R. J. Ammon Chiropractic
4200 East Ave. Suite #102 Livermore, CA 94550 Phone: (925) 371-7300

Initial Health Status

Patient Name: _____ Birth date: ____/____/____ Age: _____ Sex: M / F

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

Home Phone: _____ Cell Phone: _____ Email: _____

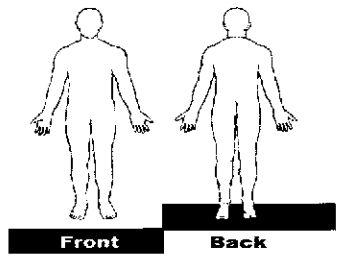
Occupation: _____ Employer: _____ Work Phone: _____

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

Marital Status: S M D W Spouse: _____

Social Security #: _____ Driver's License #: _____ Referred By: _____

MARK AN X ON THE PICTURE WHERE YOU
HAVE BEEN HAVING PAIN OR OTHER SYMPTOMS



Describe your current problem and how it began:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Arm pain ☐ Shoulder pain
☐ Hand pain ☐ Low back pain ☐ Leg pain ☐ Foot pain ☐ Other: _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date problem began; _____

How problem began; _____

_____

In general would you say your overall health right now is;

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

In the past week, how much has your pain interfered with your daily activities?
(e.g., work, social activities, or household chores)

0 1 2 3 4 5 6 7 8 9 10

No interference **Unable to carry on any activities**

How do you feel today? (Mark an X on the line)
Best ◄——————————► Worst

Pain Scale
0 1 2 3 4 5 6 7 8 9 10
No Pain **Unbearable Pain**

On a daily basis, how often are your symptoms present?

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Can you perform your daily activities? ☐ Yes ☐ No If no, please describe: _____

Have you seen another: M.D. _____ D.C. _____ Other: _____

Have you had: ☐ X-Rays ☐ MRI ☐ CT Scan Date Of: _____ Where: _____

What areas were taken? _____

Please check all of the following that apply to you: ☐ **None apply**

No	Yes	Condition	No	Yes	Condition
__	__	History of recent infection	__	__	Prostate problems
__	__	Recent fever	__	__	Frequent urination
__	__	HIV/AIDS	__	__	Pregnancy/ # of births: _____
__	__	Diabetes	__	__	Abnormal weight ☐ gain ☐ loss
__	__	Corticosteroid use	__	__	Epilepsy / Seizures
__	__	Recent trauma	__	__	Cancer/Tumor; type: _____
__	__	Birth control pills	__	__	Marked morning pain/stiffness
__	__	Menstrual problems	__	__	Pain at night
__	__	Visual disturbances	__	__	Pain unrelieved by position or rest
__	__	High blood pressure	__	__	History of low/mid back pain
__	__	Stroke / Date: _____	__	__	History of neck pain
__	__	Dizziness/Fainting	__	__	History of headaches or migraines
__	__	Numbness in groin/buttocks	__	__	Arthritis
__	__	Urinary retention	__	__	History of alcohol use
__	__	Bowel /Bladder problems	__	__	History of tobacco use
__	__	Osteoporosis/osteopenia	__	__	Other health problems (explain) _____
__	__	Aortic aneurysm	_____		

Family History:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular problems/Strokes ☐ Rheumatoid Arthritis

Please list/provide your past surgeries:

_____

_____

Please list/provide your current medications:

_____

_____

- I agree to pay in full for all services rendered at the time of visit, unless other arrangements have been made and agreed to. If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for the legal fees, collection agency fees, and any other expenses incurred in collecting my account balance.
- I authorize the staff to perform any necessary services needed during treatment.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand that I am liable for all charges for services rendered.
- I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.
- We reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.
- **The missed appointment fee is $20.00.**

_____	_____	_____
Print Patient Name	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

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IN THE EVENT OF AN EMERGENCY

Who should we contact? _____

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

Home Phone #: _____ Work Phone #: _____

Who is your medical doctor? _____ Phone #: _____

Nearest relative not living with you: _____

Relationship to you? _____ Phone Number: _____

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

ACCOUNT INFORMATION

Person ultimately responsible for this account

Name: _____ Relation: _____

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

Social Security #: _____ Driver's License #: _____ Phone #: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my insurance/financial status.

☐ Adult Patient ☐ Parent/Guardian ☐ Spouse _____ Date: _____

Signature

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for us both to be working towards the same objectives.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine and or extremities.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral and/or extremity subluxation.

I,_____ have read and fully understand the above statement.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____

(Signature) (Date)

HIPAA GUIDELINES PRIVACY NOTICE

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

In the course of your care as a patient, we may use or disclose personal and health related information about you in the following ways:

*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party such as an insurance company, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.

*Your name, address, telephone number, e-mail address and health records may be used to contact you, regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

This office utilizes an "open-treatment" environment for ongoing patient care. "Open-treatment" involves several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing routine details or care, are discussed within earshot of other patients and staff. The use of sign in sheets and treatment cards may reveal your name to other patient's incidental to being treated in the office.

You have the right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

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 the 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 judgment, we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

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

Any use of disclosure of your protected health information, other than as outlines 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.

(SEE REVERSE SIDE)

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 chiropractic care from us. 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 if you would like the information in a specific form, please advise us in writing as to your preference.

We reserve the right by state and federal law to maintain the privacy of your patient file and health protected health 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 as soon as possible 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: Dr. Ammon.

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

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 of with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created.

Printed Name	Signature	Date

If you are a minor, or if you are being represented by your parent or guardian:

Printed Name	Signature	Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

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 and federal 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement 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 the health care provider and/or other licensed health care providers, preceptors, or 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. This agreement is intended to create an open book account unless and until revoked.

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 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 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 of 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 Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE