ANACAPA CHIROPRACTIC

3550 HARBOR BLVD STE 215 • CHANNEL ISLANDS HARBOR • CA 93035

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CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City & State: _____ Zip: _____ Cell Phone: _____

SS#: _____ E-Mail Address: _____

Occupation: _____ Employer: _____

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

Birth Date: _____ Age: _____ Sex: **M F** Marital Status: **S M W D**

Spouse's Name & Age: _____

Names of Children & Ages: _____

_____

How were you referred to our office? _____

Have you ever been to a Chiropractor before? _____ If so, when? _____

Circle your complaint/s and write how long you've had it/ them.

Neck pain/Stiffness	_____	Rib Problems	_____
Headaches	_____	Low Back Pain	_____
Shoulder Pain	_____	Hip/Groin Pain	_____
Arm/Hand Pain	_____	Leg Pain (R/L)	_____
High/Low Blood Pressure	_____	Dizziness	_____
Allergies	_____	Upper/Mid Back Pain	_____

What type of care have you already received for your condition?

Chiropractic _____ Massage _____ Medication _____ Surgery _____ Other _____

Name of Doctor(s) who have cared for you: _____

Circle any conditions you have currently or previously have had.

AIDS/HIV	Arthritis	Asthma	Anemia	Anorexia
Appendicitis	Bulimia	Cancer	Bleeding	Breast Lump
Bronchitis	Diabetes	Emphysema	Cataracts	Addiction
Chicken Pox	Goiter	Gonorrhea	Epilepsy	Fractures
Glaucoma	Hernia	Herniated Disc	Gout	Heart Disease
Hepatitis	Liver Disease	Measles	Herpes	Kidney Disease
MS	Mumps	Osteoporosis	Miscarriage	Mono
Pinched Nerve	Pneumonia	Polio	Pacemaker	Parkinson's
Psychiatric Care	Rheumatoid Arthritis	Rheumatic Fever	Prostate Problem	Stroke
Suicide Attempt	Thyroid Problems	Tonsillitis	Scarlet Fever	Ulcers
Tumors/ growths	Typhoid Fever	Vaginal Infections	Vision Problems	Fibromyalgia
Migraine	Cold/Flu	Viral Infections		TB
Whooping Cough	Ear Infections	High Cholesterol	Other _____	

The vast majority of our patients have been involved in dozens of **IMPACTS** that could cause **VERTEBRAL SUBLUXATION** (spinal misalignments): Dr. Packard wants to discover 5 of yours.

1. When was your MOST recent **Auto/Motorcycle Accident**, even as a passenger? Date: _____

Circle: Major / Minor Impact What body part did you injure? _____ Treatment: Medical / Chiropractic

2. When was the accident before that? Date: _____

Circle: Major / Minor Impact What body part did you injure? _____ Treatment: Medical / Chiropractic

Most people have a slip, strain, twist or fall playing sports, at home or at work, whether it was reported or not.

1. When was your most recent injury? Date: _____

Describe: _____

What body part did you injure? _____ Treatment: Medical / Chiropractic

2. When was your injury before that? Date: _____

Describe: _____

What body part did you injure? _____ Treatment: Medical / Chiropractic

3. When was your injury before that? Date: _____

Describe: _____

What body part did you injure? _____ Treatment: Medical / Chiropractic

Please list any surgeries, traumas, fractures, etc. that have not been mentioned above.

Date: _____ Describe / Treatment: _____

Date: _____ Describe / Treatment: _____

Date: _____ Describe / Treatment: _____

Date: _____ Describe / Treatment: _____

Exercise	Work Activity	Habits
None	Sitting_____ Hrs/Day	Smoking Packs/Day _____
Moderate	Standing_____Hrs/Day	Alcohol Drinks/Week _____
Daily	Light Labor_____Hrs/Day	Coffee/Caffeine Cups/Day_____
Extreme Sports	Heavy Labor _____ Hrs/Day	High Stress Level Reason _____
Weight Lifting	Other _____	_____
Other_____	_____	Other _____

For Women only: Are you pregnant? Yes No Due Date_____ Last menstrual period _____

Medications/Vitamins/Herbs/Minerals

Please list all meds, vitamins, and supplements you are currently taking: _____
_____

Goal Question: If you could accomplish one important thing or mission for your life, what would that be?

