Adult Member Health Record

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	GENDER:
MARITAL STATUS: (PLEASE CIRCLE) M / S / W / D	NUMBER OF CHILDREN:
EMPLOYER ADDRESS & CITY	
WORK PHONE:	POSITION TITLE:
PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD	

EMERGENCY CONTACT

SPOUSE / SIGNIFICANT OTHER /PARENT (IF MINOR)
TELEPHONE:
EMPLOYER / POSITION:

HEALTH HABITS

DO YOU SMOKE? ❑ YES ❑ NO
DO YOU DRINK ALCOHOL? ❑ YES ❑ NO
DO YOU DRINK COFFEE, TEA OR SODA? ❑ YES ❑ NO
DO YOU EXERCISE REGULARLY? ❑ YES ❑ NO
DO YOU WEAR: ❑ HEEL LIFTS ❑ SOLE LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

MEDICATIONS YOU TAKE

❑ CHOLESTEROL MEDICATIONS	❑ INSULIN
❑ STIMULANTS	❑ PAIN KILLERS
❑ TRANQUILIZERS	❑ BLOOD PRESSURE MEDICINE
❑ MUSCLE RELAXERS	❑ OTHER

HEALTH EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): ❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ❑ YES ❑ NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:
PLEASE BRIEFLY DESCRIBE, INCLUDING THE IMPACT IT HAS HAD ON YOUR LIFE. I F YOU'RE ONLY HERE FOR CHIROPRACTIC WELLNESS SERVICES PLEASE SKIP TO NEXT PAGE: ❑ WELLNESS ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY ❑ JOB ❑ CHRONIC DISCOMFORT ❑ OTHER PLEASE EXPLAIN IMPACT?
WHEN DID THIS CONCERN BEGIN?
HAS THIS CONCERN: ❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE
DOES THIS CONCERN INTERFERE WITH: ❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES PLEASE EXPLAIN:
HAS THIS CONCERN OCCURRED BEFORE? ❑ YES ❑ NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? ❑ YES ❑ NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: ❑ GOOD ❑ BAD ❑ INDIFFERENT
HOW ARE YOU 'FEELING' TODAY? (CIRCLE BELOW, 1= LOW PAIN 10= UNBELIEVABLE PAIN) 1 2 3 4 5 6 7 8 9 10
HOW OFTEN ARE YOUR SYMPTOMS PRESENT? 0-25% 25-50% 50-75% 75-100% OF THE TIME

Leucadia Chiropractic Wellness Center
280 N. Coast Hwy 101
Encinitas, CA 92024

"The doors we open and close each day decide the lives we live."

ARE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ❑ YES ❑ NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ❑ YES ❑ NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ❑ YES ❑ NO

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ❑ **Relief care:** Symptomatic relief of pain or discomfort.
- ❑ **Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- ❑ **Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ❑ ***I want the Doctor to select the type of care for my condition.***

MEDICATIONS / SUPPLEMENTS

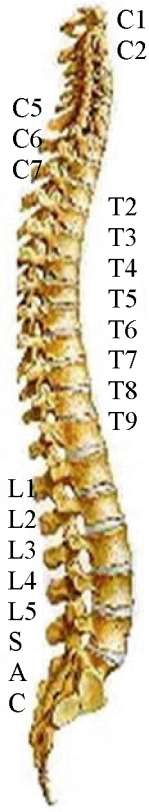
❑ CHOLESTEROL MEDICATIONS	❑ BLOOD PRESSURE MEDICINE
❑ STIMULANTS	❑ BLOOD THINNERS
❑ TRANQUILIZERS	❑ PAIN KILLERS (INCLUDING ASPIRIN)
❑ MUSCLE RELAXERS	❑ VITAMINS:
❑ INSULIN	❑ SUPPLEMENTS:
❑ ESSENTIAL FATTY ACIDS	❑ PROBIOTIC
❑ MULTIVITAMIN	❑ VITAMIN C
❑ CALCIUM / MAGNESIUM	❑ OTHER:

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.

YOUR CONCERNS

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems



Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Middle Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems
Ulcers
Gastritis
Kidney Problems

OTHER:

_____

_____

_____

HEALTH CONDITIONS...

