CONFIDENTIAL CASE HISTORY

oakbaychiropractic
family and sports care

NAME: LAST	FIRST	MIDDLE	SEX	AGE	BIRTH DATE	TODAY'S DATE

STREET ADDRESS			MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED	WEIGHT	FEMALES: ARE YOU... PREGNANT?_____ LMP_____
CITY	STATE	ZIP	SOCIAL SECURITY #		OCCUPATION
HOME PHONE	BUSINESS PHONE		REFERRED BY	REFERRED TO	DRIVER'S LICENSE #
E-MAIL ADDRESS			AUTO ACCIDENT ☐	MEDICARE ☐	MEDI-CAL ☐ BLUE CROSS ☐ WORKER'S COMP ☐
NEXT OF KIN	RELATIONSHIP		OTHER INSURANCE COMPANY		NO COVERAGE ☐
STREET ADDRESS (IF DIFFERENT FROM PATIENT'S)			NAME OF INSURED PERSON		IDENTIFICATION #
CITY	STATE	ZIP			
YOUR EMPLOYER'S NAME & ADDRESS					
STREET ADDRESS					
CITY	STATE	ZIP			

ASSIGNMENT AND RELEASE:
I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE UNDERSIGNED PHYSICIAN. I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED.

SIGNED_____
(PATIENT SIGNATURE - OR PARENT SIGNATURE, IF PATIENT IS A MINOR)

DATE_____

WHY ARE YOU SEEING THE DOCTOR?

_____

_____

_____

THIS IS A NEW / OLD ILLNESS. IT WAS NOT / TREATED BEFORE.

IF TREATED BEFORE, WHAT WAS DONE?_____

_____

_____

WHEN?_____ BY WHOM?_____

HAVE YOU HAD PROBLEMS WITH THE FOLLOWING? ✓CHECK YES OR NO

	YES	NO		YES	NO
LUMPS	☐	☐	HEARING	☐	☐
MOLES	☐	☐	SEEING	☐	☐
SWELLING	☐	☐	SMELLING	☐	☐
STIFF JOINTS	☐	☐	RACING HEART	☐	☐
DIZZINESS	☐	☐	DIGESTION	☐	☐
BALANCE	☐	☐	WEIGHT	☐	☐
APPETITE	☐	☐	CONSTIPATION	☐	☐
SLEEPING	☐	☐	MOOD OR FEELINGS	☐	☐
BREATHING	☐	☐	(WOMEN ONLY)		
PAINS, ACHES	☐	☐	MENSTRUATION	☐	☐
HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE?				☐	☐

HAVE YOU BEEN X-RAYED BEFORE? WHAT PARTS?_____

_____

PAP SMEAR (WOMEN ONLY) NEVER ☐ DATE_____

CHEST X-RAY NEVER ☐ DATE_____

LAST MEDICAL EXAMINATION NEVER ☐ DATE_____

WHO IS OR WAS YOUR REGULAR DOCTOR?_____

_____

CITY AND STATE_____

PATIENT SIGNATURE_____

CHECK IF YOU OR A BLOOD RELATIVE HAVE HAD OR HAVE THESE:

	YOU	BLOOD RELATIVE		YOU	BLOOD RELATIVE
ANEMIA	☐	☐	KIDNEY/BLADDER TROUBLE	☐	☐
ASTHMA	☐	☐	MENTAL DISORDER	☐	☐
BLEEDING TENDENCIES	☐	☐	RHEUMATISM OR ARTHRITIS	☐	☐
CANCER OR TUMOR	☐	☐	STROKE	☐	☐
DIABETES	☐	☐	TUBERCULOSIS	☐	☐
EPILEPSY	☐	☐	ULCER/STOMACH TROUBLE	☐	☐
GLAUCOMA	☐	☐	NUMBNESS	☐	☐
GOUT	☐	☐	SCIATICA	☐	☐
HEART TROUBLE	☐	☐	HEADACHES	☐	☐
HIGH BLOOD PRESSURE	☐	☐	SCOLIOSIS	☐	☐

ARE YOU TAKING ANY MEDICATION?_____

SPECIFY_____

_____

HOW ARE YOUR DIETARY / NUTRITIONAL HABITS?_____

_____

_____

DO YOU EXERCISE REGULARLY?_____

EXPLAIN_____

_____

HAVE YOU EVER HAD SURGERY, OR BEEN HOSPITALIZED?
(WOMEN: DO NOT COUNT NORMAL BIRTHS)

YES ☐ NO ☐ IF YES, WHAT YEAR?_____

WHAT WAS WRONG?_____

_____

_____

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Oakbay Financial Policy

- It is the policy of this office that all services rendered are charged directly to you, the patient, and ultimately the patient is responsible for all services rendered.

- All payments are expected at the time of service. Patient balances may not exceed $150.00 at any time.

- Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month. We reserve the right to charge for missed chiropractic appointments and those cancelled without 24 hours notice.

- Cancellations for massage appointments must be done at least 24 hours in advance, patients who fail to do so will be responsible for a fee of $50.

Oakbay Insurance Policy

- All deductible payments MUST be made prior to insurance submittal.

- You are considered to be a private pay patient until our office verifies your coverage to determine the extent of benefits under your policy.

- All co-payments are payable when service is rendered. A $150.00 deductible or co-payment balance may not be exceeded by any patient.

- Should you discontinue care for any reason other than discharge by the doctor, any and all balances accumulated will become immediately due in full with interest charges of 1.5% charged for every delinquent month.

- As a courtesy, Oakbay Chiropractic will attempt to verify your health insurance benefits and/or necessary authorizations for you. Please be aware, this is only **"A QUOTE of Benefits/Authorizations."** We cannot guarantee payment or verify that definite eligibility of benefits conveyed to us or to you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, and exclusions of the member's contract at the time of service. Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Our office will make every effort to bill your insurance in a timely manner. If your carrier determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service and it will become your responsibility. We recommend you to be familiar with and verify your benefits with your insurance company prior to your services at Oakbay Chiropractic.

- Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know.

Printed Name: _____ Signature: _____ Date: _____

INFORMED CONSENT DOCUMENT

To the patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use this procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you may have experience when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures; if necessary:

-Spinal manipulative therapy	-radiographic studies	-vital signs
-Range of motion testing	-orthopedic testing	-palpitation
-Muscle strength testing	-Basic Neurological testing	-Postural
-Active release technique	-Hot/cold therapy	-Analysis

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make everyone reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risk occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history, examination, and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability of nature of the other treatment options

Other treatment options for your condition may include: self-administered, over-the-counter- analgesics and rest; medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers; hospitalization; surgery.

If you chose to use one of the above noted "other treatments" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up pain reaction further reducing mobility. Over time this proves may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read [ ] or had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I understand that if I have any questions, they can be addressed by the doctor and by signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____

PATIENT NAME (print)

_____ **DATE:** _____

Signature

_____

Signature Of Parent of Guardian (if a minor)

Notice of Privacy Practice

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures
Your protected health information is accessed and used for healthcare related purposed only.
Your protected health information in never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
Your protected health information in not disclosed to third party entities without your written authorization for the purpose of treatment, and for healthcare operations.
The practice maintains patient sign-in sheets that are visible and accessible to patients, staff, and others who may enter this office.

Certain Circumstances
Your protected health information can be disclosed without your written authorization in certain limited circumstances,

Medical emergencies
In situations required by law
When requested by a public health agency
Individuals involved in your care
When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing any time.

Patient Rights
You have the right to request in writing to inspect and/or receive a copy of your health information. *
You have the right to request an alternate means or location to receive a copy of your health information. *
You have the right to request in writing to amend, correct, or delete any recorded health information in our possession. *
You have to right to request in writing to restrict some of the uses and disclosures of your health information. *
You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office. *

** A fee may apply for any request, conditions and limitations may apply. Obtain additional information from the front desk.*

Changes to this notice:
We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you upon request.

This document acknowledges that you have read and understand the NOTICE of PRIVACY PRACTICES. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

_____ _____ _____
Name **Patient's Signature** **Date**

If the patient is a minor, a parent or legal guardian must sign. _____

Parent or Legal Guardian **Date**