# CONFIDENTIAL PATIENT INFORMATION

Name: _____ Other Legal Name(s):_____

Home Phone: _____ Work/Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Marital Status (circle one): M / S / D / W Sex: F / M Age: _____

Social Security Number: _____-_____-_____ Email Address: _____

Occupation: _____ Employer: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ # of Children: _____

Who may we thank for referring to our office: _____

Have you ever had chiropractic care before? ☐ Yes ☐ No Date: _____

Is this injury/illness related to an Automobile Accident? ☐ Yes ☐ No

Date/Time of accident: _____ Location: _____

Your Auto Insurance Co: _____ Phone: _____

Third Party Auto Insurance Co: _____ Phone: _____

# YOUR HEALTH INFO

What brings you in today? _____

_____

_____

Is the pain (circle): Sharp / Dull / Achy / Nagging / Shooting / Pressure / Stabbing / Throbbing

| | | | |
|---|---|---|---|
| ☐ Neck Pain | ☐ Low back pain | ☐ Headaches | ☐ Leg Pain |
| ☐ Upper back pain | ☐ Numbness | ☐ Migraines | ☐ Carpal Tunnel |
| ☐ Mid-back pain | ☐ Sciatic Pain | ☐ Hip pain | ☐ Other:_____ |

How long has this been going on? (circle): Days / Weeks / Months / Years / Decades

Does the pain stay in one spot or does it travel? Where? _____

What have you tried that makes it better?

| | | | |
|---|---|---|---|
| ☐ Ice | ☐ Medication | ☐ Exercising | ☐ Chiropractic |
| ☐ Heat | ☐ Lying down | ☐ Stretching | ☐ Other: _____ |
| ☐ Rest | ☐ Sitting | ☐ Massage | ☐ Other:_____ |

What makes the pain worse?

| | | | |
|---|---|---|---|
| ☐ Sitting | ☐ Bending | ☐ Morning time | ☐ Sneezing |
| ☐ Standing | ☐ Twisting | ☐ Evening time | ☐ Coughing |
| ☐ Walking | ☐ Running | ☐ Seasonal | ☐ Other: _____ |

Height: _____ Weight: _____

Are you pregnant? ☐ Yes ☐ No ☐ Not Sure

Please list all current medications you are taking: _____
_____
_____

Please list all surgical procedures you have had: _____
_____
_____

Please explain any significant traumas you have had: _____
_____
_____

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All charges are due when services are rendered…

Method of payment: ☐ Check ☐ Cash ☐ Credit Card

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Why chiropractic? People go to chiropractors for a variety of reasons. Some go 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.

| RELIEF CARE | CORRECTIVE 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 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. |

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I authorize Rabo Chiropractic to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

# THANK YOU FOR ALLOWING US TO SERVE YOU!

**Rabo Health and Wellness**

**Patient Payment Policy**

Rabo Health and Wellness strives to ensure a clear understanding of your financial responsibility with respect to the chiropractic services we provide. These policies apply to all procedures and departments.

**Co-Pays**: We require payment of co-pays at the time of service and reserve the right to refuse treatment.

**Insurance Doesn't Cover/No Insurance:** If you have no insurance, we collect payment up front at the time of your visit for services rendered. (Note: there may be additional charges to your office visit of ancillary procedures are required.) Should your insurance not cover chiropractic services, you are responsible for payment in full at the time of your visit.

**Payments**: We accept cash, Visa, and MasterCard, and check. We may hold a credit card number on file to reserve an appointment for reoccurring appointments.

**Regular appointments**: We charge $25 to your credit card if you do not call and cancel your appointment 24 hours ahead of time for all regular scheduled appointments.

Attestation Statement:

I have read, understand, and agree to the above Rabo Health and Wellness Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

(Print name of patient) _____ (Date signed) _____

(Signature of patient)_____

# Rabo Health and Wellness Inc.

670 Rio Lindo Ave., Ste. 600
Chico, CA. 95926
530-520-8840

# HIPAA 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.

Rabo Health and Wellness is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of Rabo Health and Wellness authorized to remove the files from the Practice's office.

**NO CONSENT REQUIRED**

Rabo Health and Wellness may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.
(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

Rabo Health and Wellness may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.
(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

**Appointment Reminders**

· Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
· You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

**Sign-in Log**

This Practice maintains a sign-in log for individuals seeking care and treatment in the office. This sign-in sheet are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

**Family/Friends**

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.
- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

**AUTHORIZATION**

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

**Your Right to Revoke Your Authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing.

**Restrictions**

You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

**You Have a Right to**

# Rabo Health and Wellness Inc.

670 Rio Lindo Ave., Ste. 600
Chico, CA. 95926
530-520-8840

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

**PRACTICE'S REQUIREMENTS**

1. Rabo Health and Wellness Inc.:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- 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.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Signature:_____ Date: _____

# Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: Your chiropractor will use her hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or a "pop" and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she determines is most appropriate for your condition.

**Possible Risks:** Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy. Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. ***Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.***

**Other options for the treatment of pain include**: Do nothing- Live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

> *My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment. I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all the other conditions that have caused me pain in the past.*

Printed name_____Signature_____Date_____

# X-RAY CONSENT FORM

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment. By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary.

Patients Signature _____ Date_____

**PORTION FOR WOMEN ONLY:**

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I am aware that the ten days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

_____ with full understanding of the above, and believing that I am currently not at risk, I wish to have an x-ray examination performed today if requested by the doctor.

Signature_____ Date_____


Rabo Health and Wellness
670 Rio Lindo Ste 600
Chico, CA 95926
Phone: 530-846-6262 Fax: 530-846-4004

# Authorization to Release Medical Records

This authorization to release medical information is being requested of you to comply with terms of the Confidentiality of Medical Information Act, Section 56 sect of the California Civil Code.

I hereby release and authorize: *Rabo Health and Wellness*

To release or discuss all my information, including:

medical records, x-rays, and or MRI, CT scan, lab reports, medical history, and findings, prognosis pertaining to the medical condition of services rendered, or treatment given.

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_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Phone Number

_____ _____

Last 4 of SSN Date