Patient Information

CSI

Name:_____ Address:_____

City:_____ State:_____ Zip:_____ Home:_____ Cell:_____

Email:_____ Date of Birth: ____/____/____ Age:_____

By documenting your email address on this page, you are agreeing that health information for yourself can be freely shared via email between yourself and Singer Chiropractic Wellness Center.

Height:_____ Weight:_____ SSN:_____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Window(er) ☐ Divorced Name of Spouse (or parent):_____

No. of children:_____How were you referred to us?_____

(*Females only*) Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Employer:_____ Address:_____

City:_____ State:_____ Zip:_____

Work Phone:_____ Occupation:_____

In case of emergency, who should we contact? Name_____Phone_____

Have you ever received Chiropractic care before? ☐ Yes ☐ No If yes, when?_____

If you are experiencing any health problems, please list your chief complaints in order of severity

1._____ For how long?_____

2._____ For how long?_____

3._____ For how long?

Who in your family has same or similar condition?_____

List other doctors consulted for these conditions:

1._____ 2._____

Family Physician's Name:_____ Phone:_____

Have you been involved in an auto accident in the past 12 months? ☐ Yes ☐ No If yes, when?_____

Are these complaints the result of a work-related injury? ☐ Yes ☐ No If yes, when?_____

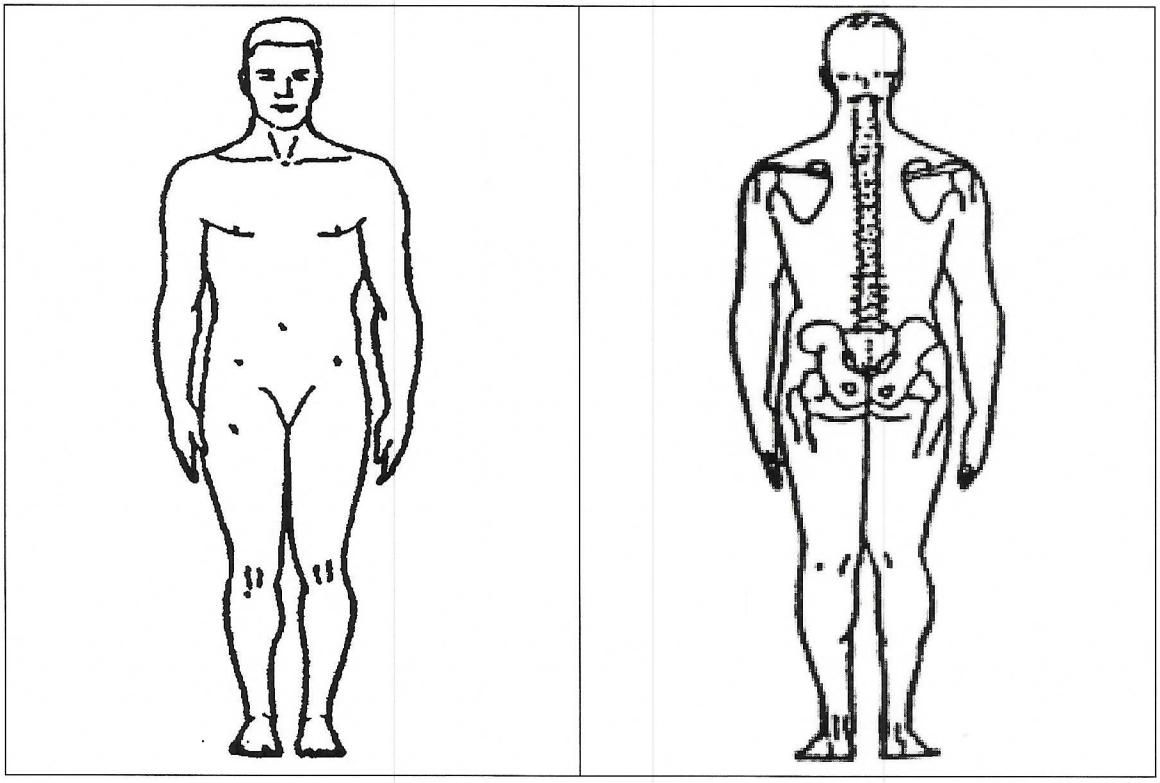
Are these complaints related to an event outside of work? ☐ Yes ☐ No If yes, when?_____

For your convenience, a complimentary insurance verification may be provided.