INSTRUCTIONS: *Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.*

❑ SEVERE OR FREQUENT HEADACHES	❑ THYROID PROBLEMS	❑ PAIN IN ARMS/LEGS/ HANDS	❑ NUMBNESS	**FOR WOMEN ONLY:**
❑ HEART SURGERY/ PACEMAKER	❑ SINUS PROBLEMS	❑ LOW BLOOD PRESSURE	❑ ALLERGIES	ARE YOU PREGNANT? ❑ YES ❑ NO
❑ LOWER BACK PROBLEMS	❑ HEPATITIS	❑ RHEUMATIC FEVER	❑ DIABETES	IF YES, WHEN IS YOUR DUE DATE?
❑ DIGESTIVE PROBLEMS	❑ DIFFICULTY BREATHING	❑ ULCERS/COLITIS	❑ SURGERIES:	ARE YOU NURSING? ❑ YES ❑ NO
❑ PAIN BETWEEN SHOULDERS	❑ KIDNEY PROBLEMS	❑ TUBERCULOSIS	❑ ASTHMA	ARE YOU TAKING BIRTH CONTROL? ❑ YES ❑ NO
❑ CONGENITAL HEART DEFECT	❑ HIGH BLOOD PRESSURE	❑ ARTHRITIS	❑ LOSS OF SLEEP	<u>DO YOU:</u> EXPERIENCE PAINFUL PERIODS? ❑ YES ❑ NO HAVE IRREGULAR CYCLES? ❑ YES ❑ NO
❑ FREQUENT NECK PAIN	❑ CHEMOTHERAPY	❑ SHINGLES	❑ DIZZINESS	HAVE BREAST IMPLANTS? ❑ YES ❑ NO

SURGERIES/HOSPITALIZATIONS: (PLEASE LIST ALL SURGERIES / HOSPITALIZATIONS YOU HAVE HAD)

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

By signing below I agree to the above and allow the doctor, affiliated with Leucadia Chiropractic, to perform such. This consent will cover the entire course of my treatment.

Patient Name: _____ *Date:* _____

Patient or Guardian Signature: _____ *Date:* _____

AUTHORIZATION FOR CARE / ASSIGNMENT OF BENEFITS

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

SIGN IF READ ABOVE _____ DATE _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description is posted in the reception room of Leucadia Chiropractic for anyone to view. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

LEUCADIA CHIROPRACTIC OFFICE FEE SCHEDULE

OFFICE FEE SCHEDULE

Welcome to our office! The information below regarding our fees is provided to you to make you aware that our fees are different if you are a cash paying patient versus if you have insurance, a personal injury (auto accident) or workers compensation case.

CASH: Currently, our cash rate for an adjustment is $50.00. Co-pay and co-insurance amounts vary. These fees are also called point-of-service fees as they are paid at the time services are rendered. Understand also that this is a *discounted* fee and that our regular fees range from $95-$170.00 per visit (dependent on therapies performed including ultrasound, heat, massage, muscle stim, etc.). Since this is a *discounted* rate off of our usual fees, if, at any time, you have any other coverages either through insurance, an auto accident, or workers compensation claim, please notify our office immediately so that we can make efforts to receive our regular fees.

WORKERS COMPENSATION: Patients are not responsible for any costs incurred with a workers comp injury with the possible exception of supplements. You are also entitled to mileage reimbursement and our office can provide you with print outs of your visits for you to fill out the mileage paperwork provided by workers comp for you to be reimbursed.

PERSONAL INJURY: Otherwise known as auto accidents and sometimes, slip and falls.
The fees for personal injury cases range from $95-$170.00 per visit, dependent on the therapies you receive. With these slightly higher rates, extended wait time for payment is considered as is elaborate documentation of the patients care, including lengthy narrative reports, etc. Also, our charges are used by the responsible parties insurance to determine the extent of the patients need for care and are also used in calculating settlement offers to the patient. Therefore, we itemize all services performed at the visit and charge for them accordingly.
If our final bill is not paid by your attorney, med-pay or a third party payor, you are ultimately responsible for payment of your account.

