



TO THE New Patient

OUTLINE OF PROCEDURES FOR CARE

STEP ONE:

All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:

The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:

You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of

how our treatment works and what results can be obtained. You will also be advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

STEP SIX:

Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

STEP SEVEN:

An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State _____ Zip Code: _____
Home Phone: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F
Cell Phone: _____ E-mail Address: _____
Social Security # _____ Driver's License Number: _____
Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Business Employer: _____ Type of Work: _____
Business Phone: _____
Name of Spouse _____ Spouse's Social Security # _____
Spouse's Employer _____ Business Phone _____
Type of Work _____ Name and Ages of Children _____
Referred To This Office By: _____
Name and Number of Emergency Contact: _____ Relationship: _____
Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid
☐ Personal Health Insurance (Name) _____ ☐ Health Card # _____
Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____
Other Doctors Seen For This Condition: ☐ Yes ☐ No _____ Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No
Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____
Date of Accident: _____ Time of Accident: _____
Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No
Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Other _____
Do You Wear A Shoe Lift? ☐ Yes ☐ No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other _____
Major Accident or Falls: _____
Hospitalization (Other Than Above): _____
Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- ☐ Coffee
☐ Tea
☐ Alcohol
☐ Cigarettes
☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficult Chewing/Clicking Jaw
☐ General Stiffness

- ☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discolored Urine

NERVOUS SYSTEM CODE

- ☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Extremities
☐ Stress

C-V-R CODE

- ☐ Chest Pain
☐ Short Breath
☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke

GENERAL CODE

- ☐ Fatigue
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches

EENT CODE

- ☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Problems
☐ Gall Bladder Problems
☐ Weight Trouble
☐ Abdominal Cramps

MALE/FEMALE CODE

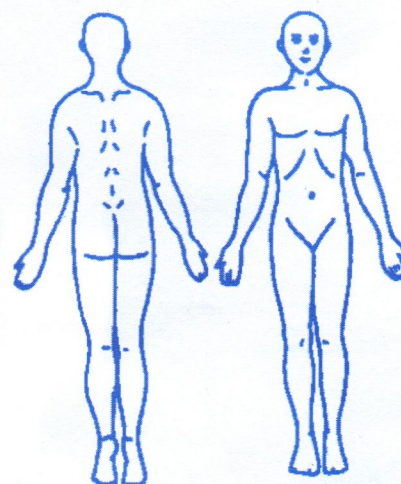
- ☐ Menstrual Irregularity
☐ Menstrual Cramps
☐ Vaginal Pain/Infection
☐ Breast Pain/Lumps
☐ Prostate/Sexual Dysfunction
☐ Other Problems
☐ _____
☐ _____
☐ _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
☐ Father
☐ Brother
☐ Sister
☐ Spouse
☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

 Doctor's Signature

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief
Care

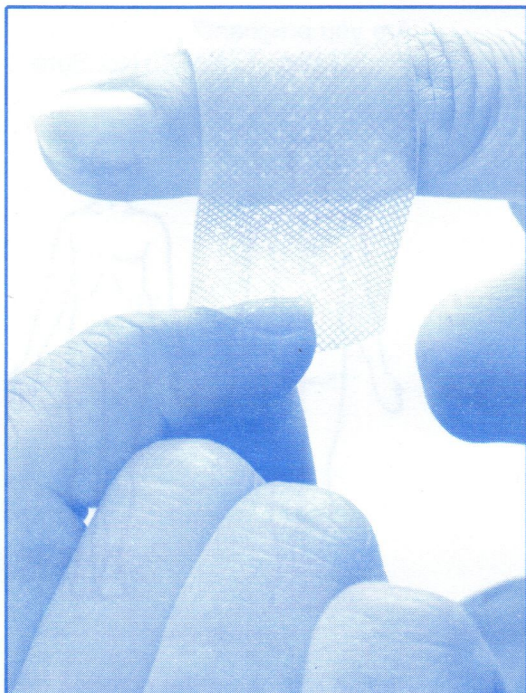
☐ Corrective
Care

☐ Check here if you want the Doctor to select the
type of care appropriate for your condition

Date

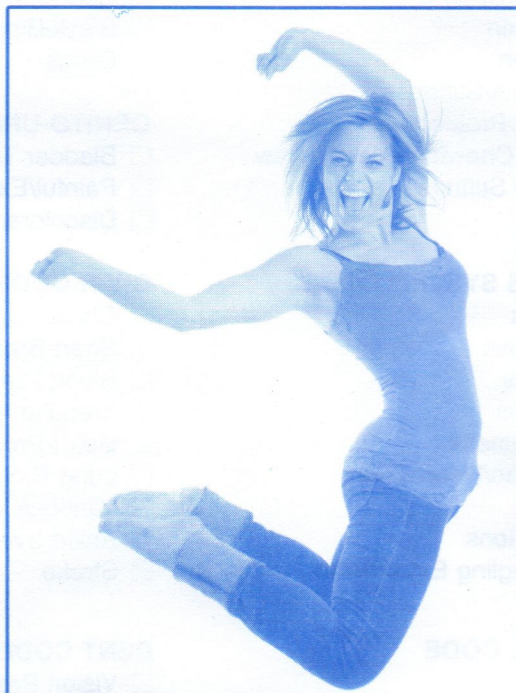
Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____

Date _____

Consent to Treat a Minor _____

Date _____

Guardian or Spouse's
Signature of Authorizing Care _____

Date _____

Neck Disability Index

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU.

ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ☐ I have no neck pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

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

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without causing extra neck pain.
- ☐ I can lift heavy weights, but it gives me extra neck pain.
- ☐ Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - READING

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

SECTION 5 - HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 - WORK

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8 - DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive my car with only slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my car at all because of neck pain.

SECTION 9 - SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 10 - RECREATION

- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some neck pain.
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my recreational activities because of neck pain.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

PATIENT NAME _____

DATE _____

SCORE _____ [50]

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HVERNON@CMCC.CA

The Roland – Morris Low Back Pain and Disability Questionnaire

Patient name: _____ File # _____ Date: _____

Please read instructions: when your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my sock (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Score: _____

Improvement: _____ %

Cline Chiropractic Care

800 Magnolia ste.102 Corona, Ca 92879

(951) 279-2339 fax (951) 279-1307

PATIENT – DOCTOR AGREEMENTS

The purpose of this agreement is to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that those patients who follow through with these agreements get the best results.

SIGNING IN

When you arrive, sign in. You will be called and assigned a treatment area in the order you signed in for the doctor. On each visit, pick up your Routing slip at the front desk, to the assigned treatment area and lie face down (Unless you are told otherwise). Rest and relax the Doctor will be with you as soon as possible.

NEW PATIENT ORIENTATION

It is the policy of this office that you, the patient, participate in your recovery. It is **mandatory** that all patients attend our Spinal Care Class as soon as possible after starting care. This class explains how the body functions, how Chiropractic works, and how results are produced. Family and friends are always welcome. There is no charge for the class. While children are welcome in the office during our normal treatment times, child care is not available during our evening classes, so it is important that other arrangements are made for children under the age of 12 during the Spinal Care Class.

MISSING OR CHANGING APPOINTMENTS

The doctor has set up a specific course of treatment for you. A certain number of treatments in a set amount of time is required to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day. If the same day is not possible, **it is important that you make up the missed appointment within one week.** If you want to be here and have your spine corrected, you will be expected to follow the Doctor's treatment recommendations. There will be no exceptions on this. If you are not ready to make your health a priority by making a commitment to your treatment, then do not waste your time and money now and plan to have your spine corrected at a later date. SCHEDULE YOUR LIFE AROUND YOUR HEALTH, NOT YOUR HEALTH AROUND YOUR LIFE.

Family care. Modern Equipment. Complete X-Ray Facility. Automobile Injuries. Sport Injuries
MY GOAL FOR YOU.... BETTER HEALTH!

APPOINTMENT TIMES

We will set a specific time for your adjustment. Try to be prompt, as the Doctor has set this time aside to detect and correct vertebral subluxations and during this time that is all he will do.

If you come at another time, you may have to wait a few minutes, as the Doctor also sets aside specific times to see new patients and conduct extended consultations. We value your time and do not want you to wait needlessly. If you wish to discuss your case with the doctor, a specific Doctor/Patient conference can be arranged at no additional charge.

PAYMENT OF BILLS

We will expect you to honor the financial agreement you make with our office. In order to serve you better, please plan to make any payments at the front desk before you go to your assigned treatment room for your adjustment. Upon being release from care, a three-month time period is allowed for settlement of your account. If your settlement has not been reached within this time period, or if you suspended or terminated your care without your Doctor's approval, payment for services will be due immediately.

PROGRESS EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, re-examinations and progress reports will be done on a regular basis.

COMMUNICATION

Please communicate directly to your Doctor any upsetting matter such as waiting too long, rudeness by any staff member, failure to understand treatment, need for extended consultation, etc... We are here to serve you. Your criticism will help us to help you, as well as others.

CASH PATIENT FINANCIAL POLICY

We request that 100% of the first visit be paid at the time of the first visit. For your convenience, future payments may be arranged at the first visit of each week. We are happy to accept your check, MasterCard, Visa, or Discover card. We also have special financing available if you qualify.

MAJOR MEDICAL/GROUP INSURANCE

You are expected to make a payment toward your services on the first day in this office. Bring it with you to your next visit. Any checks sent to your home by the insurance company must be brought or sent to our office within three days.

AUTO ACCIDENT/PERSONAL INJURY

You are usually covered 100% for these injuries. You are responsible for obtaining insurance form or address to which we send statements for your care. You are also responsible for reporting your accident to the insurance company and your insurance agent.

WORKER'S COMPENSATION

If your care is related to Worker's Compensation, you must obtain written consent from your employer allowing you to receive care at our office. Also, you must request that your employer notify his insurance company that you are under care at our office and have them send the appropriate forms to our office, immediately. If you have been referred by another doctor's office, the previous office will supply the information.

MEDICARE

This office is a Medicare provider and we will bill Medicare for you. Most people will have a small copay unless they have a secondary insurance. Medicare will cover 12 visits per year and once your benefits are exhausted you are responsible for total payment.

I, _____ understand the above policy and agree to
Print Name abide by it.

Signature

Date

HIPPA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPPA); provides safeguards to protect you privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been our practices for years. This Form is a "friendly" version.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you the quality professional service and care. Additional information is available from the U.S.

Department of Health and Human services. www.hhs.gov

We have adopted the following practices:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than staff. You agree to the normal procedures utilized within the office for handling charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We do this by telephone, e-mail, U.S. mail or by other means convenient for the practice and /or as requested by you. We may send you other communications informing you of changes to office policy and new technology you may find valuable and informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree and abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the practice.
8. You have the right to request restrictions in the use of your protected health information and request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I acknowledge that I have received and have been informed of the above information

Patient name and signature

Date: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures including examination test, diagnostic x-ray(s) and physical therapy techniques on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and other licensed doctors of chiropractic who now or in the future renders treatment to me in while employed by, working for or associated with, or serving as back up for the doctor of chiropractic named below.

I understand that as with any health care procedure there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to; fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgement during the course of procedure(s) which the doctor feels at the time, based upon the facts then known are my best interest.

I have had an opportunity to discuss with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction, I understand that results are not guaranteed.

I have read () or have read to () the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that this is in my best interest to undergo the chiropractic treatment recommended. Having been informed of all the risk I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name(s) and Address (es) of office or cline

Name(s) of Doctor(s) treating the Patient

Cline Chiropractic Care
800 Magnolia Ave Ste. 102
Corona, Ca 92879

Jeffrey J. Cline D.C

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed name of Patient

Signature of Patient

Date

Signature of Patients Representative

Date

Witness of Patients Signature

Date

Translated By

Date

CLINE CHIROPRACTIC CARE

NOTICE OF PRIVACY PRACTICES

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.

Cline Chiropractic Care is required, by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

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

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Cline Chiropractic Care.”

“It is our policy to provide a substitute health care provider, authorized by Cline Chiropractic Care to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

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

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Cline Chiropractic Care for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describes the health care services received.”

Workers’ Compensation

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

Emergencies

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

Public Health

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

Judicial and Administrative Proceedings

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

Law Enforcement

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

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in producing, banking, or transplanting organ and tissues.

Research

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

Public Safety

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

Specialized Government Agencies

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

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below. (example)

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

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. during these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Cline Chiropractic Care sponsored fund-raising events.”

Change of Ownership

In the event that Cline Chiropractic Care is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Cline Chiropractic Care is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.

- You have a right to request that Cline Chiropractic Care amend your protected health information. Please be advised, however that Cline Chiropractic Care is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with and explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Cline Chiropractic Care.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

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

Cline Chiropractic Care is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have question about any part of this notice or if you want more information about your privacy rights, please contact:

Cline Chiropractic Care by calling 909-279-2339. If Cline Chiropractic Care is not available, you may make an appointment for personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Cline Chiropractic Care has handled your health information should be directed to Cline Chiropractic Care by calling this office at 951-279-2339 if Cline Chiropractic Care is not available, you may an appointment for a personal conference in person or by telephone with in 2 working days.

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

DHHS, Office of Civil Rights
200 Independence Ave. S.W.
Room 509F HHH Building
Washington DC 20201

This notice is effective as of ____/____/____

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

By way of my signature, I provide Cline Chiropractic Care with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patients Name (Print)

Patients Signature

Date

Authorized Facility Signature

Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME: _____

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 and federal law, and not by a lawsuit or resort to court process except as state and federal 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

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. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. 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, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: 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 legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional 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.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE