



# PATIENT APPLICATION FORM

WELCOME TO HEALTH IN BALANCE INTEGRATIVE MEDICINE INC. We look forward to partnering with you on your journey to health. Please fill out the following information thoroughly. The more information you provide, the better we will be able to determine if we can accept your case and restore your health. In addition, once a correct diagnosis is determined, an individualized and effective plan of care will be designed for you and treatment can begin in order to provide long-term relief and restoration. Our team is dedicated to helping you get well and stay well.

## PATIENT INFORMATION

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 (Title) (First) ( Last) (Middle Initial)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email \_\_\_\_\_ Best way to contact you \_\_\_\_\_

Occupation Description \_\_\_\_\_ Employer \_\_\_\_\_

Employment Status:  Full  Part  Unemployed  Retired  Student: Full \_\_\_\_ Part \_\_\_\_  Other \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed  Other: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Health in Balance? \_\_\_\_\_

If through a referral, who can we thank for this referral? \_\_\_\_\_

How can we thank them (Email, Phone, Address): \_\_\_\_\_

Did you also see Health in Balance on one of the following (Circle all that apply) :

Yelp   Google   Facebook   Instagram   Stu's News   Ad in Laguna Beach Indy

## PURPOSE OF THIS VISIT / CHIEF COMPLAINTS

Please list your top 4 health concerns in order of priority and rate the range of severity of your pain. \* See below\*

Health Concern	Range of Severity of Pain (ie 2-8)	Date of Onset
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____

 0 No Pain	 1 2 3 Annoying Pain	 4 5 6 7 Pain that causes you to slow down	 8 9 10 Pain that limits your ability to perform Worst pain imaginable
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Regarding your #1 health, concern On a scale of 0-10 (0- no pain, 10- unbearable pain) please indicate the following:

- |  |                        |
|--|------------------------|
| The lowest level of pain WITHOUT medication  | 0 1 2 3 4 5 6 7 8 9 10 |
| The highest level of pain WITHOUT medication | 0 1 2 3 4 5 6 7 8 9 10 |
| The lowest level of pain WITH medication     | 0 1 2 3 4 5 6 7 8 9 10 |
| The highest level of pain WITH medication    | 0 1 2 3 4 5 6 7 8 9 10 |

## AREAS OF PAIN / SYMPTOMS

Draw a line from each type of pain/symptom that you are experiencing, to the corresponding area of the body.

Achy

Burning

Cramping

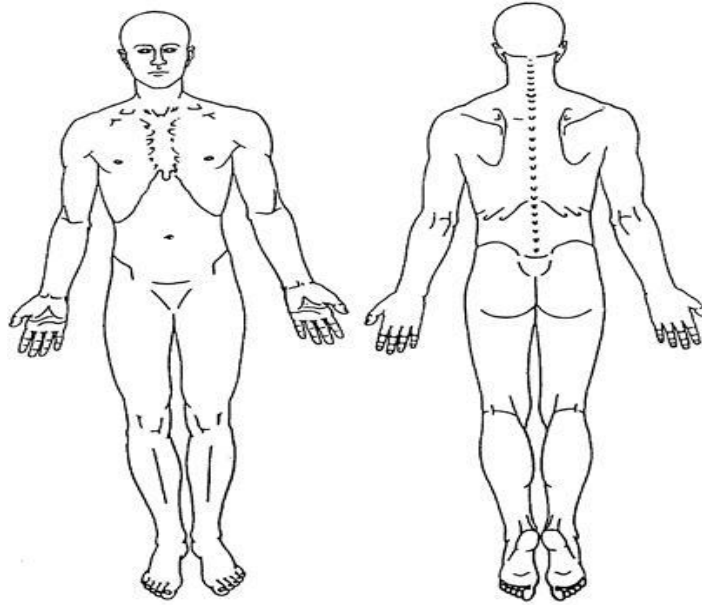
Dull

Electrical Shock

Numbness

Radiating

Bloating



Sharp

Shooting

Stabbing

Stiffness

Swelling

Throbbing

Tingling

Cold/Hot

## INJURY HISTORY

Please list and briefly describe all significant injuries that you have experienced: (ie. falls, car accidents, sports injuries, etc)

1. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_
3. \_\_\_\_\_ Date: \_\_\_\_\_
4. \_\_\_\_\_ Date: \_\_\_\_\_
5. \_\_\_\_\_ Date: \_\_\_\_\_
6. \_\_\_\_\_ Date: \_\_\_\_\_

## Health Goals

Please list your top 4 long term lifestyle and health goals in order of priority.

