NORTH COUNTY FAMILY CHIROPRACTIC
WWW.WELLNESSHOTSPOT.COM
"Loving Service is our First Technique"

WELCOME

Congratulations on taking the first step towards better health!!!

Thank you for choosing our office for your health and wellness needs. We will be working together to help you and your family reach your health and wellness goals. If you have any questions about your care, please do not hesitate to ask one of our highly educated team members. We are committed to providing you and your family with the highest quality corrective and wellness care available so that you and your family can enjoy an active healthy life.

The following information will outline what you can expect as a new member at our wellness center.
Please read carefully:

First Visit

Your initial office visit will include a comprehensive health and spinal examination, computerized nervous system scan and any necessary x-rays. Upon completion of the First Visit you will schedule a separate appointment known as Report of Findings. *We strongly recommend that your spouse or significant other joins you for the Report of Findings; as their support and understanding of your health status is pivotal in your healing process*. Report of Findings is scheduled on the following day; thus, giving the doctor an adequate amount time to study the results of your x-rays and computer scans and to develop an appropriate treatment plan for your condition. Duration of the first visit is typically 30 to 45 minutes.

Second Visit

The second visit is referred to as **Report of Findings**. During this visit, the doctor will sit down with you and go over the examination findings and how we can serve you best. At this time we will recommend treatment type and duration most desirable for your health condition. We will go over financial plans and insurance contributions for your care. Most patients choose to receive their first treatment at this time. Duration of the Second Visit typically lasts 30 to 45 minutes.

Once Again a Big WELCOME to You and Your Family from Our Wellness Family!

Dr. Ivana S. Nedic
Dr. Cameron S. Sutter
With
Your Wellness Team

TERMS OF ACCEPTANCE

When a patient seeks care in our office and we accept the patient for such care, it is essential for both to be working towards the same objectives.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be able to attain it. This will prevent any confusion and disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____have read and fully understand the above statements.
(print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ Date:_____
Signature

CHILDREN & MINORS ONLY – Consent to Treat a Minor (completed by a parent or guardian).

I hereby authorize the doctor and whomever he /she may designate as assistants to administer chiropractic care as deemed necessary to my son/daughter _____ dated at North County Family Chiropractic this _____day of _____, 20__.

Parent or Guardian's Signature x_____ Date: _____
Signature

OFFICE FEE SCHEDULE AND FINANCIAL POLICY

Our experience has shown that it is wise to have an understanding with our patients as to our office fee policies. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan which best fits your needs. This information will enable us to better serve you and help avoid any misunderstanding in the future. If special arrangements are necessary, please discuss with the Doctor during your consultation. Our main concern is your health and wellbeing, and we will do our best to help you.

PROFESSIONAL FEE SCHEDULE

Consultation	No Charge
Examinations	$75 - $175
Surface EMG	$50 - $200
X-ray Studies	$60 - $150
Spinal Adjustments	$45* - $60
Adjunctive Therapies	$20 - $50
Massage Therapy	$40 - $100

All fees are primarily based on the usual & customary fees for our community and on the fee schedule set by the Industrial Medical Council of California.
** This fee reflects the At Time Of Service Payment Discount.*

CASH PLANS: You are expected to pay in full for today's services. Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. We accept Cash, Check, MasterCard, Visa and Discover. For active patients who qualify, you may enroll in one of our care programs which allows care to be paid for on a monthly basis. The greatest savings are available with family and pre-pay plans. The doctor will discuss your options with you after he finds out if he can help you.

INSURANCE: Unless we are a contracted provider for your insurance, you are expected to pay in full for today's services. Once we have verified your chiropractic coverage, we will accept assignment and directly bill your insurance company. **Until coverage is verified, our policy is for you to pay for services as they are rendered**. We offer monthly payment installments to cover your deductible, co-payments and non-covered care. Family plans are available. Ask the doctor for details.

Insurance Co. _____ Phone #:_____

Group#: _____ ID#: _____

Insured's Name:_____ Date of Birth:____/_____/_____

Relation with the Insured: _____ Insured's Employer: _____

INSURANCE ASSIGNMENT OF BENEFITS – Read & Sign if you believe you have chiropractic insurance benefits.

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to North County Family Chiropractic at 10175 Rancho Carmel Dr., Ste. 116, San Diego, CA 92128. If my current policy prohibits direct payment to the doctor, then I hereby also direct you to make out the check to me and mail it C/O the North County Family Chiropractic at 10175 Rancho Carmel Dr., Ste 116, San Diego, CA 92128. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved with this case.

Patient or Guardian's Signature X _____ Date:_____

WORK RELATED: Under California law, work injuries are covered 100% by your employer's insurance carrier provided certain conditions are met. You are required to notify your employer of your injury within 30 days of the injury. When verification has been completed and the proper forms are filed, we will accept assignment on work related cases.

UNDER 30 DAYS SINCE INJURY - We will need to obtain prior authorization from your employer before treating you. We can either call your employer now, or you may return a written authorization on your next visit.

MORE THAN 30 DAYS SINCE INJURY - We do not need authorization from your employer.

AUTO & PERSONAL INJURY: If a liability claim exists, you do not have to pay for your services as they are rendered, unless notified by the Doctor. Doctor will discuss your options with you. If medical coverage is available through an auto or liability policy, our office policy is to bill this coverage first. These policies usually cover 100% of your medical bills. In the event there is no coverage under such a policy, we may accept a lien. Thereby, we will extend the courtesy of waiting for payment for services rendered, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. You should understand that you are responsible for services, even if you receive no insurance settlement. Too guarantee future payment, it is our policy that you sign a Personal Injury Lien Financial Agreement. If an attorney is involved, you & your attorney must sign a Doctor's Lien. If no attorney is involved, you must sign a Letter of Authorization, which authorizes the liable insurance carrier to include North County Family Chiropractic on the settlement check.

