Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name ______________________________ Soc. Sec.# ______________
Last Name First Name Initial

Address ______________________________

City ______________ State _____ Zip _______ Home Phone ______________

Cell Phone ______________ Email ______________

Sex ☐ M ☐ F Age _______ Birth Date __________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by ______________ Occupation ______________

Business Address ______________________________

Business Phone ______________ Business Email ______________

Notify in case of emergency ______________ Home Phone __________ Work Phone __________

Cell Phone ______________ Email ______________

Whom may we thank for referring you? ______________________________

Primary Insurance

Person Responsible for Account ______________________________
Last Name First Name Initial

Relation to Patient ______________ Birth Date __________ Soc. Sec.# ______________

Address (if different from patient) ______________ Home Phone ______________

City ______________ State _______ Zip _______

Cell Phone ______________ Email ______________

Person responsible employed by ______________ Occupation ______________

Business Address ______________________________

Business Phone ______________ Business Email ______________

Insurance Company ______________________________

Phone ______________ Email ______________

Contract # ______________ Group # __________ Subscriber # __________

Name of other dependents under this plan ______________________________

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? ______________

Your reason for *this* visit: ______________________________

Please describe your current pain and its location: ______________________________

When did symptoms begin (date)? __________ Have you had similar conditions in the past? ______________

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? ______________

Have you been treated by a medical physician for this condition? ______________

If so, when and where? ______________________________

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other ______________

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: ______________________________

____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls	____________	______
Head Injuries	____________	______
Broken Bones	____________	______
Dislocations	____________	______
Surgeries	____________	______
Other Serious Injuries	____________	______

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? ____________ Nursing? ☐ Y ☐ N

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

☐ Heart Attack/Stroke
☐ Congenital Heart Defect
☐ Alcohol/Drug Abuse
☐ Fainting/Seizures/Epilepsy
☐ Shingles
☐ Psychiatric Problems
☐ Difficulty Breathing
☐ Hepatitis
☐ Anemia
☐ Arthritis
☐ Frequent Neck Pain
☐ Jaw Pain
☐ Wrist Pain
☐ Shoulder Pain
☐ Arm Pain
☐ Leg Pain
☐ Lower Back Problems
☐ Severe/Frequent Earaches
☐ Ringing in Ears
☐ Severe/Frequent Headaches
☐ Diabetes/Tuberculosis
☐ Dizziness
☐ Emphysema/Glaucoma
☐ Kidney Problems
☐ Artificial Bones/Joints
☐ Cancer
☐ HIV Positive/AIDS
☐ Ulcer/Colitis
☐ Gout
☐ Numbness, where? ____________
☐ Tingling, where? ____________
☐ Muscle Spasms, where? ____________

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______________________________ Date ____________

Payment is due in full at time of treatment unless prior arrangements have been approved.

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Self-pay

LAWSON & FISHER CHIROPRACTIC
PAYMENT AGREEMENT

I, ________________________________, hereby agree to meet the following financial arrangements.

Please check one of the following:

1. ______ I agree to pay for each visit on the day services are rendered, via cash, check, or credit card.

2. _____ I agree to pay a minimum of $_____ per month on my account by the 1st/16th of each month. I further understand that if I go 60 days without a payment, my account becomes due and payable in full within 10 working days of written notice.

I understand there will be a minimum service charge of $1.80 or 18% annually based on balances over 60 days. I further understand that I am solely responsible for my balance and all accounts without payment for 60 days are due and payable in full.

______________________ ______________________________

Date Signature of Responsible Party

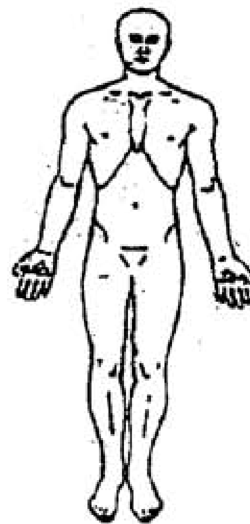
DATE: ____________________

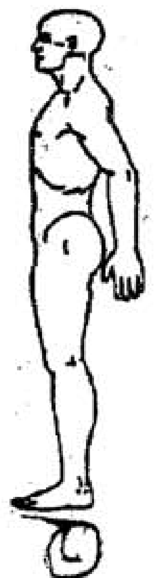
ARENDING: ____________________

PATIENT: ____________________

L R

L R





Informed Consent for Chiropractic Treatment of your Pain

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

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery.* There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

____

____

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

________________	________________	________
Patient Name	**Signature**	**Date**
________________	________________	________
Witness Name	**Signature**	**Date**

LAWSON & FISHER CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

PURPOSE: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

THIS NOTICE IS EFFECTIVE AND REQUIRED BY FEDERAL MANDATE AS OF APRIL 14, 2003. IT REMAINS EFFECTIVE UNTIL WE REPLACE IT OR MAKE CHANGES. WE ARE SORRY FOR ANY INCONVENIENCE FOR THESE FORMALITIES, BUT THIS IS REQUIRED BY LAW.

1. **OUR PRIVACY PLEDGE REGARDING MEDICAL INFORMATION.**
   The privacy of your medical information is important to us. We understand that this information is personal and we are committed to protecting it. We create a record of the care and services you receive at Lawson & Fisher Chiropractic. We need this record to provide you with quality care and to comply with certain legal requirements, including the federally mandated *Health Insurance Portability and Accountability Act (HIPAA)*. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.
   A. **LAWSON & FISHER CHIROPRACTIC PRIVACY OFFICERS:**
      The Privacy Officer is Kevin Fisher, D.C.

2. **OUR LEGAL DUTY.**
   A. LAW REQUIRES US TO:
      1. Keep your medical information private.
      2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
      3. Follow the terms of the notice that are now in effect.
   B. WE HAVE THE RIGHT TO:
      1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
      2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.
   C. NOTICE OF CHANGE TO PRIVACY PRACTICES:
      1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. **USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.**
   The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. **We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at: 25 E. Arrellaga Street., Santa Barbara, CA 93101.**

   A. **FOR TREATMENT AND DIAGNOSES:**
   We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other health care providers involved in your care.
      1. EXAMPLE: You are referred out for an x-ray. A number of health care providers (radiologists, orthopedists, general physician, etc.) may need to know about your medical condition to correlate x-ray findings.

   B. **FOR PAYMENT:**
   We may use and disclose your medical information for payment purposes.
      1. EXAMPLE: You are treated in our office for a lower back sprain. We will need to submit your health insurance information and procedure and diagnosis codes so that your bill will be paid or partially paid.
      2. EXAMPLE: We may also be required to submit similar information to your insurance plan to get *pre-approval* for the treatment plan.

   C. **FOR HEALTH CARE OPERATIONS:**
   We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

   D. **ADDITIONAL USES AND DISCLOSURES:**
      1. Notification: Medical information to notify or help notify a family member, your personal representative, or another person responsible for your care. We may be required to share information about your location, general condition, or death. If you are present, we will get your permission, if possible, before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up x-rays, MRI's, medicines/supplements, supplies, or other information for you.
      2. Workers' Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar industrial programs.
      3. Directory: We choose *not* to list any of your information in any directories.
      4. Fundraising: We choose *not* to disclose information about you to any fundraising organizations so that they may not solicit you for support via our office.
      5. Disaster Relief: Medical Information with a public or private organization or person who can legally assist in disaster relief efforts.
      6. Medical Examiner, Coroner, Funeral Directors: To help them carry out their duties, we may share medical information of a person who has died with a medical examiner, coroner, funeral director, or an organ procurement organization.
      7. Research in Limited Circumstances: We will *not* disclose any information about you for research purposes without your prior written consent.
      8. Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
      9. Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. We may share limited information with a law enforcement official

concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

10. Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration (FDA) for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the FDA. We may also, when we are authorized by law to do so, notify a person who may have been exposed to communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
11. Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
12. Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
13. Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. **YOUR INDIVIDUAL RIGHTS.** You Have a Right To:

A. Look at or get copies of your medical information. You must provide a request *in writing* that we provide photocopies of your file. **If you request copies, we will charge you our standard fee of $15.00 for our time, postage and photocopies of the records. Payment is required at the time of the written request.** In the rare cases of extremely large files, we reserve the right to charge reasonably more for our time and resources.

B. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

C. Request, in writing, that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

D. Request, in writing, that we communicate with you about your medical information by different means or to different locations.

E. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a written request to Lawson & Fisher Chiropractic.

F. Request, in writing, that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

5. **QUESTIONS AND COMPLAINTS.** If you have any questions or complaints, contact:

Dr. Kevin J. Fisher
Lawson & Fisher Chiropractic
25 E. Arrellaga Street
Santa Barbara, CA 93101.
(805) 963-1924

If you think that we may have violated your privacy rights, please contact the privacy officer. You may also submit a written complaint to the U.S. Department of Health & Human Services.

6. **SPECIFIC PRIVACY DISCLOSURES REGARDING OUR OFFICE:**

______A. OUR FILE CABINET AND PATIENT FILES: These are behind the front desk and are off-limit to patients. This cabinet is not locked and the shelves with charts on them are not behind doors.

______B. FAX MACHINE: We send out faxes that contain patient information, and we receive faxes with patient information, the fax machine can be seen by patients that use the phone. We do check the faxes frequently so information is sitting for long periods of time.

7. **CHANGING YOUR MIND ABOUT THIS AUTHORIZATION:**
I understand that I may revoke this authorization at any time by giving written notice to Lawson & Fisher Chiropractic. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

8. **SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT:**
I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.

9. **ACKNOWLEDGEMENT AND AUTHORIZATION FORM (INDIVIDUAL OR GUARDIAN):** I have received the Notice of Privacy Practices. I have been provided an opportunity to review it. I voluntarily give my authorization to use or disclose my protected health information:

NAME (Print): ______________________________

ADDRESS: ______________________________

TELEPHONE: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________