PRIMARY INSURANCE: (Group _____ Work Comp _____ Auto _____ Other _____)
Insurance Co.: _____ Name of *insured*: _____
Claim# or Policy#: _____ Group#: _____

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED. THE FEE PAID FOR TREATMENT AND X-RAYS IS FOR ANALYSIS ONLY. THE FILMS THEMSELVES ARE THE PROPERTY OF THIS OFFICE. ONCE FILMS ARE USED FOR TREATMENT PURPOSES, THEY CANNOT BE RELEASED WITHOUT PROPER WRITTEN REQUEST.
2. Method of payment you plan to use for today's services:
   Cash_____ Check_____ Charge_____
3. I hereby authorize the doctor, and/or his associates to examine me, and to perform any necessary diagnostic procedures, including x-rays to fully evaluate my condition for the presence of vertebral subluxation.
4. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that David A. Packard, D.C. will prepare any necessary reports and forms to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient Signature: _____ **Date:** _____

Parent/Guardian (if under 18) Signature for

Authorized Care: _____ Date: _____

Name of Minor: _____

In Case of Emergency Notify: _____ Relation: _____ Phone: _____

TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. It is important that each patient understand 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.

Health: A state of optimal physical, mental and social wellbeing, not merely the absence of disease or 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 it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, 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 subluxations.

I _____ have read and fully understand the above statements.
(print name)

All Questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____

Signature ***Date***

Informed Consent to Chiropractic Care

Patient: *Please discuss any questions or concerns with the doctor before signing this consent.*

I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by Dr. David A. Packard, his staff, and/or his associates.

The Nature of The Chiropractic Adjustment

I will use my hands or a mechanical device upon your body in such a way as to move joints. That may cause an audible "pop" or "click", much as you have experienced when you "pop" your knuckles. You may feel a sense of movement.

The Material Risks inherent with The Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: Fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness following the first days of treatment.

The Probability of those Risks Occurring

Fractures are very rare occurrences and generally result from some underlining weakness of the bones which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, we look for risks factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as "rare".

Ancillary Treatment

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

Heat ~ risk of 1st and 2nd degree burns, hemorrhage
Cryotherapy (cold packs) ~ risk of skin reactions
Trigger Point Therapy ~ risk of bruising, release of emboli
Massage ~ risk of deep vein thrombosis

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

Self-administered over-the-counter analgesics and rest
Medical care with prescription drugs
Hospitalization
Surgery

The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependant upon the patients general health severity of the patents discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result form such exposure dependant upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks and Dangers Attendant To Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer is it postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had all my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

_____
Date:

_____ _____
Printed Name of Patient Signature of Patient

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Our Promise!

Dear Patient:
This is not meant to alarm you! Quite the opposite!

It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not want you to delay your treatment because you were afraid your personal health history might be unnecessarily made available to others outside our office.

So what has changed?
Why a privacy policy now?
Very good question!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws; we want you to understand our procedures and your rights as out valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purpose of providing your treatment, obtaining payment and conduction health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntary given your written permission.

How your Health Information may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing your treatment.

To Obtain Payment

We may include information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of you best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you if treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, letters, telephone reminders, or electronic reminders such as email (unless you tell us that you do not want to receive these reminders)

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Securities

We may be required to disclose to Federal officials or military authorities health information necessary to complete on investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if your are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers

We may share you health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves lairing from the careful study of the medical histories of prior patients. Formal review and study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

ALL CALLS WILL BE RECORDED TO EMSURE QUALITY CONTROL

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____
Patient Signature
Date_____/_____/_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information

Restrictions

Your have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communication that are sealed. We will make every effort to honor your reasonable requests for confidential communication.

Inspect and Copy Your Health Information

You have the right to copy your health information including your complete chart, x-rays and billing records. If you would like a copy of your health information please let s know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process please provide us with your request writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage form the date of your first visit and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Policy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Please appoint your health spokesperson

Name_____

Date_____