(Examples: Pain free living as I age, able to golf, surf, weight lift, exercise, achieve/maintain ideal body weight, stop using pain meds, sleep more/pain free, decrease/manage stress, improve nutrition, play with grandchildren)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## SPIRITUALITY

Many people believe spirituality plays an important role in their lives and that there is a correlation between spiritual beliefs/practices and health outcomes. We value the whole person and want to include care that acknowledges and supports your faith. We respect your decision to include or decline sharing your personal beliefs.

Faith Preference: \_\_\_\_\_



# MEDICAL HISTORY QUESTIONNAIRE

## PAST MEDICAL HISTORY

Please mark all conditions you have or are currently experiencing.

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Hypertension                | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Heartburn (GERD)        | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Head Injury        | <input type="checkbox"/> Gall Bladder Problems   | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Stomach Ulcer           | <input type="checkbox"/> Gout                 |
| <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Seizure Disorder   | <input type="checkbox"/> Colitis                 | <input type="checkbox"/> Plantar Fasciitis    |
| <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Vertigo            | <input type="checkbox"/> Irritable Bowel Disease | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Aneurysm                    | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Crohn's Disease         | <input type="checkbox"/> Herniated Disc       |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> COPD               | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Scoliosis            |
| <input type="checkbox"/> Bleeding Disorders          | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Enlarged Prostate    |
| <input type="checkbox"/> Blood Clots                 | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Kidney Infection        | <input type="checkbox"/> Ovarian Cysts        |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Uterine Fibroids     |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Immune Disorder    | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Eczema                      | <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Other _____          |

## SURGERY HISTORY

Have you had any surgeries or procedures? Yes / No

If yes, please list year and all surgeries:

Procedure: _____	Date: _____
Procedure: _____	Date: _____
Procedure: _____	Date: _____
Procedure: _____	Date: _____
Procedure: _____	Date: _____

## SOCIAL HISTORY

Which of these activities do you engage in and how often?

	Occasionally	Often	Never
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke Cigarette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## FAMILY HISTORY

Do you have any family members that have or are currently experiencing any of the following conditions:

- |                                    |   |   |
|------------------------------------|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Stroke    | <input type="checkbox"/> Mental Illness   | <input type="checkbox"/> Neurological Disease |
| <input type="checkbox"/> Diabetes  |   |   |

## MEDICATION & SUPPLEMENTS

List current medications/ supplements	Prescribed?
_____	Yes / No
_____	Yes / No
_____	Yes / No
_____	Yes / No
_____	Yes / No
_____	Yes / No

## ALLERGIES (to food/medications)

**Food:**

<input type="checkbox"/> Dairy/Lactose	<input type="checkbox"/> Soy	<input type="checkbox"/> Peanuts
<input type="checkbox"/> Gluten/Wheat	<input type="checkbox"/> Corn	<input type="checkbox"/> Sulfites
<input type="checkbox"/> Shellfish	<input type="checkbox"/> MSG	<input type="checkbox"/> Others: _____

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**Medication:** \_\_\_\_\_ **Reaction:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## REVIEW OF SYSTEMS

Please identify any symptoms that you experience:

### Constitutional:

- Fever
- Chills
- Night Sweats
- Sudden Weight Loss
- Loss of appetite
- Fatigue
- Lethargy
- Frequent colds

### Ear/Nose/Throat:

- Sore throat
- Bleeding gums
- Gingivitis
- Sneezing
- Post nasal drip
- Itchy eyes
- Watery eyes
- Tooth pain
- Dental problems
- Earache
- Ear discharge
- Nasal stuffiness
- Sour mouth
- Dry mouth
- Burning tongue

### Skin:

- Rashes
- Itching
- Sores
- Acne
- Hives
- Brittle nails

### Cardiovascular:

- Chest Pain
- Rapid heart rate
- Palpitations
- Bleeding prolonged
- Slow heart rate
- Irregular heart beat
- Swelling in hands \*
- Swelling in feet \*
- Shortness of breath
- Dizziness
- Fainting
- Poor circulation
- Cold hands \*
- Cold feet \*
- Varicose veins
- Bruise easily

### Lungs:

- Dry Cough
- Cough with phlegm
- Difficulty breathing
- Frequent bronchitis
- Coughing blood
- Wheezing
- Pain with breathing