INSURANCE: If your health insurance offers coverage, we will do our best to verify your benefits and bill it in accordance with any contractual guidelines, usually these charges range from $65-150.00 dependent on the therapies you receive. All billing is done as a courtesy to you, to help offset your cost, however, there may be times when we are mis-quoted information or payment is not made as described by your insurance. These additional amounts are your responsibility and we will do our best to keep you apprised of any information regarding your benefits if they should change. If your health coverage or health condition changes, you must notify the Doctor immediately. You are also responsible for payment of any deductibles, co-pays, and co-insurance amounts not covered by your insurance.

CANCELLATION FEES: Please note that massage therapy cancellation requires **24-hour notice** to avoid a cancellation fee of $30.00 for an hour and $15 for a ½ hour massage. Please understand that we pay the therapists for all visits not cancelled with 24-hour notice and therefore we must, in-turn, charge the patient missed appointment fees for massage only.

All fees charged at Leucadia Chiropractic are reasonable and in keeping with industry standards. We use the workers compensation fee schedule as a guideline for setting our fees, as is also typically done in the chiropractic industry.

I have read and understand the fees charged at Leucadia Chiropractic.

_____ _____

Patient Signature Date

LEUCADIA CHIROPRACTIC CLINIC

ASH LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Procedure:	*Charges:*
Massage done with Adjustment and/or Vibratory Massage	$10.00 Flat Fee
Ibuprofen Cream (used with Ultrasound, if necessary)	$ 5.00
E-Stim Pad Purchase (to keep in your file for future use)	$ 5.00
½ Hour or 1 Hour Massage Therapy	$45.00/$70.00
Acupuncture (if not covered by ASH)	$65.00
K-Laser	$50.00 to $70.00

This agreement may only be used to allow the member to agree to "self pay" for Specific, non-covered services in advance.

I, _____ acknowledge that I have been told in advance of treatment What portion of my care I will have to pay for, and agree to make financial arrangements With my Chiropractor, Dr. SeBastian.

Member Signature: _____ Date: _____

Maintenance/Elective Care Notification

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all **non**-covered services, including care determined to be elective or **maintenance.**

Maintenance/elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary (**pain does not** automatically prove medical necessity). You maybe also choose to receive maintenance care once maximum benefit from treatment has been reached.

Examples of maintenance care include: Treatment that seeks to PREVENT disease or PROMOTE health and enhance quality of life as well as MAINTAIN or PREVENT DETERIORATION of a *chronic* condition. When care becomes supportive rather than corrective, treatment is considered to be maintenance. Treatment is also considered to be maintenance when a patient has reached maximum therapeutic benefit. This can be reached when complaints either fully resolve or when pain and/or disability persist – even with ongoing treatment. Healthcare benefits do no cover treatment beyond this point. This is not to say that an individual would not benefit from further treatment, the only limitation is that treatment is usually not covered by insurance beyond this point.

Unfortunately, your insurance has cracked down on treatment that they deem not medically necessary. We are forced to administer pain questionnaires regularly and perform re-exams to justify your care, by actively showing a positive response to your treatment here. If, when your condition has stabilized and you are no longer making significant improvement, we will have no choice but to transition you to a cash basis. If your condition changes, flares or you have a new condition, we can reinstate billing your health insurance.

I understand the above conditions for billing my health insurance. I understand that when my care is deemed for maintenance that I will be financially responsible or my care.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

CONSENT TO TREATMENT OF MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of

_____, a minor, do hereby authorize
(Name of Minor)

_____as agent(s) for the undersigned
(Name of Agent)

to consent to any x-ray, examination, and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until _____, 20_____,
(Month and Day) (Year)

unless sooner revoked in writing delivered to the agent(s) noted above.

Date_____

Signature_____
(Parent/legal guardian/person having legal custody) (circle relationship)

Signature_____
(Parent)

Health Status Questionnaire

YOUR PHYSICAL LIFE

Rate based on a frequency scale of 1-5. 1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly

Presence of physical neck/backache pain, headaches...	1	2	3	4	5	Incidence of nausea, diarrhea or constipation	1	2	3	4	5
Feelings of tension, stiffness, lack of flexibility.	1	2	3	4	5	Incidence of allergies, eczema, or skin rash.	1	2	3	4	5
Incidence of fatigue or low energy.	1	2	3	4	5	Incidence of dizziness or lightheadedness.	1	2	3	4	5
Incidence of colds or flu.	1	2	3	4	5	Ability to work out or engage is activity	1	2	3	4	5

