Date:_____

JOHN MUIR CHIROPRACTIC CENTER

CONFIDENTIAL PATIENT INFORMATION

(Please Print)

PATIENT INFORMATION

Patient's Name:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.		Marital status (circle one) Single / Mar / Div / Sep / Wid
Social Security #:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Email Address:	Home Phone: ( ) -		Cell Phone: ( ) -
Address:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )	
Address:	City:	State:	ZIP Code:
Patient's Nearest Relative:	Address:		Phone:

Chose clinic because/Referred to clinic by (please check one box):

❑ Family ❑ Friend ❑ Close to home/work ❑ Doctor ❑ Other:

Is condition due to injury or sickness arising out of patient's employment?	❑ Yes	❑ No	Date symptoms appeared or accident happened:
Has patient ever had same/similar condition? *If yes, when and describe:*	❑ Yes	❑ No	
Have you lost any days from work?	❑ Yes	❑ No	Date of last physical examination:
Females Only: Are you pregnant?	❑ Yes	❑ No	
Have you ever been under Chiropractic Care?	❑ Yes	❑ No	Doctor's name:

What operations have you had:	Serious Illnesses:

Purpose of this appointment (major complaint):

What activities aggravate your condition:

Is this condition progressively getting worse?	❑ Yes	❑ No	❑ Constant	❑ Comes and goes
Is your condition interfering with your:	❑ Work	❑ Sleep	❑ Daily Routine	❑ Other:

How long has it been since you really felt good?	What do you believe is wrong with you?	Other doctors seen for this condition:

Have you been treated for any health conditions by a physician in the last year? ❑ Yes ❑ No

If yes, describe:

What medications or drugs are you taking?	Remarks and additional information:

Office Use Only

JOHN MUIR CHIROPRACTIC CENTER
INSURANCE INFORMATION

Patient's Name: _____ Date: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Name of person responsible for payment:			Are you Insured? ❑ Yes ❑ No		
Name of Insurance Company:		Address:			
Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )	

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Futhermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from this insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediatoly due and payable.