### Gastrointestinal:

- Stomach pain
- Constipation
- Diarrhea
- Bloating
- Gas
- Belching
- Heartburn
- Nausea
- Vomiting
- Vomiting blood
- Black stools
- Blood in stools
- Change in bowel habits

### Genitourinary:

- Frequent urination
- Painful urination
- Burning with urination
- Blood in urine
- Changes in urination
- Dark color to urine
- Leak urine
- Can't hold urine
- Frequent bladder infections
- Difficult to start urinating
- Low back/side pain

### Endocrine:

- Excessive thirst
- Excessive hunger
- Hair loss
- Menstrual problems
- Menopausal

### Psychiatric:

- Depression
- Anxiety
- Insomnia
- Mood swings
- Difficulty concentrating
- Irritable
- Restless/Nervous

### Neurological:

- Headaches \*
- Light bothers eyes
- Slurred speech
- Ringing in ears
- Hearing loss
- Double vision
- Blurred vision
- Night blindness
- Memory loss
- Confusion
- Hoarseness
- Loss of taste or smell
- Pain in eyes
- Tremors
- Twitching
- Difficulty chewing
- Difficulty swallowing
- Restless legs
- Sensation of spinning
- Sensation of rocking (on a boat)
- Balance problems
- Frequent falls

### Musculo-Skeletal:

#### (Place a check mark & Circle)

- Pain or stiffness in: \*
  - \_\_\_ Hands, Elbows, Arms, Shoulders
  - \_\_\_ Neck, Jaw, Face, Head,
  - \_\_\_ Toes, Ankles, Feet, Knees, Joints
  - \_\_\_ Legs, Hips, Buttock, Tailbone
  - \_\_\_ Mid-back, Low-back,
- Weakness in: \*
  - \_\_\_ Hands, Arms, Shoulders, Legs, Feet
- Numbness/ Reduced Sensation in: \*
  - \_\_\_ Head, Fingers, Hands, Arms, Shoulder
  - \_\_\_ Toes, Feet, Legs, Buttocks
- Pins and needles \*
  - \_\_\_ Arms, Feet, Legs
- Hands, Arms, Feet, Legs fall asleep regularly \*
- Swelling in: \*
  - \_\_\_ Hands, Arms, Legs, Joints, Feet
- Burning pain in: \*
  - \_\_\_ Arms, Shoulder, Buttock, Legs, Feet
- Muscle Aches
- Trip over feet while walking
- Unable to sit for 30 min or less
- Unable to stand for 30 min or less
- Pain with walking
- Night pain
- Loss of balance
- Muscle weakness
- Loss of handgrip strength

\*Indicates Neurological/ Vascular Symptoms

## INSURANCE INFORMATION

### Present Your Insurance Cards and Drivers License to the Front Desk for Copying

Name of Ins. Provider: Blue Shield   Blue Cross   Aetna   Cigna   Medicare   United   Auto   Other: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Group or Policy # \_\_\_\_\_

Primary Insured \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account. I understand there could be some services that my insurance company does not cover. In addition, once the insurance has made their decision there will be a minimum payment of \$50.00 each month or 20% of the outstanding balance that will be auto-debited from my account. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court and attorney's fee's in the collection of my account.

### PROCESSED TO PATIENT CHECKS

Arthur Professional Chiropractic a Health in Balance company are Out-of-Network with some insurance providers. Therefore, there is a chance that insurance checks are distributed directly to the patient. If this is the case, I understand that regardless of whether I have received them it is still my responsibility to pay the outstanding balance that they owe, as I must contact my provider about being reimbursed for services rendered.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize Health in Balance to administer care as deemed necessary to my child, a minor under the age of 18 years old.

## RADIOGRAPH CONSENT

I hereby give my consent to allow Health In Balance and its representatives, as deemed necessary by the examining Healthcare Provider to take radiographs of my spine and/or extremities. In addition, I recognize that these X-rays are meant for postural purposes only and I should go to my PCP or the ER to determine if I have a fracture.

I also hereby declare that to my knowledge that I am not pregnant \_\_\_\_\_ (Initial)

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Parent/Guardian (minors) \_\_\_\_\_ Date \_\_\_\_\_

## MARKETING AND PRIVACY CONSENT

### ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I \_\_\_\_\_ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- \* The right to review the notice prior to signing this consent
- \* The right to object to the use of my health care information for directory purpose
- \* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

### USE OF CONTACT INFORMATION

I give permission to Health In Balance to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, products, newsletters or patient of the week/month postings.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If you would not like to be involved in this type of contact explained above, check here:  Opt Out

## DISCLOSURE & CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

Congratulations for choosing chiropractic and natural healthcare, the safest and most natural health care program in the world. This painless, natural and effective approach to healthcare has been providing healing for people all over the world for over 100 years.

