VALLEY CHIROPRACTIC 2911 Niles St. * Bakersfield, CA * 93306

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license or ID Card.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY) _____ Age _____

First Name _____ Date of Birth (MM/DD/YYYY) _____

Middle Name_____ Social Security Number _____

Last Name_____ Gender (Circle One) M F

Marital Status (Circle One) Single Married Divorced Widowed Separated

Preferred Language _____ Whom may we thank for referring you?
_____

Address _____

City/State/Zip_____

Home Phone: _____

Cell Phone: _____

Home Phone: _____

Email Address: _____

Would you like to receive appointment text reminders? (Circle One)
Yes No

Have you consulted a Chiropractor before?(Circle One)
Yes No

Occupation _____ Employer _____

Race _____ Ethnicity _____

Emergency Contact Name_____

Emergency Contact Phone Number _____ Relationship to you_____

Primary complaint that prompted me to seek care today is _____,
and are the result of (Circle One) Work Accident Other Worsing long-term problem
When did you first notice your current symptom? _____

Secondary complaint that prompted me to seek care today is _____,
and are the result of (Circle One) Work Accident Other Worsing long-term problem
When did you first notice your current symptom? _____

Additional complaint that prompted me to seek care today is _____,
and are the result of (Circle One) Work Accident Other Worsing long-term problem
When did you first notice your current symptom? _____

What have you done to relieve the symptoms?_____

What else should the doctor know about your current condition?_____
_____

How does your current condition interfere with your
Work/Career: _____
Household Responsibilities:_____
Recreational Activities: _____
Personal Relationship: _____
In addition to the main reason for your visit today, what additional health goals do you have?
_____

Injuries or Surgeries you have had

	Description	**Date**
Falls	_____	_____
Head Injurires	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
	_____	_____

All medications currently taking

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

PLEASE MARK "P" FOR IN THE PAST OR MARK "C" FOR CURRENTLY HAVE

___ Headaches	___ Migraines	___ Jaw/TMJ Pain
___ Neck Pain	___ Shoulder Pain	___ Arm Pain
___ Upper Back Pain	___ Mid Back Pain	___ Knee Pain
___ Lower Back Pain	___ Hip/Leg Pain	___ Foot Pain
___ Ear Infections	___ Hearing Loss	___ Dizziness
___Ringing in Ears	___ Loss of Energy	___ Nervousness
___ Double/Blurry Vision	___ Anxiety	___ADD/ADHD
___ Loss of Balance	___ Depression	___ Allergies
___ Sinus Issues	___ Frequent Colds	___ Thyroid Issues
___ Asthma	___ Chest Pain	___ Heart Problems
___ Nausea	___ Ulcers	___ Diarrhea
___ Digestive Issues	___ Constipation	___ Bedwetting
___ Kidney Problems	___ Bladder Problems	___ Poor Posture
___ Menstrual Problems	___ Prostate Problems	___Infertility
___ Fibromyalgia	___ Epilepsy/Convulsions	___ Tremors
___ Disc Problems	___ Muscle Spasms	___ Skin Problems
___ Sexual Dysfunction	___ Sleep Problems	___ Sports Injury
___ Tight/Sore Muscles	___ Sciatica	___ Heart Attack
___ Arthritis/Joint Pain	___ GERD/Gastric Reflux	___ Cancer
___ Numb/Tingling in Arms/Hands	___ Numb/Tingling in Legs/Feet	___ Diabetes
___ Stomach Problems	___ High/Low Blood Pressure	___ Arthritis
___ Difficulty Breathing	___Spinal Surgery	___ Seizures
___Spinal Bone Fracture	___Scoliosis	___Stroke

___ Other: _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):_____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health Information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that i am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Patient/Guardian Signature **Date (MM/DD/YYYY)**

Informed Consent For Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of soft tissue mobilization, physical therapy and, if necessary, diagnostic x-ray's on me by Dr. Christopher Berry and/or any other authorized provider at Valley Chiropractic, Dr. Christopher Berry, Inc.

I am informed that, as in all practices of medicine, in the practice of chiropractic there are some risks to treatment. Although these occurrences are extremely rare, they include but are not limited to sprains and strains, fractures, disc injuries, vascular accidents, stroke, dislocations and general aggravation of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustment and other procedures. I understand that the doctor will perform a detailed examination in order to minimize any risks. However , I do not expect the doctor to anticipate and explain all risks and complications. Rather I wish to rely on the doctors expertise and judgment to apply only procedures which are in the best interest of my health and to use the most effective and gentle of those procedures necessary. I understand that results are not guaranteed.

I have read (or have read to me) the above consent. I understand that I may discuss it with the doctor and have any questions answered. By signing below, I give consent to the chiropractic care recommended by the doctor. I intend for this consent form to cover the entire course of chiropractic care for my present condition and for any future condition(s) requiring chiropractic care.

If patient is a minor, I hereby extend this consent and authorize treatment for my child, (name of child) _____, whom is under the age of eighteen or legally considered a minor. As of today's date, I have the legal right to authorize health care services for the minor stated above. If my authority to authorize such treatment or car should change or is modified in any way, I will notify this clinic immediately.