_____ _____

Patient Signature *Date*

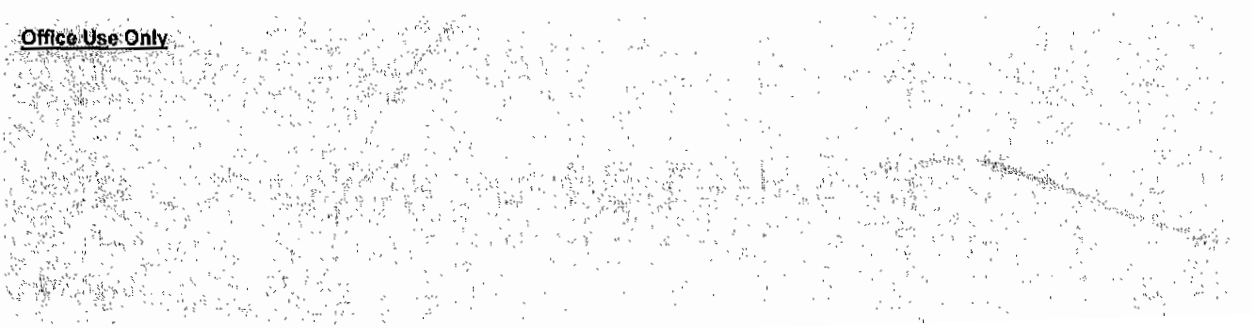
_____ _____

Guardian or Spouse Authorizing Care *Date*

_____ _____

Information taken by *Date*

Office Use Only

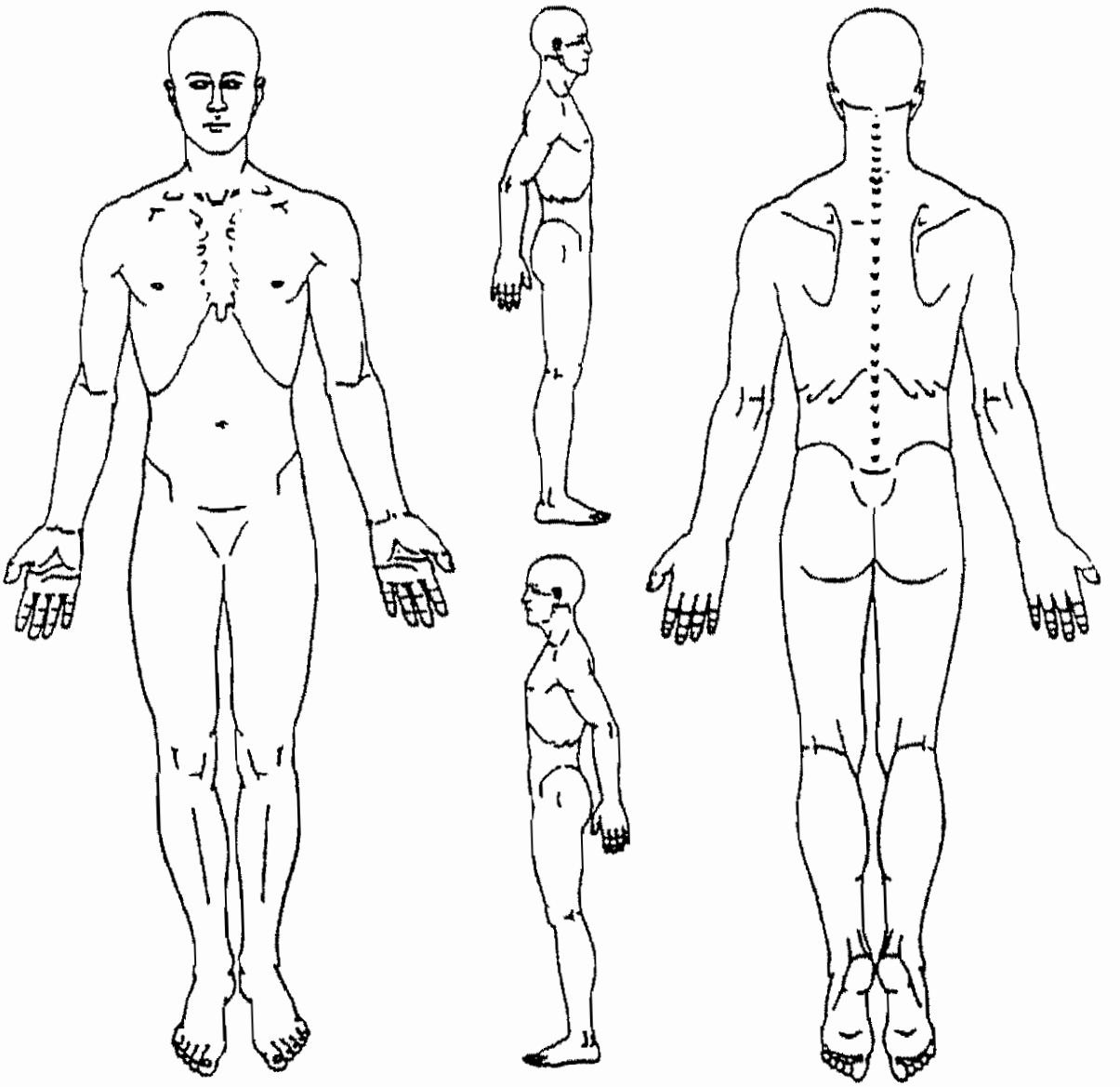


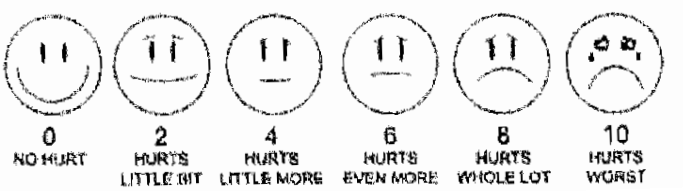
JOHN MUIR CHIROPRACTIC CENTER

CURRENT SYMPTOMS ASSESSMENT

Patients Name: _____ Date: _____

Please make the areas on your body below where you are having pain. Use the 0-10 scale below.





JOHN MUIR CHIROPRACTIC CENTER
MEDICAL HISTORY

Patient's Name: _____ Date: _____

P = Previously C = Currently

Have you ever suffered from any of the following conditions?

