Please Fill Out This Form Completely.
Write legibly and leave nothing blank

Date:

PATIENT INFORMATION

Last Name: _____

First Name: _____ Initial: _____

Nick Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:(_____) _____

Work Phone:(_____) _____

Cell Phone:(_____) _____

Cell Phone Provider: _____

E-mail: _____Sex: M F

Occupation: _____

Social Security #: _____

Birthdate: _____ Age: _____

Drivers Lic. #: _____

Height: _____ Wt: _____

Race: Hispanic, White, Am. Indian, Asian,

African Am, Portuguese, Other:_____

Circle One: Hispanic/Non Hispanic

Language: English, Spanish, Other _____

CLAIM INFORMATION

CARRIER ***(INSURANCE NAME):***

_____

(Please give insurance card to (If different from patient)

RELATION OF PATIENT TO INSURED PERSON:

Self ( ) Spouse ( ) Child ( ) Other ( ) _____

MAIN SUBSCRIBER'S INFORMATION:

Last Name: _____

First Name: _____ Initial: ____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone:(_____) _____

Birthdate: _____

Social Security Number:_____

Sex: M F

Employer/School: _____

RELATIONS AND CONTACTS

PATIENT'S EMPLOYER:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

SPOUSE: None ( ) *(if none, move to next section)*

Last Name: _____

First Name: _____ Initial: ____

Home Phone:(_____) _____

Employer: _____

SSN : _____ DOB: _____

Occupation: _____

EMERGENCY CONTACT:

Name: _____

Phone: (_____) _____

REFERRAL: *(Please be as specific as possible)*

How did you hear about our office?

GENERAL INFORMATION

Injury Date: _____

Injury Description (How did you get hurt?):_____

_____

Place of Injury: _____

Complaint (Describe your pain…):_____

_____

Is The Injury New or old? (acute or chronic): _____

Marital Status: Single ( ) Married ( ) Widowed ( ) Divorced ( )

Do You Smoke? YES NO

Employment status: Employed ( ) Unemployed ( ) _____

Off Work Due to Injury? Y N Since When? _____

Injury Is Related to: Work ( ) Auto Accident ( ) Other Accident ( )

Other ( ) _____

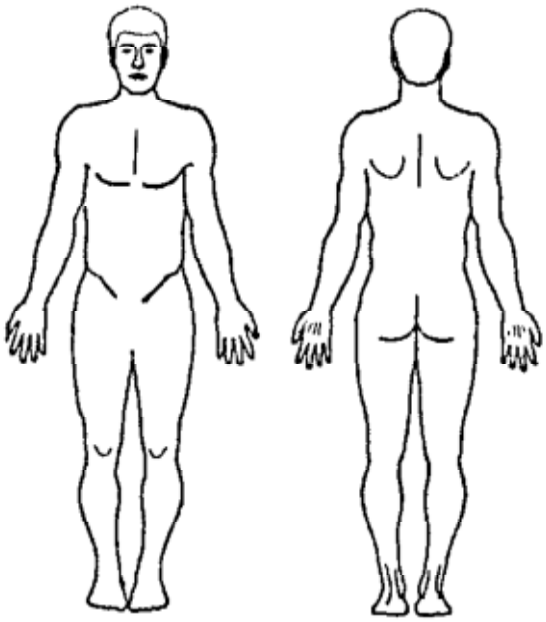
_____

Signature of Patient or Guardian

Injury Detail

Patient Name: _____ Date: _____

Please mark the location of your symptoms on the figure below and describe.



Please mark where your current complaint is on this scale (how you feel today):

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

(0 = No Pain)
(10 = Unbearable Pain)

How often are your symptoms present?

0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% ☐

Have you ever had these symptoms before? Y N

(Explain):_____

Can you perform your daily work? Y N

(If no, you've been off work since when?) _____

Have you had x-rays, MRI, CAT scan, or other? Y N

(What area taken?):_____

Have you ever seen a chiropractor before? Y N

(When, and who?): _____

Any past/current medical problems or conditions? Y N Do you take any regular medications? Y N

(Explain):_____

_____

_____

Any surgeries in the past? Y N

(Explain): _____

_____

_____

_____

Any injuries in the past? Y N

(Explain): _____

_____

_____

_____

Family History:

- ❑ Cancer
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Cardiovascular problems/stroke
- ❑ Back / Neck pain
- ❑ Other _____

Female Patients- *I certify that I am not pregnant, nor is there a likely chance that I may be pregnant. I give my permission for any necessary x-rays to be taken today.*

Patient Signature: _____ **Date:**_____

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health coverage in the future.

