Dr. Jessica Paige
Certified Chiropractic Sports Physician

Full Name: _____Email Address: _____ Date: _____

Social Security Number (If not paying in full at time of services): _____Date of Birth: _____

Age: _____ I identify my gender as_____ I prefer these pronouns _____ to be used

Height _____ Weight _____Spouse/Significant other: _____Date of Birth: _____

Children's Names and Ages: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____Cell Phone #: _____

Employer: _____ Emergency Name and Number: _____

How did you hear about the doctor? If someone referred you, what is their name? _____

Is there a specific reason for consulting our office at this time? _____

_____

YOUR HEALTH PROFILE

As a full spectrum chiropractic office we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and wellness-services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

PREVIOUS HISTORY

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE	COMMENTS
Did you have any childhood illness?				_____
Did you have any serious falls as a child?				_____
Did you play youth sports?				_____
Did you take/use any drugs?				_____
Have you fallen/jumped from a height over three feet (i.e. crib, bunk bed, trees)?				_____
Were you involved in any car accidents?				_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?				_____
Did you suffer any other traumas (physical or emotional)?				_____
Have you ever been under regular Chiropractic care?				_____

CURRENT HISTORY

YES	YES	NO	UNSURE
Do you drink water daily? Qty _____			
Do you drink caffeine? Qty _____			
Do/did you smoke? Qty _____			
Do/did you drink alcohol? Qty _____			
Any surgeries/hospitalizations?			
Do you take any supplements/vitamins?			
What kind/which brand: _____			
Do/did you play any adult sports?			

_____

On a scale of 0 – 10 describe your stress level (0 = none / 10 = extreme): Occupational _____ Personal _____

On a scale of Poor-Good-Excellent describe your: Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

CHIEF COMPLAINT IF NOT A WELLNESS VISIT

Briefly describe your chief area of complaint and location:

_____

Include effect it has had on your life: Date and how did it start? _____

Yes, it interferes with… Work__ Sleep__ Walking__ Sitting__ Hobbies__ Leisure__

If you are experiencing pain, is it… Sharp__ Dull__ Comes and goes__ Travels__ Constant__ Radiation__

On a scale of 0 – 10 describe your pain level (0 = none / 10 = extreme): _____

Since the problem started, it is… About the Same__ Getting Better__ Getting Worse__

What makes it worse? _____What makes it better? _____

Other Doctors seen for this problem (please list):

Chiropractors _____OT/PT_____

Medical Doctors/Other _____ Please check

(X) all symptoms you have ever had, even if they do not seem related to your current problem.

Headache	Pins and Needles in Legs	Fainting	Neck Pain
Fatigue	Loss of Smell	Back Pain	Loss of Balance
Dizziness	Fever	Ringing in Ears	Heartburn
Numbness in Fingers	Numbness in Toes	Loss of Taste	Stomach Upset
Pins and Needles in Arms	Depression	Cold Sweats	Tension
Sleeping Problems	Neck Stiffness	Cold Hands	Cold Feet
Diarrhea	Constipation	Buzzing in Ears	
Cold Sweats	Problem Urinating	Eyes Sensitive to Light	

List any medications you are currently taking: _____

FAMILY HEALTH PROFILE

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse/Partner/Significant Other _____

Parents _____

Siblings_____

The statements made on this form are accurate to the best of my knowledge.

_____ _____

Signature Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices (posted in the office) and I have been provided an opportunity to review it. This document states that your medical information will not be given to anyone without your written permission.

Name:_____ Birth Date:_____

Signature: _____ Date:_____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treats 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 discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in the improvement of symptoms, fractures, disc injuries, strokes, 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 further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options. 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 to cover the entire course of treatment for my present condition and for any future condition(s} for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name: _____

Patient Signature: _____ Date signed: _____

TO BE COMPLETED BY PATIENT S REPRESENTATIVE

IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient s Name: Name of Representative: _____

Date signed: _____ Signature of Representative: _____

Relationship or Authority of Patient's Representative: _____

LICENSED DOCTOR

Dr. Jessica Paige, B.S., D.C. DC-29172
1620 Westwood Drive, Suite D
San Jose, CA 95125
408-385-1849

Financial Guidelines

Thank you for choosing our office for your health care. Our office is dedicated to providing the finest quality health care with the best possible service available to you. Our financial guidelines are based on an open and honest discussion of our fees. Please read and sign this document.

Payment: We accept Cash, Checks, Visa and MasterCard. Payment for treatment is due **AT THE TIME SERVICES** are rendered. We do not send bills.