Simply provide us with a copy of your insurance card, and we'll verify your benefits.

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below.

COMPLETE THESE DIAGRAMS



1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature _____

Date _____

For your convenience, a complimentary insurance verification may be provided. Simply provide us with a copy of your insurance card, and we'll verify your benefits.

Primary Complaint

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder L25.9
002 ☐ Acne L70.8
003 ☐ Psoriasis L40.8
004 ☐ Urticaria (Hives) L50.9
005 ☐ ADD/ADHD F90.1/F90.9
006 ☐ Allergies, Unspecified J30.9
007 ☐ Allergic Rhinitis from food J30.5
008 ☐ Sinusitis J01.90
009 ☐ Alzheimer's G30.9
010 ☐ Poor Concentration/Memory F07.8
011 ☐ Parkinson's Disease G20
012 ☐ Anemia D64.9
013 ☐ Arthritic Disorder M12.9
014 ☐ Osteoporosis M81.0
015 ☐ Asthma J45.909
016 ☐ Emphysema J43.9
017 ☐ Cancer
- 018 ☐ Breast C50.919female C50.929male
- 019 ☐ Prostate C61
- 020 ☐ Lung C34.90
- 021 ☐ Colon and Rectal C18.9
- 022 ☐ Skin C44.90
- 023 ☐ Leukemia w/o remission C95.90 Leukemia w/ remission C95.91
- 024 ☐ Lymphoma, malignant C85.89
- 025 ☐ Brain Tumor, malignant C71.9

027 ☐ Anxiety Disorder F41.9
028 ☐ Autism F84.0
033 ☐ Edema R60.9
034 ☐ Eczema L25.9
035 ☐ Chronic Fatigue R53.82
036 ☐ Circulatory Disorder I99.9
037 ☐ Heart Disease I51.9
038 ☐ High Cholesterol E78.0
039 ☐ High Blood Pressure I10
040 ☐ Low Blood Pressure I95.9
041 ☐ Tachycardia (High Heart Rate) R00.0
042 ☐ Numbness R20.9
043 ☐ Constipation K59.00
044 ☐ Indigestion K30
045 ☐ Ulcerative Colitis K51.90
046 ☐ Depression F32.9
047 ☐ Diabetes Mellitus E11.9
030 ☐ Diabetes Type I E10.9
031 ☐ Diabetes Type II E11.65
029 ☐ Hyperglycemia [high blood sugar] R73.09
048 ☐ Hypoglycemia [low blood sugar] E16.2
049 ☐ Dizziness/Balance Problem R42
050 ☐ Ear Infection H65.90
051 ☐ Epstein Barr B27.90
052 ☐ Eye Problems H57.13
053 ☐ Cataracts H26.9
054 ☐ Glaucoma H40.9
055 ☐ Macular Degeneration H35.30
056 ☐ Fever R50.9
057 ☐ Fibromyalgia M79.7
058 ☐ Gallbladder Disorder K82.9
059 ☐ Gout M10.9
060 ☐ Headaches R51
061 ☐ Hearing Loss H91.90
062 ☐ Infertility, male N46.9
064 ☐ Liver Disease K76.9
- 065 ☐ Hepatitis K71.6
- 066 ☐ Hepatitis B B16.9
- 067 ☐ Hepatitis C B17.10

068 ☐ Kidney Disorder N28.9 or Bladder Disorder N32.9
063 ☐ Prostate Disorder N42.9
069 ☐ Hyperthyroidism E05.90
070 ☐ Hypothyroidism E03.9
071 ☐ Systemic Lupus M32.10
072 ☐ Infertility, female N97.9
073 ☐ Interstitial Cystitis N30.11
074 ☐ Irregular Menstrual Cycle N92.6
075 ☐ Menopausal Symptoms N95.1
076 ☐ Hot Flashes N95.1
077 ☐ Mental Disorder F99
078 ☐ Insomnia G47.00
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores K12.0
081 ☐ Overweight E66.3
082 ☐ Underweight R63.6
083 ☐ Sexual Disorder F66
084 ☐ Spinal Problems M53.9
085 ☐ Obesity E66.9
086 ☐ GERD K21.9
087 ☐ HIV B20
088 ☐ Crohn's Disease K50.90
089 ☐ Irritable Bowel Syndrome K58.9
092 ☐ Normal Pregnancy Z33.1
**only applicable if *currently* pregnant
093 ☐ Shingles B02.9
140 ☐ Migraines G43.909
141 ☐ Rheumatoid Arthritis M06.9
142 ☐ Non-Systemic Lupus L93.0
143 ☐ Multiple Sclerosis G35
144 ☐ ALS (Lou Gehrig's) G12.21
145 ☐ Polymyalgia Rheumatica M35.3
146 ☐ Scleroderma M34.9
171 ☐ Goiter E04.9
178 ☐ Raynaud's Syndrome I73.00
179 ☐ Hemochromatosis E83.119
180 ☐ Thalassemia D56.8
181 ☐ Brain aneurysm I61.9

If necessary, please state your most significant concern...

General Health

100 ☐ Fingernail base is pink
101 ☐ Fingernail base is purple
102 ☐ Fingernails have ridges or white spots
103 ☐ Fingernails are soft
104 ☐ Fingernails are splitting
105 ☐ Fingernails peel
106 ☐ Pale fingernail beds
107 ☐ Blacks out easily
108 ☐ Balance problems
109 ☐ Difficulty walking
110 ☐ Has tattoos
111 ☐ Brittle hair
112 ☐ Dry hair
113 ☐ Thin hair
114 ☐ Hair loss
115 ☐ Drinks alcoholic beverages daily
116 ☐ Drinks less than 8 glasses of water per day
117 ☐ Currently on Chemotherapy
118 ☐ Currently on radiation treatment
119 ☐ Had chemotherapy in the past
120 ☐ Has had radiation treatments in the past
121 ☐ Gained over 20 lbs in the last 12 months
122 ☐ Somewhat Overweight
123 ☐ Somewhat Underweight
124 ☐ Unexplained loss of >20lbs in last 4 months
125 ☐ Energy level is worse than it was 5 years ago
127 ☐ Sleeps less than 6 hours per night
128 ☐ Unable to recall dreams the next day
129 ☐ Sensitive to chemicals, paint, fumes, cologne
130 ☐ Had blood transfusion in the past
131 ☐ Had transplant in the past
138 ☐ Takes anti-rejection drugs
132 ☐ Had a major accident or injury
137 ☐ Sleep Apnea
139 ☐ Toxic chemical exposure
175 ☐ Has been out of the country recently
176 ☐ Had childhood vaccines
177 ☐ Had a vaccine in the last 12 months
147 ☐ Had a flu shot last year
182 ☐ Had a pneumonia vaccine last year
183 ☐ Had a Hepatitis B vaccine in the last 2 years

Has a family history of:
184 ☐ Cancer
185 ☐ Heart Disease
186 ☐ Diabetes
187 ☐ Alcoholism
188 ☐ Depression
189 ☐ Obesity

Allergies:
206 ☐ Dairy
207 ☐ Eggs
208 ☐ Garlic
209 ☐ Gluten
210 ☐ Mold
211 ☐ Peanut
212 ☐ Ragweed
213 ☐ Shellfish
214 ☐ Soy
215 ☐ Sulfa drugs
216 ☐ Tree nuts
217 ☐ Wheat
218 ☐ Other allergies

Lifestyle & Environment

380 ☐ Drinks beverages from a can
370 ☐ Drinks alcohol
371 ☐ Drinks caffeinated coffee
372 ☐ Drinks caffeinated pop/soda
373 ☐ Drinks caffeinated tea
374 ☐ Drinks decaffeinated coffee
375 ☐ Drinks decaffeinated pop/soda
376 ☐ Drinks decaffeinated tea
377 ☐ Drinks >3 cups of coffee daily
378 ☐ Drinks >3 cups of tea per day
388 ☐ Drinks diet pop/soda
379 ☐ Drinks >1 pop/sodas per day

I had 4 alcoholic drinks in one day:
172 ☐ never
173 ☐ more than 3 months ago
174 ☐ less than 3 months ago