Patient Signature: _____ **Date:** _____

Dr.'s Notes: _____

_____

_____

Tulare Chiropractic
Accident & Injury Center
Steven D. Mitchell, D.C.
1098 E. Cross Ave.
Tulare, CA 93274
(559) 685-9391
Tularechiro.chiroweb.com

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.
I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.
I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about it's content, and by signing below I agree to the above-named procedures. 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.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

Name and Address of Clinic/Office:

Tulare Chiropractic Clinic
1098 E. Cross Ave.
Tulare, CA 93274

Witness to Patient's Signature: _____ Date _____

Translated by: _____ Date _____

To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

As: _____
Relatationship or Authority of Patient's Representative

_____
Date Signed

Print name(s) of doctors treating this patient:

Steven D. Mitchell, D.C.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

• I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Tulare Chiropractic Clinic
Dr. Steven D. Mitchell
1098 E. Cross
Tulare, CA 93274

for the professional or chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

• I also authorize the release of any information pertinent to my case to any Insurance company, adjuster, or attorney involved in this case.

• I authorize Dr. Steven Mitchell to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

• I authorize Dr. Steven Mitchell to deposit checks received from insurance companies on my behalf when made out to me.

Date_____

_____ _____

Signature of policyholder Signature of Claimant, if other than Policyholder

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LETTER OF NO ACCIDENT OR INJURY

_____(pt. initials) 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.

_____ _____

Patient Signature Date

Tulare Chiropractic

Accident & Injury Center

Date:_____

Name of Patient: _____

NOTICE OF PRIVACY PRACTICES (NPP)

We are required by federal law to maintain the privacy of your Private Health Information (PHI) and to provide you with a Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI. Signing below confirms that you agree to our policy. If you would like to read the policy, one is prominently displayed, or you may receive a printed copy to review upon request. Tulare Chiropractic Clinic (TCC) is required to abide by the terms of this Privacy Notice. TCC reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains. TCC will distribute any revised Privacy Notice to you prior to implementation. TCC will not retaliate against you for filing a complaint.

Patient Signature:_____ Date: _____

If Minor: Name of Legal Guardian: _____

Legal Guardian signature: _____ Date: _____

Tulare Chiropractic

Accident & Injury Center

Date:_____

Name of Patient: _____

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Patient Signature:_____ Date: _____

If Minor: Name of Legal Guardian: _____

Legal Guardian signature: _____ Date: _____

Financial Policy

We would like to take a moment to welcome you to Tulare Chiropractic Clinic and assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, we would first like to explain how your medical bills would be handled.

It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided. If this arrangement becomes inconvenient for you, please see our billing representative so that other arrangements can be made for you. These arrangements must be made in writing. Should you suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

If you have a primary/secondary insurance carrier who has chiropractic benefits, then we will bill the primary & secondary insurance for you. If the carriers do not pay the bill within the time allowed through the California Health and Safety codes (without a legitimate reason), then the balance will be due from the patient. **Our office does not bill 3rd party insurances.**

I have read and agree to the above.

_____ _____

Patient Name **Date**

_____ _____

Financially Responsible Person **Signature**

(if different than above)

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that many health insurance companies may not pay for the item(s) or service(s) that are described below. Health insurance does not pay for **all** of your health care costs. Health insurance only pays for covered items and services listed in your particular contract. The fact that your health insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason you doctor recommended it. Right now, in your case**, your health insurance probably will not pay for:**

Items/Services: Spinal Decompression, Massage Therapy, Supplements, Durable Medical Equipment

Reason: Non-Covered Elective Services

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make any decision about your options, you should **read this entire notice carefully**.

- Ask us to explain, if you don't understand why your health insurance probably won't pay.
- Ask us how much these items or services will cost you **(Estimated Cost :$_____)**, in case you have to pay for them yourself or through other insurance.

I understand that my insurance will not cover these services

_____ _____

Date **Signature of patient or person acting on patient's behalf**