MENTAL/EMOTIONAL STATE

Rate based on a frequency scale of 1-5. 1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly

Presence of negative/ feelings or negative energy	1	2	3	4	5	Being overly worried about small things.	1	2	3	4	5
Moodiness, temper, or angry outbursts.	1	2	3	4	5	Difficulty thinking or concentrating.	1	2	3	4	5
Difficulty falling or staying asleep.	1	2	3	4	5	Feelings of depression or anxiety.	1	2	3	4	5

STRESS EVALUATION

Rate based on how the level of stress these areas cause you. 1= None 2= Rare 3= Occasional 4= Regular 5= Constant

Family	1	2	3	4	5	Work/School	1	2	3	4	5
Significant relationship	1	2	3	4	5	General well-being	1	2	3	4	5
Health	1	2	3	4	5	Emotional well-being	1	2	3	4	5
Finances	1	2	3	4	5	Coping with daily problems	1	2	3	4	5

LIFE ENJOYMENT

Rate based on the level of enjoyment experienced. 1= Extensive 2= Considerable 3= Moderate 4= Slight 5= None

Experiences of relaxation, ease, or well-being.	1	2	3	4	5	Compassion and acceptance of others.	1	2	3	4	5
Interest in maintaining a healthy lifestyle, diet, etc.	1	2	3	4	5	The level of recreation in your life.	1	2	3	4	5
Confidence in your ability to deal with adversity.	1	2	3	4	5	Time devoted to things you enjoy.	1	2	3	4	5

OVERALL QUALITY OF LIFE

Rate based on the level of enjoyment experienced. 1= Delighted 2= Mostly Satisfied 3= Mixed 4= Dissatisfied 5= Unhappy

Your personal life.	1	2	3	4	5	The handling of the problems in your life.	1	2	3	4	5
Your spouse/significant other.	1	2	3	4	5	Your physical appearance.	1	2	3	4	5
Your job and the work you do.	1	2	3	4	5	The way you adjust to changes in your life.	1	2	3	4	5

Health Goals

Of the many aspects of your life, where does your health and wellness rate as a priority (1 is highest and 5 is lowest):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

So that we may exceed your expectations, please rate each area below based on their importance to you (1 is high priority, 5 is low):

_____ Money _____ Value _____ Time _____ Service _____ Results

What health goal, if you were to complete or accomplish it, would have the greatest impact on your life?

_____

_____

NAME: _____ DATE: _____

Leucadia Chiropractic Clinic
Patient Billing Acknowledgement Form
MAINTENANCE/ELECTIVE CARE NOTIFICATION

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective **or maintenance**.

Maintenance/elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary (pain does not automatically prove medical necessity). You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

Examples of maintenance care include: Treatment that seeks to PREVENT disease or PROMOTE health and enhance quality of life as well as MAINTAIN or PREVENT DETERIORATION of a *chronic* condition. Treatment should be actively helping a person to improve to be considered medically necessary. When care becomes supportive rather than corrective, treatment is considered to be maintenance. Treatment is also considered to be maintenance when a patient has reached maximum therapeutic benefit (MTB) but continues treatment. Most treatments reach a point where no further significant improvement can be expected and this is called MTB. MTB can be reached when complaints either fully resolve or when pain and/or disability persist – even with ongoing treatment.

Most healthcare benefit certificates do not include coverage for treatment that is not resulting in a reasonable expectation of further improvement to a patient's condition.

If during the course of maintenance/elective care you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered maintenance/elective and may then be covered by your health plan.

Unfortunately, your insurance has cracked down on treatment that they deem not medically necessary. We are forced to administer pain questionnaires regularly and perform re-exams to justify your care, by actively showing a positive response to your treatment here. If, when your condition has stabilized and you are no longer making significant improvement, we will have no choice but to transition you to a cash basis. If your condition changes, flares or you have a new condition, we can reinstate billing your health insurance.

I understand the above conditions for billing my health insurance. I understand that when my care is deemed for maintenance that I will be financially responsible for my care. If my condition changes or I have a new condition, I will inform the staff immediately to see if I am eligible for coverage under my health plan.

_____ _____

Patient Name (Print) Date

_____

Patient Signature