amount? ___________________________

Insurance Information

Name of insured____ Relationship to patient__________________

Is this person currently a patient at our office? ☐ Yes ☐ No ☐ N/A

Birthdate______________ Social Security Number_______________________ Date employed___________________

Name of employer____ Work phone__________________________________

Address of employer_____________________________________ City___________________ State____ Zip__________

Insurance company____________________________________ Group #_____________Union or local #______________

Ins. co. address____ City_________________ State____ Zip_________

How much is your deductible?________________ Amount used?_______________ Max. annual benefit?____________

Do you have any additional insurance? ☐ Yes ☐ No

If yes, complete the following:

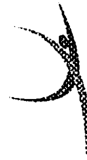
Name of insured____ Relationship to patient__________________

Birthdate______________ Social Security Number_______________________ Date employed___________________

Name of employer____ Work phone__________________________________

Address of employer_____________________________________ City___________________ State____ Zip__________

Insurance company____________________________________ Group #_____________Union or local #______________



Conscious Chiropractic & Acupuncture

Health History

Welcome to Conscious Chiropractic & Acupuncture. Please fill out this questionnaire.

Date: ____________

Patient name ______________________ Birthdate __________ Patient # ____________

Why are you seeing the doctor? ______________________________

This is a ☐ New ☐ Old illness? If treated before, what was done? ______________________________

By whom? ______________________ When? ____________

Describe your dietary/nutritional habits ______________________________

Do you exercise regularly? ☐ Yes ☐ No Type of exercise & duration: ______________________________

Doctor Notes:

Previous Hospitalization/Surgeries/Serious Illnesses When Hospital, City, State

Medications: (Include non-prescription) ______________________________

Auto accidents: ______________________________

Patient social history

Marital status: ☐ Single ☐ Married/Significant other

Alcohol use: ☐ Never ☐ Occasionally ☐ Daily

Tobacco use: ☐ Never ☐ Previously, but quit ☐ Current packs/day ________

Recreational drug use: ☐ Never ☐ Previously, but quit ☐ Type/Frequency ______________

Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ Noise

Person to contact in case of emergency ______________ Relationship __________ Phone __________

Family Health Information

Information about your immediate family members (brothers, sisters parents, grandparents) will give us a better understanding of your total health picture.

Relationship Significant present and past health problems

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch supports

How old is your mattress? __________ Is it comfortable? ☐ Yes ☐ No

How old is your pillow? __________ Type of pillow ______________ Is it comfortable? ☐ Yes ☐ No

For women: If using birth control methods, what type? ______________________________

Are you pregnant? ☐ Yes ☐ No LMP __________ Nursing? ☐ Yes ☐ No

Past Medical History

Have you ever had the following: (circle "no" or "yes", leave blank if uncertain)

Condition		
Measles	no	yes
Anemia	no	yes
Hepatitis	no	yes
Mumps	no	yes
Bladder infection	no	yes
High blood pressure	no	yes
Chickenpox	no	yes
Epilepsy	no	yes
Low blood pressure	no	yes
Migraine Headache	no	yes
Hemorrhoids	no	yes
Scarlet Fever	no	yes
Tuberculosis	no	yes
Ulcer	no	yes
Diphtheria	no	yes
Diabetes	no	yes
Asthma	no	yes
Cancer	no	yes
Hives or Eczema	no	yes
Pneumonia	no	yes
Polio	no	yes
AIDS or HIV+	no	yes
STD	no	yes
Rheumatic Fever	no	yes
Glaucoma	no	yes
Infectious Mono	no	yes
Heart disease	no	yes
Hernia	no	yes
Bronchitis	no	yes
Arthritis	no	yes
Thyroid Disease	no	yes
Mitral Valve Prolapse	no	yes
Kidney Disease	no	yes
Stroke	no	yes

Please list any other conditions ______________________________

____

Review of Systems: Please indicate any personal history below:

☐ Constitutional Symptoms		
Good general health lately	no	yes
Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes
Headaches	no	yes

☐ Eyes		
Eye disease or injury	no	yes
Wear glasses / contact lenses	no	yes
Blurred or double vision	no	yes

☐ Ears/Nose/Mouth/Throat		
Hearing loss or ringing	no	yes
Earaches or drainage	no	yes
Chronic sinus problem or rhinitis	no	yes
Nose bleeds	no	yes
Mouth Sores	no	yes
Bleeding gums	no	yes
Bad breath or bad taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes

☐ Cardiovascular		
Heart trouble	no	yes
Chest pain or angina	no	yes
Palpitations	no	yes
Shortness of breath	no	yes
Swelling (feet, ankles or hands)	no	yes

☐ Musculoskeletal		
Joint pain	no	yes
Joint stiffness or swelling	no	yes
Weakness of muscle or joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Neck pain	no	yes
Cold extremities	no	yes
Difficulty walking	no	yes

☐ Genitourinary		
Frequent urination	no	yes
Burning / painful urination	no	yes
Blood in urine	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Male – testicle pain	no	yes
Female – painful periods	no	yes
irregular periods	no	yes
vaginal discharge	no	yes
# of pregnancies	______	
# of miscarriages	______	
date of last pap smear	______	

☐ Integumentary		
Rash or itching	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose veins	no	yes
Breast pain or lump	no	yes
Breast lump	no	yes
Nipple discharge	no	yes

☐ Neurological		
Frequent headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness or tingling	no	yes
Tremors	no	yes
Paralysis	no	yes
Head injury	no	yes

☐ Psychiatric		
Memory loss or confusion	no	yes
Nervousness	no	yes
Depression	no	yes
Insomnia	no	yes

☐ Gastrointestinal		
Loss of appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Painful bowel movements or constipation	no	yes

☐ Endocrine		
Glandular or hormone problem	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Skin becoming dryer	no	yes
Change in hat or glove size	no	yes

☐ Hematologic/Lymphatic		
Slow to heal after cuts	no	yes
Bruising easily	no	yes
Anemia	no	yes
Phlebitis	no	yes
Past transfusion	no	yes
Enlarged glands	no	yes

☐ Respiratory		
Chronic or frequent coughs	no	yes
Spitting up blood	no	yes
Wheezing	no	yes

☐ Allergic/Lymphatic		
History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	no	yes
Novocaine or other anesthetics	no	yes
Aspirin or other pain remedies	no	yes
Iodine, Merthiolate or other antiseptic	no	yes

Other allergies: ______________________________

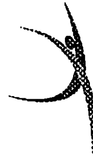
____

____

Signature of Patient, Parent or Guardian ______________________________ Date ______________

Doctor Review

Signature of Doctor ______________________________ Date ______________



Conscious Chiropractic & Acupuncture

Office Policies

Welcome to Conscious Chiropractic & Acupuncture. We are pleased you have chosen us for your health and wellness needs.

At our Wellness Spa, we treat you as an individual. Beyond treating specific injuries, we customize your therapy to meet your broader health goals, striving to offer treatment that enhances your overall wellness.

Our practice began over 12 years ago as a Chiropractic practice and has since expanded to include Acupuncture and Massage Therapy as core services. Based upon patient feedback, we have added as additional services individual diet and nutrition counseling, weight management, herbal medicine, optimal fitness training programs, exercise and injury rehabilitation, among others. Complex cases may be co-managed by several practitioners who consistently communicate with one another regarding your progress.

Our staff works to make your experiences at our office pleasant, efficient and beneficial. Since we schedule to be ready for you at your specific time, we ask that you please be on time for your appointment. A routine office visit is 10 minutes in length. We understand that some circumstances require more time; for example, a new injury or extreme pain. If you think you may require a longer appointment, please ask the office staff to schedule accordingly. Occasionally, we need to treat an emergency that takes longer than we have anticipated. If we are running behind, we ask for your patience and understanding.

If you are unable to keep your scheduled appointment, we ask that you let us know as soon as possible so we may schedule another person who needs our services into that time slot. Since we often have a waiting list, a late cancellation means someone else missed out on an appointment. There is a 24-hour cancellation policy for chiropractic appointments and a 48-hour cancellation policy for massage appointments. A missed Chiropractic appointment will be billed at $35 and a missed massage therapy or other appointment will be billed at the applicable full charge.

Our holistic approach to healthcare includes awareness that, in some cases, you may need a specialty that we do not offer. We can refer you to physicians with a like-minded commitment to consider you as the whole person you are. In some cases, to facilitate your recovery or optimal health, we may determine that co-management of your cases is the best choice.

We know you have a choice in health care and we are committed to exceeding your expectations. Please let us know if there is anything we can do to make your visits with us more comfortable.

Payments

We request payment at the time of services rendered. A 1.5% interest will accrue and be assessed monthly to accounts 30 days past due. Accounts are delinquent at 45 days and are subject to a continuing compounded interest each month.

Financial arrangements are subject to renewal at the start of each New Year. Should changes arise in your medical or financial situation that would affect your current financial agreement, you much notify our office prior to your next appointment. Should you discontinue care or be released from further service at our office, all outstanding balances will be due. Our office accepts cash, checks, Visa and MasterCard. Exceptions to this policy are detailed below.

Major Medical Insurance

If you have health insurance, please ask our staff for a 'superbill' of services rendered for you to submit to your insurance company for reimbursement. Although we cannot guarantee any reimbursement from your health insurance company, we are glad to answer any questions concerning the billing process. To enable us to better assist you, if you are not sure of your insurance benefits, please ask us for an insurance verification form. In some cases, as a courtesy to you, we will bill your insurance company. To do this, we will require an assignment of benefits to allow us to be paid directly by your insurance company.

Conscious Chiropractic & Acupuncture

Insurance Assignment

Our office accepts insurance assignment under special conditions. After insurance coverage has been verified, we will submit claim forms directly to your insurance company and collect your patient co-payment and deductible, if applicable. However, please understand that this is a courtesy to you, and that you are fully responsible for any amount not paid by your insurance. The contract for health insurance is of course between you and your insurance company.

Carefully review your "Explanation of Benefits" when you receive it in the mail. Call your insurance carrier directly to resolve any discrepancies on your claims to avoid out of pocket expenses.

We will make every attempt to facilitate the processing of claim forms. Verification of benefits by our office does not guarantee that the insurance company will pay your claim. We will not enter into a dispute with your insurance company over your claim; however, we may ask you to consider filing a dispute on our behalf.

In the event that your insurance company or attorney inadvertently sends payments to you for services we have performed, any checks should be endorsed and sent to Conscious Chiropractic & Acupuncture with the Explanation of Benefits that normally accompanies the check.

Worker's Compensation

If you have sustained an injury on the job, and it is determined to have occurred during work related to your employment, your treatment will be covered under Worker's Compensation coverage and billing will be performed entirely through our office.

Personal Injury

If you have sustained a non-work related personal injury, we may be able to bill your med pay or major insurance. There may be an occasional case in which, at your doctor's discretion, CC&A is willing to treat you on a lien. This means that payment to our offices will occur once a legal case is settled. Please be aware that we do not discount our bill at the end of treatment for any reason.

Additional Fees & Information

Returned checks will be assessed a $20.00 fee. An interest rate of 1.5% monthly may be applied to any unpaid balances.

In signing below, I understand these policies and agree to pay for treatment accordingly, and also agree that I am responsible for any unpaid balances. I further understand that with regard to personal injury legal cases, any monies due to CC&A must be paid no later than 15 days following the date of settlement. Withholding payment or defaulting on a medical debt is considered a legal breech of this contract. I understand that CC&A may report me to a credit-reporting agency or take legal action as necessary to be paid for services rendered.

______________________	______________________
PATIENT NAME (PRINTED)	DATE
______________________	______________________
SIGNATURE	Driver's License Number

Conscious Chiropractic & Acupuncture

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or her preceptor 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 below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which she feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided or forward a copy in via e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already take action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_______________________________________ ____________________

Name (Printed) Date Signed

____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

____

Witness to Patients' Signature

Conscious Chiropractic & Acupuncture
Summary and Acknowledgement of Receipt of Notice of Privacy Practices

1. Conscious Chiropractic & Acupuncture's ('CC&A' or "The Practice") Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my treatment and to carry out its healthcare operations. CC&A to provide treatment to me, to obtain payment for that treatment for that treatment and to carry out its healthcare operations. CC&A explained to me that the Privacy Notice will be available to me at any future appointment and at my request at any other time.

2. CC&A reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand, and consent to, the following communications that may be used by CC&A: a) a postcard mailed to me at the address provided by me; and b) telephoning and leaving a message on my voice mail, answering machine or with the individual answering the phone; and c) sending an electronic mail to the address of record, provided by me to CC&A; and d) a Thank You card mailed to the person/entity whom has referred me to this office.

4. CC&A may maintain a directory of and sign-in log for individuals seeking care and treatment in the office. This information may be seen by, and is accessible to, others who are seeking care of services in the Practice's offices.

5. CC&A may use and/or disclose my PHI in order for CC&A to treat me and obtain payment for that treatment, and as necessary for CC&A to conduct its specific healthcare operations.

6. I understand that I have a right to request that CC&A restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or healthcare operations. However, CC&A is not required to agree to any restrictions that I have requested. If CC&A agrees to a requested restriction, then the restriction is binding on CC&A.

7. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that CC&A has already taken action in reliance on this consent.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then CC&A will not treat me. I understand that if I revoke this consent at any time, CC&A has the right to refuse to treat me.

I acknowledge that I have received a copy of Conscious Chiropractic & Acupuncture's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy at each appointment.

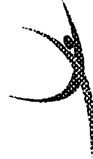
- I would like to receive a copy of any amended Notice of Privacy Practices by email at:

  ____

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer by phone at 415.677.9900. Signature below is an acknowledgement that you have received this Notice of Privacy Practice and that you have read and understood the foregoing notice, Notice of Privacy Practices, and all of your questions have been answered to your full satisfaction in a way that you can understand.

________________________________ ____________________
Name (Printed) Date Signed

____
Signature: Patient or Legal Representative (Attorney, Guardian, Parent)



Conscious Chiropractic & Acupuncture

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FOR PRIVATE INSURANCE, GROUP INSURANCE, AUTO INSURANCE AND/OR OTHER HEALTH INSURANCE

Patient Name ______________________________

Employer______________________________

Claim/Group # ______________________________

I hereby instruct and direct the ______________________ Insurance Company to make checks payable to and mailed directly to:

____
Doctor Name
Conscious Chiropractic & Acupuncture
220 Montgomery Street, Suite 305
San Francisco, CA 94104

OR

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

c/o ______________________
220 Montgomery Street, Suite 305
San Francisco, CA 94104

For professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. As payment towards the total charges of the professional services rendered to me at Conscious Chiropractic & Acupuncture, I assign to CC&A, the professional/medical expense benefits allowable, and otherwise payable to me under my current insurance policy. This payment will not exceed my indebtedness to CC&A, and I will have to pay, in a timely manner, any balance owed to CC&A for professional service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company, claims adjuster, or attorney involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original.

Dated at San Francisco County, this ________ day of __________________, 200___.

______________________ ______________________
Signature of Policyholder Witness