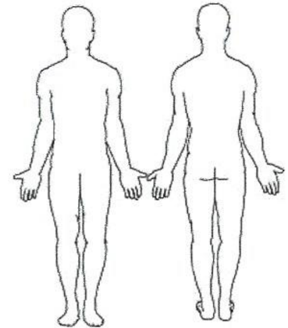
CHIROPRACTIC REGISTRATION AND HISTORY FORM

Patient Name: ______________________________ Birthdate: ______________ Sex: M / F
Address: ______________________________ City: ______________
State: ________ Zip: ____________ Cell Phone: ( ) ____________ Home Phone: ( ) ____________
I agree to accept text messages on my cell phone: ☐ Yes ☐ No Patient Primary Language: ______________
Do you require specific communication needs such as an interpreter and/or translation service? ☐ Yes ☐ No
Occupation: ____________ Employer: ______________________ Work Phone: ( ) ____________
Address: ______________________________ City: ____________ State: ______ Zip: ____________
Subscriber Name: ______________________________ Health Plan: ______________________
Subscriber ID#: ______________________ Group #: ______________ Spouse Name: ______________
Spouse Employer: ______________________ City: ____________ State: ______ Zip: ____________
Primary Care Physician Name: ______________________________ PCP Phone ( ) ____________
Emergency Contact Name: ____________________ Phone: ( ) ____________ Relationship: ____________

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

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low-back Pain ☐ Leg Pain
☐ Arm Pain ☐ Shoulder Pain ☐ Other: ____________________
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began: ______________________________
How Problem Began: ______________________________



Current complaint (how you feel today):

|____|

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0-25% ☐ 25-50% ☐ 51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?)

|____|

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL XRAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ____No ____Yes
Date(s) taken: ______________________________ What areas were taken? ______________________

What treatments have you received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other______________________

Name and address of other doctor(s) who have treated you for your condition______________________

Date of Last: Physical Exam: ____________ Spinal X-Ray: ____________ Blood Test: ____________
Spinal Exam: ____________ Chest X-Ray: ____________ Urine Test: ____________
Dental X-Ray: ____________ MRI, CT-Scan, Bone Scan: ____________

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Pack/Day__________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week__________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day__________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason__________

Injuries/Surgeries you have had	Description	Date
Falls	______________________	________
Head Injuries	______________________	________
Broken Bones	______________________	________
Dislocations	______________________	________
Surgeries	______________________	________

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
________________	________________	________________
________________	________________	________________
________________	________________	________________

Please check all of the following that apply to you:

☐ AIDS/HIV	☐ Alcoholism	☐ Allergy Shots	☐ Anemia
☐ Anorexia	☐ Appendicitis	☐ Arthritis	☐ Asthma
☐ Bleeding Disorders	☐ Bronchitis	☐ Bulimia	☐ Cataracts
☐ Chemical Dependency	☐ Chicken Pox	☐ Corticosteroid Use	☐ Diabetes
☐ Dizziness/Fainting	☐ Emphysema	☐ Epilepsy/Seizures	☐ Fractures
☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herniated Disk
☐ Herpes	☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease
☐ Liver Disease	☐ Marked Morning Pain/Stiffness	☐ Measles	☐ Menstrual Problems
☐ Migraine Headaches	☐ Miscarriage	☐ Mononucleosis	☐ Multiple Sclerosis
☐ Mumps	☐ Numbness in Groin/Buttocks	☐ Osteoporosis	☐ Pain at Night
☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problems	☐ Prosthesis	☐ Psychiatric Care
☐ Recent Fever	☐ Rheumatoid Arthritis	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Stroke – Date: ___________	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Typhoid Fever	☐ Ulcers	☐ Urinary Problems
☐ Vaginal Infections	☐ Venereal Disease	☐ Visual Disturbances	☐ Whooping Cough
☐ Taking Birth Control	☐ Cancer/Tumor (explain)__________________________		☐ Abnormal Weight Gain/Loss

☐ Pregnant, # of weeks ______

☐ Other Health Problems (explain)____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge; the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. 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.

Patient Signature____ Date_____________________

Guardian Signature____ Date_____________________
(if minor)

Dr. Janet Laney D.C. 6170 Thornton Avenue, Suite H, Newark, CA 94560 (510)792-9000

PATIENT NAME:______________________________ PATIENT PRIMARY LANGUAGE:_______________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sing if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", must as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

___spinal manipulative therapy ___palpation ___vital signs
___range of motion testing ___orthopedic testing ___basic neurological exam
___muscle strength testing ___postural analysis testing ___instrument readings
___radiographic studies and consultative report, if needed
___ultrasound ___hot/cold therapy ___EMS ___topical analgesics such as biofreeze
___cold laser therapy ___you may be given stretches and exercises in office or for home
___soft tissue release therapy, such as myofascial release, or massage therapy
___lumbar flexion/distraction, or cervical distraction

____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, burns and bruising. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics, rest, and ice/heat application
- Medical care, physical therapy, and prescription drugs such as anti-inflammatory, muscle relaxants, paint-killers, and steroid injections
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment: options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW
I have read [ ] or have had read to me [ ] the above explanations of the chiropractic adjustment and related treatment. I have discussed it with Dr. Janet Laney and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed both verbally and in writing of the risks, I hereby give my consent to that treatment.

Dated: ____________________

____
Patient's Name

____
Signature

____
Signature of Parent or Guardian
(if a minor)

Dated: ____________________

Janet L. Laney D.C.
Doctor's Name

____
Signature

JANET L. LANEY, D.C.
NOTICE OF PRIVACY PRACTICES

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

Janet L. Laney, D.C. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> "On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or heath care operations. (example)

> "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Janet L. Laney, D.C. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purposes of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such s identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Research

We may disclose your health information to researcher conducting research that has been approved by an institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you as described below: (example)

> "As a courtesy to our patients, we may call your home on the evening prior to your scheduled appointment to remind you of your appointment time, to set up a follow-up appointment. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

Change of Ownership

In the event that Janet L. Laney, D.C. is sold or merged with another organization; your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Janet L. Laney, D.C. is not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that Janet L. Laney, D.C. amends your protected health information. Please be advised, however, that Janet L. Laney, D.C. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information by Janet L. Laney, D.C.

- You have a right to a paper copy of this Notice of Privacy at any time upon request.

Changes to this Notice of Privacy Practices

Janet L. Laney, D.C. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Janet L. Laney, D.C. is required by law to comply with this Notice.

Janet L. Laney, D.C. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Janet L. Laney, D.C. by calling this office at (510) 792-9000. If Janet L. Laney, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how Janet L. Laney, D.C. has handled your health information should be directed to Janet L. Laney by calling this office at (510) 792-9000. If Janet L. Laney is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, SW.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of April 15, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Janet L. Laney, D.C. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient's Name (print)

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Authorized Facility Signature Date

Financial Policy

This is an agreement between Dr. Janet L. Laney, D.C. and the Patient/Debtor named on this form.

In this agreement the words "you", "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. Janet L. Laney, D.C.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the re-billing fee, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility

You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization may result in lower payment from the insurance company.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at time of service.

Required Payments: Any co-payments required by an insurance company must be paid at the time of services. **Because this is an insurance requirement, we cannot bill you for these.**

Returned Checks: There is a $25.00 fee for any checks returned by the bank.

Missed Appointment Fee: Patients who do not show up for an appointment, or cancel with less than 24 hours' notice will be charged a $25.00 fee. This fee must be paid before a new appointment is scheduled.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public records.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Re-billing Fee: A re-billing fee of $10.00 will be imposed on each account that is over thirty (30) days past due. We determine your account is past due by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Patient Name: ______________________________

Signature:__________________________________
If a minor, parent/guardian signature

Date:______________________________________