Confidential Patient Health Record

PERSONAL HISTORY

Today's Date:_____

Name:_____ Address:_____

City:_____State:_____Zip/PostalCode:_____

Please provide phone number(s) we may call with your medical, billing or upcoming appointment:

Home Phone: _____ Cell Phone: _____

E-Mail(No spam!):_____ Can we E-mail you with appointment info? YES NO

Birth Date: _____ Sex: Male or Female Height: _____ Weight: _____

Business Employer:_____ Business Phone:_____

Who referred you to this office or how did you hear about us? _____

Name of Emergency Contact: _____Phone Number: _____

Relationship to Emergency Contact: _____

Who is Responsible for Your Bill? You and…

□You alone □Spouse □Workers' Comp. □Auto Insurance □Medicare □Health Insurance

Insured Person's Name _____ Date of Birth: _____

Primary Care/Referring Physician:_____ Location:_____

_____

CURRENT HEALTH CONDITION

Describe reason for your visit:_____

_____

Date of onset: _____ Has this Condition Occurred Before? □ YES □ NO

Is the condition job related? □ YES □ NO Is the condition related to an auto accident? □ YES □ NO

Describe initial cause of condition:_____

_____

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

What makes your condition worse (aggravating factors)?_____

What makes your condition better?_____

What activities are more difficult because of this condition?_____

_____

Other Doctors Seen for this Condition: □ YES □ NO If Yes, Who?_____

Type of Treatment: _____ Results: _____

Drugs You Now Take: □ Nerve Pills □ Pain Killers/Muscle Relaxant □ Blood Pressure Medicine □ Insulin

Other medications: _____

Vitamins & Supplements: _____

Do you suffer from any condition other than that which you are now consulting us?_____

_____

_____

PAST HEALTH HISTORY

Surgery/Operations: □Back/Neck/Hip □Heart(□Pacemaker?) □Knee/ankle □Shoulder/Elbow/Wrist □Breast Augmentation/Reduction □Other: _____

Major Accidents or Falls: _____

Hospitalization (Other than Above): _____

Previous Chiropractic Care: _____

What medical conditions run in your family? _____

BLUE OAK CHIROPRACTIC

2260 E Bidwell St Ste 108 Folsom, CA 95630. 916-984-6555

Authorization:
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 understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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 Dr. Bradley Falke, and / or licensed Doctors of Chiropractic or those working at the clinics or office who now or in the future treat me while employed by, working or associated with, or serving as backup for Dr. Falke.

I understand and I am informed that in the practice of chiropractic there are some risks to exam and treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain, or no improvement of symptoms and pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, 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 on the facts then known, is in my best interest.

I hereby authorize the Doctor to treat my condition, as he deems appropriate. The patient also agrees that he/she is responsible for all bills incurred at this office.

►►Patient's Signature (parent if minor):_____ Date:_____

HIPAA Notice:
I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

►►Patient's Signature (parent if minor):_____ Date:_____

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PATIENT NAME:

ARBITRATION AGREEMENT

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 California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of 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 nay 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 is also intended to bind 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 unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and 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 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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 dated 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 YOUR 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 X (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE X (Date)