Stitt Chiropratic Patient Registration

Date:_____

Patient Information **Height:**_____ **Weight:**_____ **Sex at birth:** M_____ F_____

Patient:_____ **Date of Birth:**_____/_____/_____
Last First Initial

Address:_____ **City:**_____ **State:**_____

Zip:_____ **Phone:** ( )_____ **Email:**_____

Are you: Single:____ **Married:**____ **Partner:**____ **Divorced:**____ **Widowed:**_____

SS#:_____

Employer:_____ **Work Phone:** ( )_____

Emergency Contact:_____ **Phone:** ( )_____

Person Responsible for payment: Self:____ **Spouse/Partner:**_____ **Other:**_____

Whom may we thank for referring you?_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I hereby authorize and request my insurance company, third-party paters and/or my attorney to pay directly to Stitt Chiropractic the amounts due on my claim for the services rendered to me. I hereby authorize the release of all information necessary, including -rays, to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I understand I am financially responsible for all co-payments, and any charges not paid by my insurance. I authorize the doctors at Stitt Chiropractic to administer treatment as they deam necessary. I understand there is no guarantee of results from this care.

Patient Signature:_____ **Date:**_____

Please fill out other side:

Stitt Chiropractic
Patient History

Reason for your visit _____

Is the purpose of your visit related to: ☐ Job ☐ Sports ☐ Fall ☐ Auto Accident ☐ Home Injury ☐ Chronic Discomfort ☐ Other

Please explain _____

If job related, have you made a report of your accident to your employer? ☐ Yes ☐ No

When did this condition begin? _____

Has this condition: ☐ Gotten worse ☐ Stayed constant ☐ Comes and goes

Does this condition interfere with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other activities

Please explain _____

Has this condition occurred before? ☐ Yes ☐ No

Please explain _____

Have you seen other doctors for this condition? ☐ Yes ☐ No Doctor's Name _____

Results _____ Approx. Date of last visit _____

Have you ever had a serious medical problem? ☐ Yes ☐ No _____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No _____

Have you ever had a serious injury? ☐ Yes ☐ No _____

Are you currently taking any medications? ☐ Yes ☐ No _____

If a woman, are you currently pregnant? ☐ Yes ☐ No Date of last period _____

Please check any conditions you have now or have had in the past:

☐ Severe or frequent headaches
☐ Kidney problems
☐ Sinus problems
☐ Shingles
☐ Ulcers/colitis
☐ Asthma
☐ Loss of sleep
☐ Pain between shoulders
☐ High/low blood pressure
☐ Difficulty breathing
☐ Frequent neck pain
☐ Numbness
☐ Frequent colds
☐ Arthritis
☐ Dizziness
☐ Heat attack/stroke
☐ Congenital heart problem
☐ Digestive problems
☐ Problems with depression
☐ Pain in arms/legs/hands/wrist
☐ Lower back problems
☐ Constipation/diarrhea
☐ Menstrual problems
☐ Bladder problems

I guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature _____ Date _____

01/07

Stitt Chiropractic
Informed Consent for Treatment

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

Chiropractic
Chiropractic health care seeks to restore health through natural means without the use of medicine, surgery or other invasive means. Chiropractic care is not a substitute for traditional medical care, nor is traditional care a substitute for chiropractic.

Analysis/Examination
A Doctor of Chiropractic (DC) conducts an examination for the purpose of determining whether there is evidence of a Subluxation Complex or joint dysfunction which is a common cause of pain and internal organ dysfunction. When Subluxations are found, chiropractic adjustments may be given in order to restore spinal integrity and health.

As part of the analysis and examination, you are consenting to the following procedures: Palpation, range of motion testing, postural analysis, radiographic study as indicated and any other examination procedures deemed necessary by the DC which will be explained to you before being performed.

Diagnosis
Although DC's are experts in the diagnosis of Subluxations, they are not medical doctors. As a chiropractic patient you should be mindful of your own symptoms and should secure other opinions if you have any concerns as to the nature of your total condition. The DC may express an opinion as to whether or not you should take this step and will gladly refer you to the appropriate medical specialist but you are responsible for the final decision.

Chiropractic Care
In coming to a DC, you give the doctor permission and authority to care for you. The chiropractic adjustment procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render you susceptible to injury (including but not limited to bruising, stiffness and in extremely rare cases, fracture). Neurovascular complications although rare (1-4 per million cervical adjustments) have been documented. The doctor will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated or cause injury. The doctor will make every reasonable effort during the examination to screen for such contraindication; however if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to bring such condition to the doctor's attention.

Results
You are an individual and your health is unique, therefore it is difficult to predict the time schedule or efficacy of chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but very satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. The science of chiropractic and medicine may never be as exact to provide definitive answers to every problem.

CERTIFICATION

I, _____, certify that I have read and understood this Informed Consent and that my Doctor of Chiropractic has answered any and all questions in this regard to my satisfaction. I hereby consent to chiropractic care from this office.

Dated this _____ day of _____, 20___

Patient Signature_____ Witness Signature_____

Over →

Stitt Chiropractic
Notice of Financial Policy

For patients without insurance coverage, full payment is expected at the time of service.

Patients with insurance coverage may be financially responsible for any charges incurred at this office including co-payments, deductibles, and charges denied or not covered by their insurance policy. I realize that my care may be subject to pre-authorization by my insurance company, and I accept all responsibility for any treatments, which are determined to be not medically necessary. We will bill your insurance company as a courtesy. You must provide us with a copy of your insurance card for proper billing. All co-pays are due at the time services are rendered.

All patients will assume financial responsibility for care given, whether or not an insurance company is involved. We will charge a $2.00 per month billing fee on accounts with unpaid balances. There will be a $25 fee added to your account for each dishonored check. There will be a $30 administrative fee for all accounts that are sent for collection. Parents or guardians are responsible for a minor's payment. We accept Cash, Check and Master Card or Visa as forms of payment.

I have read, understand and agree to the Stitt Chiropractic Financial Policy.

Patient Name: (Print)_____Signature_____Date_____

01/07

STITT CHIROPRACTIC
12418 Burbank Blvd.
North Hollywood, CA 91607

(818) 766-1128

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Stitt Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ Last Name:_____

Email address:_____@_____

Preferred method of communication: (Circle one): Email / Phone / Mail Height:_____ Weight:_____

Date of Birth: ____/____/____ Sex at birth: M_____ F_____

Smoking status: (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one) American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)

Native Hawaiian or Pacific Islander / Other / Decline to answer.

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / Decline to answer

☐ I choose to decline receipt of my clinical summary after every visit. *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:_____ Date:_____

Blood Pressure: _____/_____