Date: ______________________ *E-mail Address*: ____________________________ Referred by: __________________________________

Patient Name: ____ *Social Security #:* __________________________________

Home #: _________________________ *Cell #:* __________________________ *Work #:* _________________________ *Email:* ________________________

Driver's License#: ____ *Birth Date:* _______________________________________*Sex:* ___________

Address: ____*City:* _______________________________*State:* ________ *Zip:* ___________

Occupation: ____ *Employer:* ____

Employer address: ____ *City:* _______________________________*State:* ________ *Zip:* __________

Marital Status: ❑*Married* ❑*Single* ❑ *Divorced* ❑*Widowed* *Number of Children:* __________________

Spouse's Name: ____ *Social Security #:* __________________________________

Work Address: ____ *City:* ______________________________ *State:* ________ *Zip:* ___________

Have you previously had Chiropractic Care? __________ *If yes, when?* _____________________________ *Did it help?* _______________________________

List your chief complaints in order of severity:

1. ____*For how long?* _____________________________
2. ____*For how long?* _____________________________
3. ____*For how long?* _____________________________

Please describe work activities that may be causing your complaint ____

Please explain any other activities outside of work, which may have caused these complaints? ____

If this is due to an injury or accident, when did it happen? ____

Has this problem been getting better, worse, or staying the same? ____

What activities make your condition worse? ____

Have you been involved in an auto accident in the last 12 months? _________________________________ *Do you have health insurance?* ________________

Name of insurance company: ____

Are you covered under additional (group or individual) health policy through yourself or spouse? ____

Name of insurance company of additional coverage: ____

Medications you take now: ❑*Aspirin* ❑*Pain Killers* ❑*Tranquilizers* ❑*Insulin* ❑*Birth Control Pills* ❑*Other (please list)* __________________________

____

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑ RELIEF CARE: Symptomatic relief of pain or discomfort

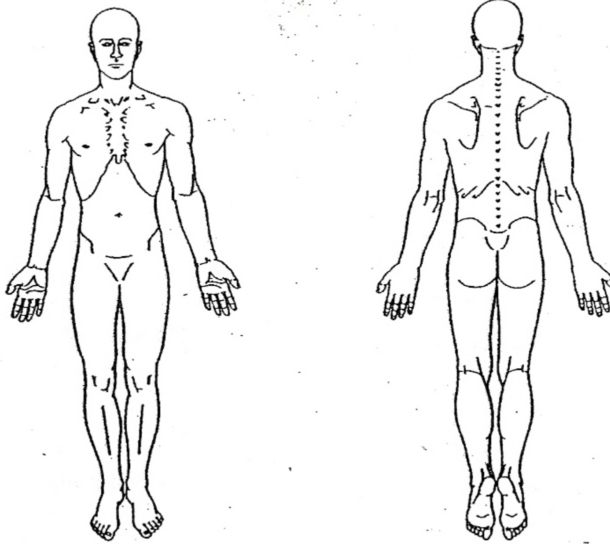
❑ CORRECTIVE CARE: Correcting and relieving the cause of the problem as well as the symptoms

❑ COMPREHENSIVE CARE: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

❑ I want the Doctor to select the type of care appropriate for my condition

Patient signature: ____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity, which brings on or aggravates the pain. For example, describe as dull, sharp, constant, off & on, when standing, when sitting, etc.



Check appropriate squares (x) past or (✓) present condition:

- ❑Headaches
- ❑Nervousness
- ❑Insomnia
- ❑Head colds
- ❑High blood pressure
- ❑Migraines
- ❑Nervous breakdown
- ❑Chronic tiredness
- ❑Dizziness
- ❑Sinus troubles
- ❑Eye problems
- ❑Excessive sweating
- ❑Ear ache
- ❑Ulcers
- ❑Stomach troubles
- ❑Indigestion
- ❑Heartburn
- ❑Gastritis
- ❑Lowered resistance
- ❑Diabetes
- ❑Mental, emotional conditions
- ❑Convulsions
- ❑Acne
- ❑Eczema
- ❑Hay Fever
- ❑Adenoids
- ❑Hearing loss
- ❑Ringing ear
- ❑Laryngitis
- ❑Hoarseness
- ❑Sore throat
- ❑Tonsillitis
- ❑Croup
- ❑Poor circulation
- ❑Swollen ankles
- ❑Cold feet
- ❑Weakness in legs
- ❑Leg cramps
- ❑Hemorrhoids (piles)
- ❑Bursitis
- ❑Thyroid condition
- ❑Asthma
- ❑Cough
- ❑Difficult breathing
- ❑Shortness of breath
- ❑Heart condition
- ❑Bronchitis
- ❑Pleurisy
- ❑Pneumonia
- ❑Congestion
- ❑Influenza
- ❑Gall bladder condition
- ❑Jaundice
- ❑Shingles
- ❑Liver condition
- ❑Fever
- ❑Low blood pressure
- ❑Arthritis
- ❑Kidney troubles
- ❑Constipation
- ❑Colitis
- ❑Dysentery
- ❑Diarrhea
- ❑Ruptures
- ❑Hernias
- ❑Cramps
- ❑Varicose veins
- ❑Bladder troubles
- ❑Menstrual problems
- ❑Miscarriages
- ❑Bed wetting
- ❑Impotency
- ❑Change of life symptoms
- ❑Knee pain
- ❑Sciatica
- ❑Difficult urination
- ❑Painful urination
- ❑Frequent urination

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN, SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.

Our office uses sign in sheets, travel cards and provides care in an “open door” adjusting environment. Adjustments are done in an open adjusting area. As a result patients are in sight of each other and some ongoing routine details of care may be in earshot of other patient’s and staff. This environment is used for ongoing care and is not the environment for taking patient’s histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity. In addition your signature below authorizes us to contact you at all the phone numbers/address you list on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

Patient’s Signature____ Date_________________________

Privacy Policy Received
Patient’s Signature____ Date_________________________

Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW PATIENT INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During the course of your care, we may use, or disclose, health-related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another healthcare provider if a referral is necessary for care, diagnosis, or assessment.
- Your healthcare and/or billing records may be disclosed to another party, such as an insurance carrier or your employer, if they are responsible for payment of services.
- Your personal information and/or healthcare records may be used to contact you regarding appointments or other health-related information that may be of interest to you.

At your request, we may restrict the use of your protected health information for patient-care or payment purposes. Such requests are not automatic and require our acknowledgement prior to initiation.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted, and may be required, to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- By order of the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in-person at the time you receive care. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or in a specific form, you may advise us in writing.

You have the right to inspect, copy, or request an amendment of your health information for as long as the information remains in our files. These requests to inspect, copy or amend your health information shall be in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in-writing following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

____

If you would like further information about our privacy policies and practices please contact:

____

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or by our staff in any manner whatsoever.

This notice is effective as of ______________________________. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

____________________ ____________________ ____________

Patient Name (please print) Signature Date

If you are a minor or if you are being represented by another party:

____________________ ____________________ ____________

Representative Title Name (please print) Signature Date

Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **G.J. Valentine D.C.** medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Dr. Gregory J. Valentine: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Gregory J. Valentine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

______________________________________ ________________
Patient/Responsible Party Signature Date

______________________________________ ________________
Witness Date

Conscious Chiropractic & Chiropractic

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 on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and his/or her preceptor 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 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. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I 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.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise of a cure for any symptom, disease, or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click”. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working like cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I’ve provided or forward a copy in via e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its 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.

____ ________________________

Name (Printed) Date Signed

____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

____

Witness to Patient’s Signature

PATIENT NAME ____:

ARBITRATION AGREEMENT AND INFORMED CONSENT

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 state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review or 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 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, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement blind 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 uniform 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 or preceptorship 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.

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 state and federal law, when applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. 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 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 SIGNATURE (Date)
(Or Patient Representative) (Indicate relationship if signing for pat

I hereby request and consent to the performance of chiropractic treatments and other procedures within the scope of the practice chiropractic on me (or on the patient named below for whom I am legally responsible) by the chiropractor named below and/or other licensed chiropractors who now or in the future treat me while employed by, working or associated with or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to chiropractic, moxibustion, cupping, electrical stimulation, Tiu-Na (Oriental massage). Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that chiropractic is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of chiropractic include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of chiropractic and other procedures, and have had an opportunity to ask questions. 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

Date

PATIENT SIGNATURE X

Or Patient Representative (Indicate relationship of signing for patient)

Date

OFFICE SIGNATURE

Acknowledgement of Receipt of Privacy Policy

I hereby acknowledge that I have read a copy of World Medicine Institute's Notice of Privacy Practice.

Date

PATIENT SIGNATURE X

Or Patient Representative (Indicate relationship of signing for patient)