381 ☐ Has >5 alcoholic drinks/week
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in last 5 years
384 ☐ Smoked for >5 years
385 ☐ Smokes >1 pack per day
126 ☐ Rarely exercises
133 ☐ Regularly exercises
386 ☐ Takes Vitamins
134 ☐ Vegetarian
135 ☐ Eats no red meat
136 ☐ Eats no meat, no dairy
387 ☐ Frequent use of artificial sweeteners
389 ☐ Anorexia
390 ☐ Bulimic
340 ☐ Home has well water
341 ☐ Home has city water
342 ☐ Home water is filtered

Home pipes are:
343 ☐ Steel
344 ☐ PVC
345 ☐ Copper
346 ☐ PEX

347 ☐ Home built prior to 1978
348 ☐ Home renovations within the last year
349 ☐ Uses chlorine bleach or other heavy duty chemicals
360 ☐ Has worked in plumbing, automotive or metallurgic industry
361 ☐ Has worked around industrial solvents, chemicals or pesticides

Surgeries

700 ☐ Tonsillectomy and/or Adenoids
701 ☐ Appendix
702 ☐ Gallbladder
703 ☐ Thyroid
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
706 ☐ Tubal ligation
707 ☐ Breast implants
708 ☐ Cancer
709 ☐ Coronary by-pass
710 ☐ Spinal surgery
711 ☐ Extremity surgery
712 ☐ Hip replacement
713 ☐ Knee replacement
714 ☐ Splenectomy

715 ☐ Radiated thyroid
716 ☐ Cataract surgery

717 ☐ Hemorroidectomy

718 ☐ Bariatric/Weight loss
Type: _____

Gastrointestinal

265 ☐ 4-5 bowel movements per week
266 ☐ 3 or less bowel movements per week
267 ☐ 6 or more bowel movements per week
268 ☐ Black tarry stools
269 ☐ Pale or yellow colored stool
270 ☐ Blood stools
271 ☐ Constipation
272 ☐ Hemorrhoids
273 ☐ Loose bowel movements
274 ☐ Frequent diarrhea
275 ☐ Frequent nausea
276 ☐ Frequent vomiting
277 ☐ Abdominal gas
278 ☐ Belching and burping after eating
279 ☐ Bloated after eating
280 ☐ Severe abdominal pains
281 ☐ Stomach ulcers
282 ☐ Uses digestive aids
283 ☐ Uses laxatives
284 ☐ Immediate indigestion upon eating
285 ☐ Indigestion in 2 hours or more after meals
286 ☐ Indigestion within 1 hour after meals
287 ☐ Difficulty swallowing
288 ☐ Eating relieves fatigue
289 ☐ Eats when nervous
290 ☐ Excessive hunger
291 ☐ Poor appetite
292 ☐ Experiences fainting spells when hungry
293 ☐ Feels shaky when hungry
294 ☐ Frequently drowsy after eating a meal
295 ☐ Gall bladder disease
296 ☐ Has had intestinal worms
297 ☐ Reflux/Hiatal hernia
298 ☐ Liver disease
299 ☐ Irritable Bowel Syndrome
300 ☐ Diverticulitis
301 ☐ Diverticulosis

Respiratory

485 ☐ Catches severe colds
486 ☐ Chronic chest condition
487 ☐ Chronic cough
488 ☐ Constant runny nose
489 ☐ COPD
490 ☐ Difficulty breathing
491 ☐ Frequent colds
492 ☐ Frequent nose bleeds
493 ☐ Frequent sinus infections
494 ☐ Frequent stuffy nose
495 ☐ Hay fever
496 ☐ Nasal polyps
497 ☐ Night sweats
498 ☐ Post nasal drip
499 ☐ Sneezing spells
500 ☐ Spits up blood
501 ☐ Spits up phlegm
502 ☐ Wheezes

Mouth and Throat

400 ☐ Bad breath
401 ☐ Bitter taste in the mouth in the morning
402 ☐ Dry mouth
403 ☐ Excessive saliva
404 ☐ Sores or cracks in the corners of the mouth
405 ☐ Glands often swell
406 ☐ Frequent canker sores
407 ☐ Frequent fever blisters
408 ☐ Frequent sore throats
409 ☐ Frequently has a sore tongue
410 ☐ Sore gums
411 ☐ Swollen gums
412 ☐ Swollen tongue
413 ☐ Tongue burns
414 ☐ Tongue has grooves or fissures
415 ☐ Tongue is coated
416 ☐ Gums bleed when brushing teeth
417 ☐ Toothaches
418 ☐ Amalgam dental fillings
420 ☐ Other dental fillings (gold, composite, etc)
419 ☐ Has had root canal(s)