In accordance with California law this disclosure is to inform you, the patient, of the potential but highly unlikely risks associated with chiropractic care. These risks include, but are not limited to fractures, disc injuries, dislocations, strains, sprains, cervical myelopathy, costovertebral strains and separations and burns.

Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke related with Vertebral Artery Defect (AVD). This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

It should be noted that in the history of chiropractic care there has been an extremely low rate of occurrence for muscle spasms, tightness, rib fractures, disc injuries and AVD. Most literature written against the use of chiropractic care and adjustments is vague and sometimes biased and there is no absolute proof that there are any actual risks from chiropractic care in general.

The largest study done in 2001 by the Canadian Medical Association Journal reported that there is a 1 in 5.85 million risk that cervical manipulation performed by a Doctor of Chiropractic would be followed by stroke due to AVD. David Cassidy a professor of epidemiology at the University of Toronto and the author of the study found that patients already had a damaged artery before ever seeking help from either a medical doctor or a chiropractor.

Our doctors will make every effort to screen for any contraindication to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination and x-rays (when warranted).

You may experience some mild symptoms like stiffness and soreness during your treatment, but these are normal and indicate healing as your health returns to its optimal state.

By signing this document, I acknowledge that I have discussed or have had the opportunity to discuss all of the possible risks associated with chiropractic treatment. I understand that the Doctor of Chiropractic listed below will not give an adjustment if they are aware that such care may be contra-indicated. I do not expect the Doctor of Chiropractic named below and / or any other office or clinic staff to be able to anticipate all risks and complications and I wish to allow them to exercise their best judgment during the course of my chiropractic adjustments and treatments. I understand that at all times the Doctor of Chiropractic named below and / or any other office or clinic staff assigned to provide care will be acting in my best interest based on the known facts and information I provide. As such I request and consent to the performance of chiropractic adjustments and other chiropractic treatments as recommended by the doctor(s) named below.

**Patient Name (Please Print):** \_\_\_\_\_

**Patient/Parent Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_

**Date** \_\_\_\_\_

**Name /Address of Clinic:**

Arthur Professional Chiropractic /Health in Balance Int. Medicine  
330 Park Avenue, Suite 3 Laguna Beach, CA 92651

**Names of doctor(s) treating this patient:**

Gary Arthur, D.C., Lisa Arthur, D.C  
Jordan Martin, D.C.

## AUTHORIZATION CARE

### OPEN ROOM TREATMENT

I give permission to Health In Balance to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or therapist in private, the doctor or therapist will provide a private room for these conversations. \_\_\_\_\_ (Initial)

A patient coming to our facility gives our Healthcare Providers permission and authority to provide medical and alternative health care for them after examination, assessment and any diagnostic testing deemed necessary. The clinical procedures and/or therapies performed are designed to benefit and aid in the healing of your body. Seldom do these therapies or care cause any adverse or unwanted effects. On rare occasion, underlying physical abnormalities or other pathologies may render the patient susceptible for complications or injury. The Healthcare Provider will not perform specific procedures or therapies if he/she feels that the therapy or procedure may be contraindicated with said abnormalities or pathologies. It is the responsibility of the patient to inform the Healthcare Provider of any latent pathological abnormalities, illnesses, or deformities which they may have. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your primary care provider, gynecologist and/or dermatologist to assess for cancers, or other illnesses and conditions. The patient assumes all responsibility/liability for adverse events related to or resulting from non-disclosure of past medical history, illnesses, medications, allergies or other conditions.

Furthermore, I authorize and agree to allow the doctors and/or therapists to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

The Doctor and/or therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or therapist for all services rendered.

**I have read, understand and agree to the above consent form.**

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient's Parent/Guardian (minors) \_\_\_\_\_  
authorizing care for minor

Date \_\_\_\_\_

## APPOINTMENT POLICIES

In an effort to efficiently provide the best care for you, we have established the following policies for our appointments, and payment requirements. Please read them carefully and feel free to present any questions you may have regarding these policies to our Clinic Director.