P	C		P	C		P	C		P	C	
☐	☐	Allergy	☐	☐	Poor posture	☐	☐	Tuberculosis	☐	☐	Itching
☐	☐	Dizziness	☐	☐	Sciatica	☐	☐	Bruise easily	☐	☐	Varicose veins
☐	☐	Fatigue	☐	☐	Spinal curvatures	☐	☐	Hay fever	☐	☐	Bed wetting
☐	☐	Headache	☐	☐	Swollen joints	☐	☐	Nosebleeds	☐	☐	Frequent Urination
☐	☐	Loss of sleep	☐	☐	Colon trouble	☐	☐	Sinus infection	☐	☐	Kidney infection/stone
☐	☐	Ulcers	☐	☐	Diarrhea	☐	☐	High blood pressure	☐	☐	Prostate trouble
☐	☐	Nervousness or Depression	☐	☐	Difficult digestion	☐	☐	Low blood pressure	☐	☐	Cramps or backache
☐	☐	Numbness	☐	☐	Hemorroids	☐	☐	Pain over heart	☐	☐	Excessive menstrual flow
☐	☐	Arthritis	☐	☐	Nausea	☐	☐	Poor circulation	☐	☐	Hot flashes
☐	☐	B	☐	☐	Asthma	☐	☐	Rapid heart beat	☐	☐	Irregular cycle
☐	☐	Foot trouble	☐	☐	Colds	☐	☐	Slow heart beat	☐	☐	Lumps in breasts
☐	☐	Low back pain	☐	☐	Deafness	☐	☐	Anemia	☐	☐	Alcoholism
☐	☐	Neck pain or stiffness	☐	☐	Ear noises	☐	☐	Stroke	☐	☐	Diabetes
			☐	☐	Enlarged thyroid	☐	☐	Chest pain	☐	☐	Polio
			☐	☐	Eye pain	☐	☐	Difficult breathing	☐	☐	Swelling of ankles
			☐	☐	Failing vision	☐	☐	P	☐	☐	Cancer
			☐	☐	Venereal disease	☐	☐	Spitting			

Tingling or Numbness in:

P	C	
☐	☐	Shoulders
☐	☐	Arms
☐	☐	Elbows
☐	☐	Hands
☐	☐	Hips
☐	☐	Legs
☐	☐	Knees
☐	☐	Feet

Do you have any of the following habits?

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Do you now take any vitamins or minerals? ☐ Yes ☐ No

Do you think you may need to take vitamins or minerals? ☐ Yes ☐ No

Are you wearing:

Heel lifts	☐
Sole lifts	☐
Inner Soles	☐
Arch supports	☐

JOHN MUIR CHIROPRACTIC CENTER
HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES JOHN MUIR CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS
I give permission to John Muir Chiropractic Center to use my address, phone number, and clinical records to contact me with birthday cards, holiday-related cards, and information about treatments or other health related information.

OPEN ROOM AUTHORIZATION
I give John Muir Chiropractic Center permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving John Muir Chiropractic Center permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION
You have the right to revoke this authorization in writing at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. New patients consent to the use and disclosure of health information for treatment, payment, or healthcare operations.

You may revoke this authorization by mailing or hand delivery of a written notice to the Privacy Office of John Muir Chiropractic Center. The written notice must contain the following information:

Your full name, Social Security number, and date of birth. A clear statement of your intent to revoke this authorization, then sign and date it. The revocation will not be in effect until the Privacy Official has received it.

I understand that as part of my health care, John Muir Chiropractic Center originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as plans for future care or treatment. I understand the following serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnoses and surgical information to pay my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a notice of information. I understand that I have the following rights:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purpose.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that John Muir Chiropractic Center reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should John Muir Chiropractic Center change their notice they will send a copy of any revised notice to the address I have provided. Whether U.S. mail or if I agree email.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses.

John Muir Chiropractic Center for its own use/disclosure of PHI requests this authorization. (Minimum necessary standards apply).

You have the right to refuse to sign this authorization. If you refuse to sign this, John Muir Chiropractic Center will not refuse to provide treatment.

A copy of the signed authorization will be provided to you.

_____ _____

Patient Signature *Date*

JOHN MUIR CHIROPRACTIC CENTER
ARBITRATION AGREEMENT

Patient's Name: _____

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 California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any 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 the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physical therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physical therapist, and the physical therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physical therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

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 of a demand of a neutral arbitrator by either party. 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 or witness fees, or other expenses incurred by party for such a party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.
Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of a person or entity which 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 California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: 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 California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physical therapist within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____ (Patient's or Patient Representative's Initials)

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 YOU RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____
Patient Signature *Date*

_____ _____
Patient Representative *Relationship to Patient* *Date*

_____ _____
Office Signature *Date*

Also Sign the Informed Consent on Reverse/Next Page

JOHN MUIR CHIROPRACTIC CENTER
INFORMED CONSENT TO TREAT

Patient's Name: _____

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, 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 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 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 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, and 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 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.

_____

Chiropractor Name

_____ _____

Patient Signature *Date*

_____ _____

Patient Representative *Relationship to Patient* *Date*