Endocrine

245 ☐ Coarse hair
246 ☐ Coarse skin
247 ☐ Diabetic
248 ☐ Excessive thirst
249 ☐ Frequently feels cold
250 ☐ Frequently feels hot
251 ☐ Gets lightheaded when standing quickly
252 ☐ Heals slowly
253 ☐ Unusually jumpy or nervous
254 ☐ Unusually tired most of the time

Cardiovascular

190 ☐ Cold feet
191 ☐ Cold hands
192 ☐ Experiences shortness of breath while sitting still
193 ☐ Heart skips beats
194 ☐ Tendency of High blood pressure
195 ☐ Leg cramps during bedtime
196 ☐ Leg cramps during daytime
197 ☐ Low blood pressure at times
198 ☐ Pain in leg/hips when walking
199 ☐ Frequent swollen ankles
200 ☐ Pains in the heart or chest
201 ☐ Spells of rapid heart rate
202 ☐ Troubled with blood clots
203 ☐ Unusually slow pulse rate
204 ☐ Varicose veins
205 ☐ Heart palpitations

Skin

520 ☐ Bruises easily
521 ☐ Excessive perspiration
522 ☐ Frequent goose bumps
523 ☐ Has acne
524 ☐ Has Psoriasis
525 ☐ Hives
526 ☐ Itchy skin
527 ☐ Problems with Eczema
528 ☐ Has moles which are changing in size and/or color
530 ☐ Skin is rough, especially on the back of the arms
529 ☐ Skin eruptions
531 ☐ Skin is tender
532 ☐ Sores that heal slowly
533 ☐ Troubled with boils
534 ☐ Dry skin

Ears

220 ☐ Discharge from ears
221 ☐ Hard of hearing
222 ☐ Punctured ear drum
223 ☐ Recurrent ear infection
224 ☐ Ringing or noises in the ears
225 ☐ Tinnitus

Eyes

320 ☐ Bloodshot eyes
321 ☐ Blurred vision
322 ☐ Cross eyes
323 ☐ Eye pain
324 ☐ Eyes feel gritty
325 ☐ Eyes watery
326 ☐ Mild Glaucoma
327 ☐ Far sighted
328 ☐ Developing cataracts
329 ☐ Mild Macular degeneration
330 ☐ Itchy eyes
331 ☐ Near sighted
332 ☐ Dry Eyes

Feet

350 ☐ Corns
351 ☐ Frequent foot cramps
352 ☐ Heel spurs
353 ☐ Painful feet
354 ☐ Plantar warts
355 ☐ Swelling in the feet and/or ankles
356 ☐ Plantar fasciitis
357 ☐ Fungal Infection

Neuromuscular

440 ☐ Bites nails
441 ☐ Frequent muscle soreness
442 ☐ Muscle spasms
443 ☐ Muscle weakness
444 ☐ Tremors
445 ☐ Frequent headaches
446 ☐ Often dizzy
447 ☐ Frequently feels faint
448 ☐ Has Epilepsy
449 ☐ Has motion sickness
450 ☐ Has Osteoarthritis
451 ☐ Has Rheumatism
452 ☐ Rheumatoid Arthritis
453 ☐ Joint stiffness in the morning
454 ☐ Swollen joints
455 ☐ Leg pain at rest
456 ☐ Spinal curvature
457 ☐ Low back pain
458 ☐ Neck pain
459 ☐ Pain between the shoulders
460 ☐ Shoulder/arm pain
461 ☐ Numbness/tingling in the body
462 ☐ Sleep walks
463 ☐ Stutters or stammers
464 ☐ Nerve pain

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
162 ☐ Recurrent bad dreams
163 ☐ Sometimes wishes to be dead or away from it all
164 ☐ Upset by criticism
165 ☐ Poor memory
166 ☐ Scared to be alone
167 ☐ Strange people or places cause fear
168 ☐ Under considerable emotional stress
169 ☐ Unhappy when others are happy
170 ☐ Brain fog