Patient Name: _____

Patient Signature: _____ Date: _____
(Signature must be provided by parent/guardian if patient is less than 18 years of age)

Witness Signature: _____ Date: _____

Financial Policy

Thank you for choosing Valley Chiropractic, Dr. Christopher Berry, Inc. for your health care needs. The following is a statement which explains our financial policy. This policy must be read and signed prior to treatment. If you have any questions regarding this policy please discuss these matters with us immediately. We will be happy to explain any statements which appear unclear or confusing, as to avoid any misunderstandings.

PAYMENT AT THE TIME OF SERVICE

Payments may be made by cash, check, or credit card. By paying at the time of service, you will receive a discount, which is only valid when payment is received on the day of service. If any billing is to occur, which should be arranged before the time of service, you will be billed at the regular office rates.

USUAL AND CUSTOMARY RATES

The rates established for this clinic fall within the usual and customary rates for this area. We are dedicated to provide our patients with the best treatments possible for these rates. Regardless of your insurance company's agreement with these rates, you are responsible for payment in full.

INSURANCE

As a courtesy to you, we will bill pre-authorized insurance companies for you. All co-payments, deductibles, and payments for services which are not covered under your insurance policy are due at the time of service unless prior arrangements have been made. Payments can be made by cash or check. Any balances which remain unpaid for 60 days or longer will be charged interest of 2.5% per month. If you are unable to pay in full at the time of your service , it is your responsibility to contact our office to arrange a payment plan. Your insurance policy is a contract between you and your insurance company, and Valley Chiropractic, Dr. Christopher Berry, Inc is not included in this contract.

ACCIDENT/INJURIES

This clinic will make every effort to recover our fees from all available sources, including health insurance, auto insurance, etc. However, any unpaid balances are ultimately your responsibility, and you will be required to pay this balance in full.

MINORS

Minors will be accompanied by a parent/legal guardian for the first visit. Payment is the responsibility of the parent/legal guardian.

MISSED APPOINTMENTS

24 hours notice is required for cancellation of appointments with this office. This office reserves the right to charge $25.00 for any appointments that are not canceled within this time frame.

PATIENT'S AGREEMENT

I have completely read and understand the Financial Policy of Valley Chiropractic, Dr. Christopher Berry, Inc. I understand and agree that I am responsible for payment for services and products provided by this clinic. I am also responsible for payment of any fees that may accumulate while trying to collect my unpaid balance: this may include but is not limited to attorney fees.

Signature: _____ Date: _____

(Signature must be provided by parent/guardian if patient is less than 18 years of age)

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize _____
(name of physician or healthcare provider authorized to use or disclose information)
To furnish to **Valley Chiropractic**

Health information described below on: _____

For the purpose of :_____

This information is limited to the following type and amount of information. (Use date where appropriate).

- Progress Notes
- Consultation Reports
- Laboratory and Pathology Reports
- Radiology Reports/Imaging Reports
- Medical Records relating to injury
- Immunization Records
- Any and all Records for the last 2 years
  From _____ to _____
  From _____ to _____
- Other _____

DISCLOSURE REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis or treatment for: (initial appropriate area)

HIV/AIDS Virus _____ Sexually Transmitted Diseases _____
Mental Health/Psychiatric Disorders_____ Drug, Alcohol Abuse/Treatment _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and present at the Health Information Management Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Direct of Health Information. I understand I have the right to receive a copy of this authorization,

_____ _____
Signature of Patient, Parent or Legal Guardian Date of birth

_____ _____
If signed by other than patient, indicate relationship Patient Address

_____ _____
Patient telephone number Patient social security number

_____ _____
Witness Signature Date

Note: There will be a charge for a personal copy or transfer of your records, Your cost is $25 one time fee(1-100 pages), $.15 per page (101 + pages), actual postage & tax. I have read and understand that there is a charge for my records.

_____ _____
Signature Date

PHYSICIAN - PATIENT ARBITRATION AGREEMENT

ARTICLE 1: Binding 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 binding arbitration as provided by California Law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional rights 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 the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners. associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

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 of a demand for a neutral arbitrator by either party. 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 or witness fees, or other incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which 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 California law applicable to health care providers shall apply to disputes within this arbitration agreement, including but not limited to Code Civil Procedure Sections 340.5 and 677.7 and Civil Code Sections 333.1 and 333.2. any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of civil Procedure section 1283.05.. However, dispositions may be taken without prior approval of the neutral arbitrator.

ARTICLE 4: General Provisions: 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 civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

ARTICLE 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 15 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

ARTICLE 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

Independent Counsel: Each party has had the opportunity to be separately represented by independent counsel prior to the execution of this agreement and in the absence of having obtained independent counsel has waived that opportunity prior to the execution hereof. If any provisions of this arbitration agreement are held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be effected by the invalidity of any other provisions.

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 ISSUES 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: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

If Representative, Print Name and Relationship to Patient: _____

Physician Signature/Authorized Representative: _____ **Date:** _____

Print/Stamp Name of Physician Medical Group or Association: