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 (*required*)
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

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

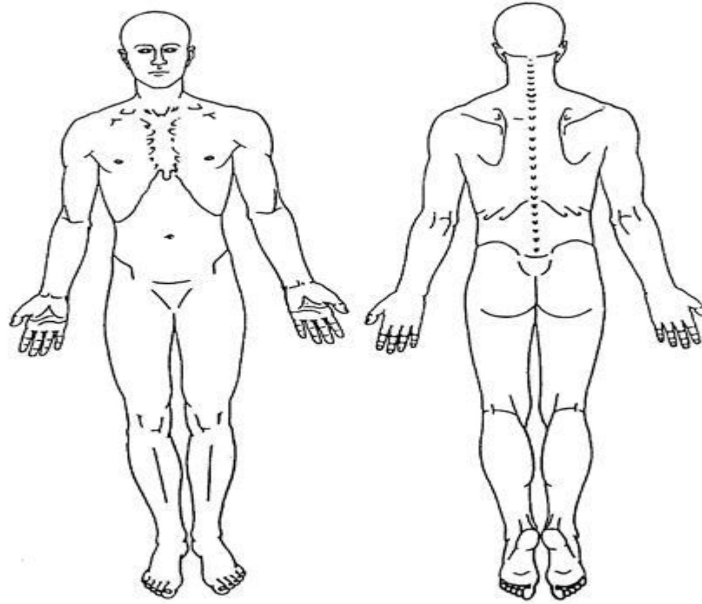
Dull

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.

☐ Hypertension	☐ Stroke	☐ Heartburn (GERD)	☐ Cancer
☐ Heart Attack	☐ Head Injury	☐ Gall Bladder Problems	☐ Rheumatoid Arthritis
☐ Heart Disease	☐ Migraines	☐ Stomach Ulcer	☐ Gout
☐ Pacemaker	☐ Seizure Disorder	☐ Colitis	☐ Plantar Fasciitis
☐ High Cholesterol	☐ Vertigo	☐ Irritable Bowel Disease	☐ Cancer
☐ Aneurysm	☐ Asthma	☐ Crohn's Disease	☐ Herniated Disc
☐ Peripheral Vascular Disease	☐ COPD	☐ Hernia	☐ Scoliosis
☐ Bleeding Disorders	☐ Chronic Bronchitis	☐ Kidney Disease	☐ Enlarged Prostate
☐ Blood Clots	☐ Emphysema	☐ Kidney Infection	☐ Ovarian Cysts
☐ Diabetes	☐ Thyroid Disease	☐ Urinary Tract Infection	☐ Uterine Fibroids
☐ Glaucoma	☐ Immune Disorder	☐ Hepatitis	☐ Other___________________
☐ Eczema	☐ HIV/AIDS	☐ Liver Disease	☐ 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	☐	☐	☐
Drink Caffeine	☐	☐	☐
Drink Alcohol	☐	☐	☐
Smoke Cigarette	☐	☐	☐

FAMILY HISTORY

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

☐ Arthritis	☐ High cholesterol	☐ High Blood Pressure
☐ Cancer	☐ Heart Problems	☐ Thyroid Problems
☐ Stroke	☐ Mental Illness	☐ Neurological Disease
☐ 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:

☐ Dairy/Lactose	☐ Soy	☐ Peanuts
☐ Gluten/Wheat	☐ Corn	☐ Sulfites
☐ Shellfish	☐ MSG	☐ Others:_______________

____

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**

.Form C- 10 NDI

NECK DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing,Dressing,etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration/

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

COMMENTS:____

Name ________________________ Age ____ Date __________ Score __________

Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name ____ Date ______________________

Please read carefully:

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE*** *which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just* ***mark the one box which most closely describes your problem right now.***

SECTION 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me sitting more than ½ hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

____

____

SECTION 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

A I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling

A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

____

Examiner

With Permission from:Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

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 RECIEPT & 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.

Out 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 the 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)____ Date__________________________
authorizing care for minor

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 desire 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 3rd 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 expect 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:______________________________________   BY: ARTHUR PROFESSIONAL CHIROPRACTIC & HIB

Patient's Signature or Representative (DATE)

____

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/ Representative Legal Relationship Date Witness

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.

I. Signature:	**J. Date:**

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