Urinary

555 ☐ Urinates more than 2 times per night
556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
559 ☐ Painful urination
560 ☐ Frequent urination
561 ☐ Troubled by urgent urination
562 ☐ Incontinence when sneezing or laughing
563 ☐ Loses bladder control
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
566 ☐ Kidney stones

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
593 ☐ Sores on external genitalia
594 ☐ Herpes
595 ☐ Sexual diseases

Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are currently taking on a daily basis.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

VITAMIN	***BRAND***	***DOSAGE***

Records Release

AUTHORIZATION TO RELEASE X-RAYS & INFORMATION

To: _____

I, _____ Birth date _____/ _____/ _____

request the following information: ☐ X-RAYS ☐ History ☐ Records

☐ Diagnosis ☐ Reports ☐ Prior Care Details

concerning my: ☐ Illness ☐ Accident ☐ Injury

☐ Other: _____

Signature: _____ Date _____

☐ Patient ☐ Parent ☐ Spouse ☐ Guardian

Case Types

Consultation:	No Charge
Chiropractic Examinations:	$85 to $175
Chiropractic Office Visits:	$35 to $95
Chiropractic X-ray studies:	$44 to $152
Doctor/Patient consultation:	$85
Thermograph:	$165

(All fees are standard and primarily based on our professional association's guidelines.)

Our experience has shown that it is important to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment, and you may choose the plan which best fits your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary please let us know. Our main concern is your health and well-being, and we will do our best to help you.

Case #1 – General Health Insurance: If you have insurance that covers Chiropractic care, we will bill your insurance directly. Please bring us your insurance card on or before your second visit. Until we have the completed, necessary insurance information to verify Chiropractic coverage, you will be required to pay for your care. After we verify your insurance company's benefit details, we will discuss them with you. Most insurance companies will not cover "maintenance" care and therefore, we can offer other arrangements if your condition requires further care beyond your insurance limits.

Case #2 – Private Pay / Cash: Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

Case #3 – Industrial (Work-Related) Injury: You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

Case #4 Auto Injury: You need to supply us with the accident report, your car insurance, health insurance, liable party's insurance, and attorney information (if applicable). Until necessary insurance information is gathered and benefits verified, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are required to bring the check to us.

I QUALIFY FOR, AND UNDERSTAND, PLAN #_____ REQUIREMENTS.

SIGNATURE: _____ **DATE:** _____

Health Insurance Portability and Accountability Act (HIPAA)

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

During the course of your care, we may use, or disclose, health-related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another healthcare provider if a referral is necessary for care, diagnosis, or assessment.
- Your healthcare and/or billing records may be disclosed to another party, such as an insurance carrier or your employer, if they are responsible for payment of services.
- Your personal information and/or healthcare records may be used to contact you regarding appointments or other health-related information that may be of interest to you.

At your request, we may restrict the use of your protected health information for patient-care or payment purposes. Such requests are not automatic and require our acknowledgement prior to initiation.

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 a 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.
- By order of the courts or another appropriate agency.

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

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

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 care. 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 in a specific form, you may advise us in writing.

You have the right to inspect, copy, or request an amendment of your health information for as long as the information remains in our files. These requests to inspect, copy or amend your health information shall be in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected 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 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. Cory J. Singer, D.C. at (714) 582-6235

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

Dr. Cory J. Singer, D.C. at (714) 582-6235

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

This notice is effective as of _____ . This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Patient Name (please print)	Signature	Date

If you are a minor or if you are being represented by another party:

_____	_____	_____
Representative Title Name (please print)	Signature	Date

PATIENT NAME: _____

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE1 OF 2 ·PLEASESIGN BOTH SIDES

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 any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the 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 health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as a back-up for the health care provider, including those wor1dng 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 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 healthcare 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 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 SIGNATURE Date (Indicate relationship if signing for patient)

(Or Patient Representative)

PLEASE SIGN REVERSE SIDE ALSO

ARBITRATIONAGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

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 on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discus with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to the treatment, including but not limited to, fracture, disc injuries, stroke, dislocations and sprains. 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 upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____ _____

PATIENT SIGNATURE Date (Indicate relationship if signing for patient)

(Or Patient Representative)

_____ _____

OFFICE SIGNATURE Date

PLEASE SIGN REVERSE SIDE ALSO