- When scheduling your appointments, we will make every effort to accommodate you to the best of our ability.
- Keep in mind that appointment times vary according to the type of treatment you will be seen for that day, so please arrive on time as our goal is to be able to stay on schedule. If you find that you will be more than 10 minutes late to your appointment, please contact our office as soon as possible. Often, we are still able to accommodate you, but may also need to reschedule your appointment, depending on the procedure(s) being done.
- The patient agrees to pay for all services received from Health in Balance. Any unpaid balance owed to HIB at the end of 90 days will be subject to a rate of 1% a month (12% per year) until paid.
- At HIB, we value our patients and their health. We know that you want to find relief and healing, and we want to ensure your best possible outcomes. Missing your scheduled appointments loses continuity in your treatment and may slow your improvement and positive outcomes; consistency is key in order to receive the highest benefit from your care plan.
- You will receive a text (possibly a call on occasion) the day before your appointment reminding you of your scheduled time.
- All Durable Medical Equipment (DME) has a 30-day return policy from the date given with a restock fee of \$10 per item. After that date there will be no returns of the product.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

**CANCELLATION & NO SHOW POLICY**

Please understand that when an appointment is scheduled for you, a time is set aside and reserved for you on the master schedule. Failure to cancel without appropriate notice prevents us from filling the vacancies in our schedule and often prevents people in need from receiving desired services in a timely manner. Therefore,

**I understand and agree to the following:**

1. It is my responsibility to notify:

**HEALTH IN BALANCE  
AT 949.497.2553  
OR Office@HealthinBalance.com**

24 Hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.

2. I agree that I will be billed 50% of the scheduled services in the event that I miss an appointment and fail to cancel 24 hours prior to the scheduled appointment.

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



## LETTER OF NO ACCIDENT OR WORK INJURY

**Patient Name:** \_\_\_\_\_

**I hereby state with my signature that I was not involved in any auto accident, slip and fall, or work injury. My treatment is in no way associated with any 3<sup>rd</sup> party, and no other party is responsible or liable for the cost of my treatment.**

**Please process and pay all claims immediately.**

**Sincerely,**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

## PHYSICIAN-PATIENT ARBITRATION AGREEMENT

**Article 1 – Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2 – All claims must be arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. IN the case of any pregnant mother, the term “patient” herein shall mean bot the mother and the mother’s expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician’s partners, associated, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, any fee from the patient shall not waive the right to compel arbitration or any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

**Article 3 – Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties’ consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including but not limited to Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Section 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary adjudication in accordance with the Code of Civil Procedure.

**Article 4 – General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedure prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

**Article 5 - Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

**Article 6 – Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment)

Effective as of the date of first services.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL SEE ARTICLE 1 OF THIS CONTRACT.**

BY: \_\_\_\_\_  
Patient’s Signature or Representative (DATE)

BY: ARTHUR PROFESSIONAL CHIROPRACTIC & HIB

\_\_\_\_\_  
Print Patient’s Name or Representative

*A signed copy of this document is available if the patient requests one*



# HIPPA COMPLAINT MEDICAL AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

*If there is a provider that you want APCC or HIB to obtain medical records or labs from please sign the below form:*

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Patient's Phone Number: \_\_\_\_\_

The undersigned hereby authorize the release of all medical documentation and other information, including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse or any other covered entity under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") to :

Health In Balance Integrative Medicine  
330 Park Ave Ste 3  
Laguna Beach, Ca, 92651  
Phone 949.497.2553  
Fax: 949.497.5273  
Email: Office@HealthinBalance.com

I intend the person(s) listed above to have authority to gain immediate access to my medical records.

Upon presentation of this authorization (or a photocopy), you are authorized to release a copy of these records to any person who is my personal representative. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law.

The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all requirements of HIPAA (45 CFR Section 164).

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending written notice to my medical providers or by using any method capable of revoking a health care agency under California law.

\_\_\_\_\_  
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

\_\_\_\_\_  
Name of Guardian/ Legal Relationship Date Witness  
Representative

*In furtherance of this authorization, we do hereby waive all provisions of law and privileges relating to the disclosure hereby authorized.*

## MEDICARE PATIENTS ONLY

The following form will be discussed with you further by our medical staff in case you have any questions:

**Section 1 - A. Notifier:**

**Section 2 - B. Patient Name:**

**C. Identification Number:**

### 2-1. Advance Beneficiary Notice of Noncoverage (ABN)

2-2. **NOTE:** If Medicare doesn't pay for **D.** \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** \_\_\_\_\_ below.

D. Service	E. Reason Medicare May Not Pay:	F. Estimated Cost (Visit)
Chiropractic Exam	Not a covered service	\$57-197
X-Rays	Must be performed by a M.D.	\$300
Therapy	HIB utilizes physio-therapists not PTs	\$49-98
Decompression	Not a covered service	\$77-124
Foam Roller	Non-medical device	\$34
Wedge/Block	Non-medical device	\$24
Pro-lordotic	Non-medical device	\$70

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

**OPTION 1.** I want the **D. Services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

**OPTION 2.** I want the **D. Services** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

**OPTION 3.** I don't want the **D.** services listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

<b>I. Signature:</b>	<b>J. Date:</b>
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

## Patient Privacy

It is the policy of the Clinic to maintain the privacy and security of all individually identifiable health information for all patients. The Clinic provides notice to all Clinic patients who arrive for appointments, informing them of their right to privacy of their protected health information (PHI). This policy describes procedures implemented by the Clinic to ensure the privacy of PHI. The Clinic obtains acknowledgment of receipt of such notice.

## Procedures

1. A designated privacy officer is appointed from within the Clinic to oversee the policies and procedures to ensure that patient's rights to privacy are fulfilled.
2. All patients arriving for care receive a Notice of Patient's Privacy Rights and the Clinic's Receipt of Notice of Privacy Practices Written Acknowledgment Form. All patients are asked to sign the acknowledgment of receipt form.
3. The Clinic website contains the privacy notice, privacy practices, and the acknowledgment response.
4. The Clinic obtains written acknowledgment from the patient or legal guardian prior to engaging in treatment, payment, or health care operations.
5. Patients may request an accounting of certain non-routine disclosures of their PHI. The request may be a time period not longer than six (6) years and may not include dates prior to April 14, 2011, as stated in the request for an accounting of certain disclosures for non-treatment, payment, or health care operations (TPO) purposes.
6. The Clinic obtains written authorization for use or disclosure of PHI in connection with research and marketing.
  - a. When appropriate, the Clinic uses a combined informed consent authorization form, especially as it relates to patients participating in research studies
7. The Clinic discloses only the minimum PHI to requesting entities and insurance companies in order to accomplish the intended purpose
8. As a covered entity, the Clinic fully complies with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA).
9. The Clinic provides the patient, in the Notice of Privacy Practices, a clear, written explanation of how the covered entity may use PHI.
10. Patients are provided access to their medical records and receive copies upon completing a Request to Inspect and Copy PHI. If the Clinic is unable to provide copies based upon the HIPAA guidelines, written notice, in the form of the Patient Denial Letter, is provided to the patient.
11. Patients are given the opportunity to request a correction or amendment to their PHI by completing the Request for Correction/Amendment of Protected Health Information. Any allowed amendments must be in a written amendment; no changes are made directly to the medical record. The Clinic must inform patients that a written request for a correction or amendment is required, and that the patient is required to provide a reason to support the requested change. The amendment is accepted or denied in a provider's written response, on a Disposition of Amendment Request.
12. Anyone who feels the confidentiality of a patient's PHI has been violated may must submit a Patient Complaint Form to the privacy officer. Complaints are kept confidential and no repercussion may occur due to the report. Complaints are logged by the privacy officer.
13. Sanctions are imposed upon employees who violate the privacy of a patient's PHI; sanctions could be disciplinary action, up to and including termination of employment.

ll employees of the Clinic receive initial and ongoing training on how to prevent misuse of PHI and how to obtain authorization for its use.
14. The Clinic secures a signed release form whenever a patient requests files be sent to another provider or vice versa.
15. The Clinic releases no PHI to employers or financial institutions without explicit authorization from the patient or legal guardian.
16. Electronic, physical, and logistical safeguards are implemented to secure the confidentiality of PHI of all patients.
17. The patient may submit a written Request for Limitations and Restrictions of Protected Health Information.
18. The clinic does not sell or distribute the patient's information for any reason.

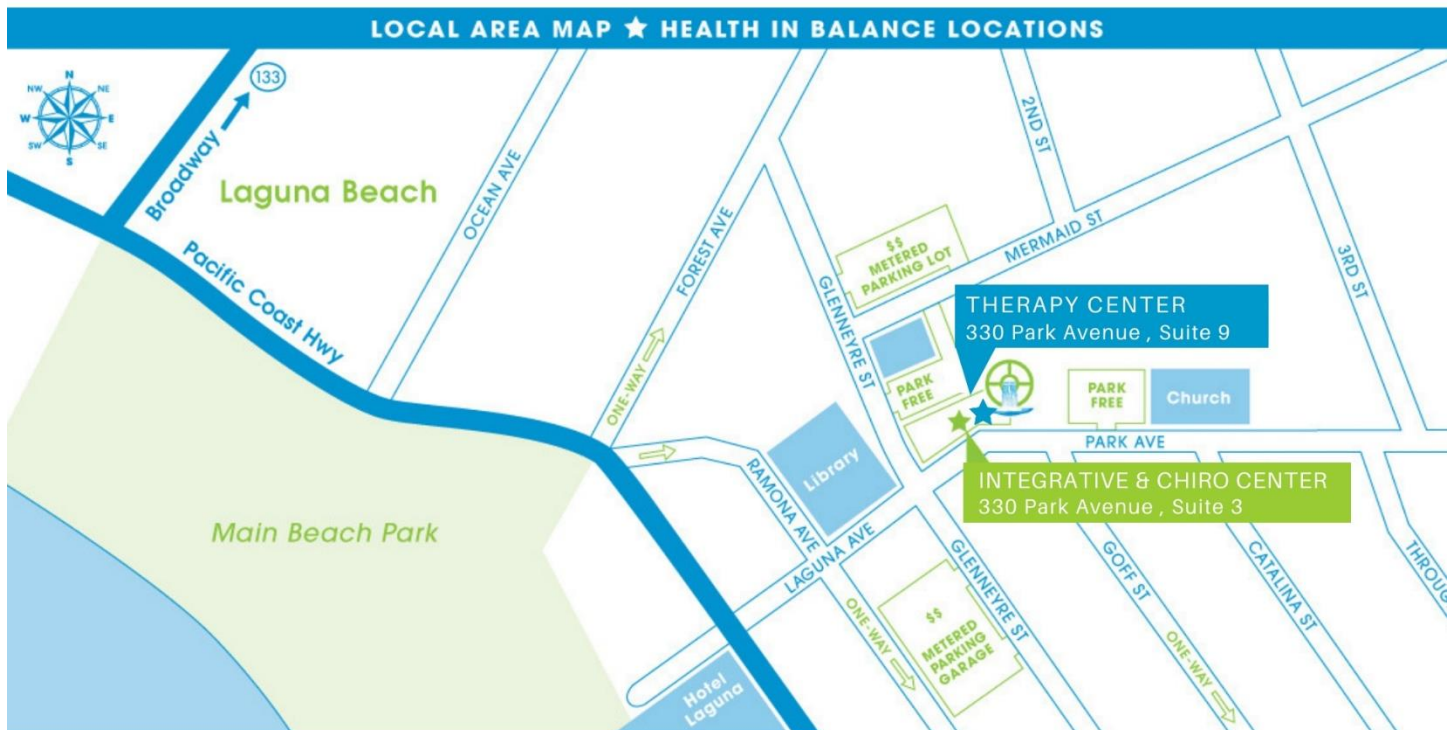
## DIRECTIONS TO HEALTH IN BALANCE

- Welcome to Health In Balance! We are located at 330 Park Ave #3, Laguna Beach, CA 92651.
- **Please arrive on time to your exam with the paperwork filled out so that this will not interfere with your scheduled appointment**
- In addition, please allow additional time to find our office for your first visit, as well as an additional 15 minutes during summertime commute as traffic can cause unnecessary delays.
- There is parking just past our office on the left-hand side. You can use the first (covered) or second (open) driveway. Please note that the second driveway, you must park facing the ocean. If both lots are full there are parking lots and parking spaces on the street that take quarters.
- Our office #3 is located just off the sidewalk level with a small staircase up with bamboo planter boxes. Please let our office know if you require handicap access and we will walk you through how to enter our office.

We look forward to working with you and your healthcare needs!

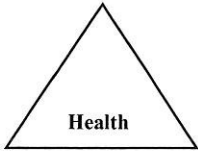
Please do not hesitate to call or email if you have any additional questions.

Office #: 949.497.2553      Email: [Office@HealthinBalance.com](mailto:Office@HealthinBalance.com)



**NET Work Sheet**

We all have ideals and values that we have adopted over the course of our lives. Write a very short description of what you want in your life or what you can ideally visualize (incorporating these values) for each of the nine sections below. Then prioritize by placing a number in the triangles for each category of your life as it is TODAY with a #1 being the most important and #9 being the least important. ***This worksheet is confidential.***



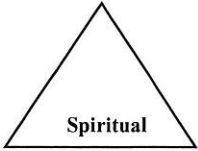
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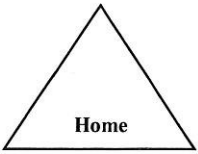
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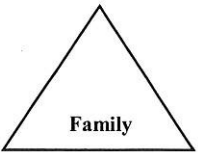
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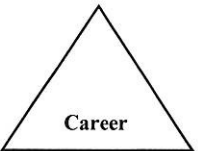
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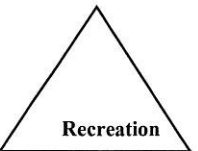
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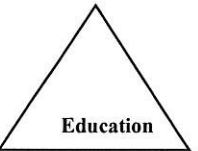
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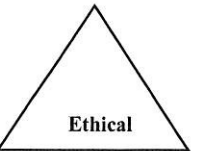
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**Consider the same nine areas of life as on the 1<sup>st</sup> page when answering the following questions:**

List the names of family members, close friends and other important people that have affected your life. Try to do this for the same 9 areas of your life as above.

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List any significant traumas (deaths, divorces, injuries, etc)

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List what you feel are the main reoccurring challenges, bad feelings, or self sabotaging patterns that you are experiencing

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# NEC 18 QUESTIONNAIRE

Name (Please PRINT) \_\_\_\_\_ Date \_\_\_\_\_

18 Question NEC quantifying scale v1.2

Please answer all 18 questions.

**Have you often watched yourself do something like eat a big dessert, even though you *know without a doubt* this behavior is not good for you to do so?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10

**Do you have bodily symptoms, which can get better for a short while after treatment but then always return?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10

**Do you have fearfulness or discomfort with "putting yourself out there", which prevents you from being successful?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10

**Have you ever watched yourself get upset with a significant other over the same subject material time and time again?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10

**Do you feel people frequently misunderstand you?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10

**Do you have a health problem for which no traditional medical tests have seemed to verify or diagnose?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10

**Have you observed yourself going through a particular pattern of failures (such as jobs not working out or relationships ending in an unsatisfactory way) time and time again?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10

**Have you been under some sort of psychotherapy for a problem you now feel you intellectually understand, yet are still unable to make the changes in your life you feel are necessary?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10

**Have you often gotten disgusted with yourself, even to the point of feeling that you are somehow fundamentally flawed?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10

**Are you having (an ongoing) difficulty resolving a conflict with another person?**

Seems true	Seems partially true			Seems unlikely to be true				Seems untrue	
1	2	3	4	5	6	7	8	9	10



**Have you asked yourself with true perplexity, "Why do I do this?" ["this" being something you don't want to do or keep doing]**

Seems true                      Seems partially true                      Seems unlikely to be true                      Seems untrue  
1                      2                      3                      4                      5                      6                      7                      8                      9                      10

**Have you had many seemingly conflicting medical diagnoses?**

Seems true                      Seems partially true                      Seems unlikely to be true                      Seems untrue  
1                      2                      3                      4                      5                      6                      7                      8                      9                      10

**Are you forever frustrated at earnestly and industriously, trying to please someone in a relationship (including bosses and loved ones) and yet always failing in almost the same way?**

Seems true                      Seems partially true                      Seems unlikely to be true                      Seems untrue  
1                      2                      3                      4                      5                      6                      7                      8                      9                      10

**Do you often "shoot yourself in the foot" in life?**

Seems true                      Seems partially true                      Seems unlikely to be true                      Seems untrue  
1                      2                      3                      4                      5                      6                      7                      8                      9                      10

**Are you having difficulty attaining personal goals?**

Seems true                      Seems partially true                      Seems unlikely to be true                      Seems untrue  
1                      2                      3                      4                      5                      6                      7                      8                      9                      10

**Has anyone close to you ever told you your body symptoms get worse when you are under a general or specific type of stress?**

Seems true                      Seems partially true                      Seems unlikely to be true                      Seems untrue  
1                      2                      3                      4                      5                      6                      7                      8                      9                      10

**Do you feel trapped, out of options, in your work or personal life?**

Seems true                      Seems partially true                      Seems unlikely to be true                      Seems untrue  
1                      2                      3                      4                      5                      6                      7                      8                      9                      10

**Do you often experience uncomfortable anger or emotional upsetness, but are not sure why?**

Seems true                      Seems partially true                      Seems unlikely to be true                      Seems untrue  
1                      2                      3                      4                      5                      6                      7                      8                      9                      10

**Please add any comments these questions may have stimulated.**

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*Thank You*

