Welcome

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

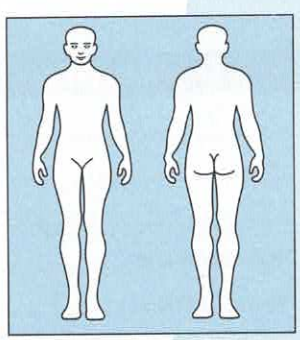
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other _____
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	
Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No			
		Measles	☐ Yes ☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name _____		
Pharmacy Phone (____) _____		

INFORMED CONSENT TO TREAT

I hereby authorize and request to have performed on me chiropractic adjustments and any other chiropractic procedures, including examination, tests, diagnostic X-ray(s) and physical therapy techniques (or on the patient named below for which I am legally responsible), which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for, or are associated with or serving as backup for the doctor of chiropractic named below.

I understand, as with any health care procedure, that there are certain complications that may arise during a chiropractic adjustment or therapy. Those complications may include the risk of serious bodily harm. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s), which the doctor feels at the time based on the facts then known, are in my best interest.

I have had the opportunity to discuss with the doctor named below the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. 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 to undergo the chiropractic treatment recommended. Having been informed of the risks I hereby give my consent to that treatment. 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.

Name and address of office/clinician:

Bartlett Chiropractic, Inc. 2718 Tachevah Drive, Santa Rosa, CA 95405

Name of Patient: _____
(Please Print)

Patient Signature: _____
(Please Sign)

Patient's Representative (if minor or physically incapacitated): _____
(Please Print)

Patient's Representative's Signature: _____
(Please Sign)

Date: _____

REVELATION HEALTH
Bartlett Chiropractic, Inc.

2718 Tachevah Drive Santa Rosa CA 95405 707-579-8150

FINANCIAL POLICY

We are committed to providing you with the best possible care. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibilities.

Full payment is due at the time of service.

We accept cash, check, MasterCard, Visa and Care Credit.

Insurance
If you have insurance we will help you receive maximum benefits. All co-payments and deductibles are to be paid at the time of your visit. If your insurance company has not paid the FULL BALANCE WITHIN 45 DAYS, YOU WILL HAVE 15 DAYS TO PAY THE BALANCE.

Non-Covered Services
Any service/product provided that is not an existing benefit or that is denied or not paid by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. Insurance is a contract between you and your insurance company. We are NOT a party to your insurance contract. We file insurance claims as a ***courtesy*** to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than to supply factual information as necessary. ***You are responsible for timely payment of your account.***

Missed Appointments
Missed appointments without proper notice will be charged at the normal office rate.

Overdue Accounts
Accounts with late or outstanding balances of 30 days overdue must make arrangements for payment prior to scheduling appointments. We realize that people may have financial difficulty. Please communicate with our office so we may assist in solving the matter with you. In the instance of default payment on this account, I agree to pay 2.0% per 30 days that the account is overdue plus any collection costs and reasonable attorney fees the office may incur while attempting to collect on this amount or any future outstanding balances. Any check returned to our office deemed Non-Sufficient Funds will be charged a $30 fee.

Patient Agreement
I have read, understand, and agree to the terms of this Financial Policy.

Patient Name:_____ Date:_____
Please Print

Responsible Party Signature:_____
Patient OR Parent/Guardian if patient a minor

REVELATION HEALTH
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Why Chiropractic?

People go to Chiropractors for a variety of reasons.

Some go for symptomatic relief of pain or discomfort (*Relief Care*).

Others are interested in having the cause of the problem as well as the symptoms corrected and relieved *(Corrective Care*).

Your Doctor will weigh your needs and desires when recommending your treatment program.

Please Circle Below the type of care that best meets your needs.

RELIEF CARE

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

PLEASE LIST YOUR CURRENT HEALTH GOALS:

1) _____

2) _____

3) _____

DESCRIBE WHAT YOUR HEALTH LOOKS LIKE IN YOUR ELDERLY YEARS…

_____

_____

_____

WHAT ONE (1) THING DO YOU WANT TO BE ABLE TO CONTINUE TO DO WHILE YOU AGE?

_____

THANK YOU FOR ALLOWING US TO SERVE YOU!

PATIENT SIGNATURE_____ **DATE**_____

REVELATION HEALTH
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Bartlett Chiropractic, Inc.
NOTICE OF PRIVACY PRACTICES

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

Bartlett Chiropractic, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

How your health care information will be visible.

- **Medical Information**
- **Health History**
- **Billing Information, i.e., Deductibles, Co-Pays and/or Account Balances**
- **Appointment Day Sheet**
- **Treatment, Travel Cards**
- **Frequent Mailings, i.e., Birthday, Christmas, Thank You Referral Notes, and/or Reminders**
- **Storyboards, Testimonials, Surveys, Etc.**

Treatment
We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. (Example):

> "On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Bartlett Chiropractic, Inc."
>
> "It is our policy to provide a substitute health care provider, authorized by Bartlett Chiropractic, Inc., to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situation."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example):

> "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Bartlett Chiropractic, Inc. for health care services rendered. Insurance billing is sent electronically. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing for you to submit to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition and codes, which describe the health care services received."

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws

Emergencies
We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Office Administration
(Example):

> "As a courtesy to our patients, we may call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."
>
> "Reminders and/or additional messages may also come via text messages or emails."

Marketing
Sharing your chiropractic story may take the form of storyboards, reviews, testimonials, pictures, videos, etc., which Bartlett Chiropractic, Inc. uses to educate others about the health benefits of chiropractic care. They may be used for social media and/or advertising. We may contact you for marketing purposes or fundraising purposes, as described below. (Example):

> "We may participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard or email invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Bartlett Chiropractic, Inc. sponsored fund-raising events."

Change of Ownership
In the event that Bartlett Chiropractic, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Bartlett Chiropractic, Inc. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Bartlett Chiropractic, Inc. amend your protected health information. Please be advised, however, that Bartlett Chiropractic, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reasons(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Bartlett Chiropractic, Inc.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Bartlett Chiropractic, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Bartlett Chiropractic, Inc. is required by law to comply with this Notice.

Bartlett Chiropractic, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact our office & the person responsible for our Notice of Privacy Practices form 707-579-8150.

Complaints
Complaints about your Privacy rights, or how Bartlett Chiropractic, Inc. has handled your health information should be directed to the office by calling 707-579-8150, and speaking with the person who handles the Notice of Privacy Practices form.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Bartlett Chiropractic, Inc.'s** "NOTICE OF PRIVACY PRACTICES," revision date: April 24, 2018.

As required by the Privacy Regulations, the office of **Bartlett Chiropractic, Inc.** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **Bartlett Chiropractic, Inc.** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

_____
Print Name

_____ _____
Signature Date

Requests:

☐ I wish to file a "Request for Restriction" of my Protected Health Information.

☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

☐ I wish to object to the following in the "Notice of Privacy Practices":
_____
_____

_____
(Office Use Only)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe)_____
_____

REVELATION HEALTH
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