Initial _____

Financial Consent: The patient (guardian) agrees to be fully responsible for the total payment of the treatment performed in this office.

Initial _____

Minors: Payment for services of the treatment of minors is the responsibility of the adult accompanying the minor.

Initial _____

Missed Appointments: Your appointment time has been reserved specifically for you. If you choose to **CANCEL** or **RESCHEDULE** an appointment with **LESS THAN 24 hours notice**, by phone, online (Setmore) or email, or if you fail to appear for an appointment, ***you will be CHARGED $80*** for that appointment. We cannot make special circumstances for every individual therefore the policy pertains to all cash and insurance paying patients. Insurance **WILL NOT** be billed for the missed visit. Both the Wellness Plans and Visit Plans have their own specific missed appointment policy (see them for 24 hour policy).

Initial _____

Late Arrival For Your Appointment: The office strives to maintain a punctual schedule. If you arrive 10 minutes or more after your scheduled appointment time we CANNOT guarantee you will be seen at that time. You will be rescheduled according to availability and subject to the 24 hour missed appointment policy.

Initial _____

Past Due Charges: An interest charge of 1.5% per month (18% ANNUAL PERCENTAGE RATE) will be applied to your account if over 90 days past due. Any accounts which are over 120 days past due may be referred to our collection agency. Interest does not occur on the outstanding insurance portion as a courtesy to you. A charge of $35.00 will occur for returned checks.

Initial _____

Collection Fees: Fees incurred to collect payment will be billed to and is payable by the patient.

Initial _____

I, the undersigned, have read the above financial guidelines, and agree to abide by these policies.

Sign and Print Name:_____

Date:_____

Insurance Acknowledgement Form

As a service to our patients, we will bill some insurance companies. As a reminder, your insurance policy is a contract between ***YOU*** and ***YOUR INSURANCE COMPANY***. As a healthcare provider, **we are not a part of that agreement**.

******Please verify your benefits with your insurance company, what they tell us is NOT a guarantee of coverage.***

In-Network Policy:

- In-network with ONLY Blue Shield of California PPO and Medicare (depending on which plan)

***As a courtesy to you, we will collect your **estimated** patient's portion at the time of your visit and bill your insurance company for the balance.

****If your insurance company does not pay as expected, or delays payment beyond 90 days, you are responsible for the balance.**

***We are always available to answer your questions regarding this matter. If your insurance company adjusts our fees, the resulting balance will be your responsibility.

***Our goal is to help you achieve and maintain optimum health, which is not necessarily the goal of your healthcare insurance company.

***Medicare requires a separate ABN to be signed by card holders

Out-of-Network Policy:

- All other insurances are considered out-of-network
- We will provide a statement for you to submit directly to your insurance company
- Your insurance will reimburse you directly at the specific rate stated in your contract

****Please notify our staff ahead of time if you are going to require the insurance specific statements for insurance reimbursement.**

I, the undersigned, have read the above insurance acknowledgement form, and agree to abide by this policy.

.

Sign and Print Name:_____

Date:_____

COVID-19 INFORMED CONSENT TO TREAT

1. COMPLETE TESTING, HEALTH and VACCINATION INFORMATION

- Patient Name: _____
- Have you ever tested positive for COVID-19? ☐ Yes ☐ No *If Yes*: Date diagnosed: _____ Hospitalized? ☐ Yes ☐ No
- Are you experiencing any of the following potential symptoms of COVID-19: 1) Fever, 2) Dry Cough, 3) Shortness of Breath, 4) Runny Nose, 5) Sore Throat, 6) Loss of Taste or Smell? ☐ Yes ☐ No
- Have you received a COVID-19 Vaccination: ☐ Yes ☐ No
  If Yes, which Vaccine: _____ Date(s): 1st Dose: _____ 2nd Dose(if applicable): _____

2. REVIEW, CONFIRM UNDERSTANDING, CONSENT TO CARE - Initial in 4 places, Sign and Date

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my healthcare. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of healthcare during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

	Initial Below
• I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.	_____
• I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.	_____
• I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. For example, I understand that given the nature of care, simply being in a healthcare office, where frequent patient appointments occur, may elevate the risk of contracting COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.	_____
• I have been offered a copy of this consent form.	_____

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic. I confirm all of my questions were answered to my satisfaction.

I have read, or have had read to me, the above COVID-19 risk informed consent to treat. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Signature: _____
[Parent or Guardian Signature if applicable]

Name: _____

Date: _____

Witness Signature: _____
Witness

Name: _____

Date: _____