MEDICARE: Medicare recipients must present their enrollment cards at the onset of care. Spinal manipulation is the ONLY service covered by Medicare. There is no guarantee Medicare will pay for any more than 12 visits. All non-covered services (such as exams and x-rays) must be paid-in-full at the time of service. We offer monthly payment installments to cover your deductible, co-payments and non-covered care or you can pay your deductible & co-pay as care is rendered.

By signing below, I verify that I have read the Financial Policies.

Patient or Guardian's Signature X _____ Date:_____

FEMALE PATIENTS ONLY - Non-Pregnancy Verification for X-rays

Let it be known by all people by my signature that I am not pregnant. If it later becomes known that I was pregnant during this x-ray examination, that I do not hold North County Family Chiropractic and/or Ivana Nedic D.C. and Cameron Sutter D.C., liable.

Patient or Guardian's Signature X _____ Date: _____

Primary Care Physician Information

Name: _____ Clinic Name_____

Address_____ Phone Number_____

Emergency Contact: _____ Phone Number_____

Informed Consent for Chiropractic Treatment of your Pain

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.

Other options for the treatment of pain include: do nothing – live with it, over-thecounter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.
My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Witness Name	Signature	Date

NORTH COUNTY FAMILY CHIROPRACTIC

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.

North County Family Chiropractic 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

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations:

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with North County Family Chiropractic."

"It is our policy that we may provide a substitute health care provider, authorized by North County Family Chiropractic 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."

"It is possible that you will be treated in an open treatment room. In the case that another patient is present during your treatment, personal health information may be discussed between you and the provider. Should you wish to address issues that you may wish to remain confidential, a private room will be made available to you upon your request."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations:

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to North County Family Chiropractic for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing 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

Your health information may be disclosed 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.

Marketing

We may contact you for educational, marketing, or fundraising purposes, as described below:

"As a courtesy to our patients, it is our policy to 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."

"Postcards are mailed as another method for reminding our patients of their appointments."

"As part of our responsibility to educate our patients about chiropractic and massage therapy we often send postcards, newsletters, e-mails, promotions, and personal letters by mail."

"We post pictures of our patients on our wall of Chiropractic Stars as well as voluntarily submitted testimonial letters."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, 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 North County Family Chiropractic sponsored fund-raising events."

Change of Ownership

In the event that North County Family Chiropractic 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 North County Family Chiropractic 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 North County Family Chiropractic amend your protected health information. Please be advised, however, that North County Family Chiropractic 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 reason(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 North County Family Chiropractic.
- 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

North County Family Chiropractic 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, North County Family Chiropractic is required by law to comply with this Notice.

North County Family Chiropractic 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 Dr. Cameron Sutter by calling this office at 858-674-6400. If Dr. Cameron Sutter is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how North County Family Chiropractic has handled your health information should be directed to Dr. Cameron Sutter by calling this office at 858-674-6400. If Dr. Cameron Sutter is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

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
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 01/01/2009.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide North County Family Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient's Name

_____ _____

Patient's Signature Date

_____ _____

Authorized Facility Signature Date

NORTH COUNTY FAMILY CHIROPRACTIC
10175 Rancho Carmel Drive, Ste 116
San Diego, CA 92128
Tel: 858.674.6400

It's Your Life…Live It in Health!!!

Name _____ **Email**_____

Date of Birth ___/___/_____ **Age** _____ **Date** _____/_____/_____

Your e-mail address is for in-office purposes only and as such will not be released to any third party as with accordance with privacy regulations. Please note that our office utilizes e-mail for office announcements, schedule of events and education purposes only.

Personal and Family Health History

Address _____ Employer _____
City _____ State ____ Zip _____ Marital Status S M D W
Phone: (C) _____ (W) _____ Spouse's Name _____
Occupation _____ Spouse's Occupation _____

Referred by: _____□ MD □ Physical Therapist □ Massage Therapist □ Family Member

Number of Children and Ages ***Previous Chiropractic Care?***

Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____

Circle all that Apply	**Patient**	**Child 1**	**Child 2**	**Child 3**	**Doctor *Comments***
Birth History					
Long Delivery?	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	_____

Growth and Development		
Did you ever once...		
Learn to care for your spine?	Y	_____
Have regular spinal check ups	Y	_____
Fall out of bed?	Y	_____
Bang your head?	Y	_____
Breastfeed?	Y	_____
Childhood sickness?	Y	_____
Have any Accidents?	Y	_____
Have reoccurring ear infections?	Y	_____
Have Surgery?	Y	_____
Child abuse	Y	_____
Fall down the stairs?	Y	_____
Pulled by your arm?	Y	_____
Experience other traumas?	Y	_____

Current Health Habits **Patient**

Did/do you...

Smoke? Y _____

How long: _____

Drink Y _____

Have you been in accidents? Y _____

Have you had surgery and organs replaced/removed? Y _____

Have hobbies/sports injuries? Y _____

Take:

Prescriptive medication Y _____

Non-prescriptive medication Y _____

List: _____

Vitamins/Supplements Y _____

List: _____

Have Teeth Problems? Y _____

Have Eye Problems? Y _____

Have Hearing Problems? Y _____

Trouble sleeping Y _____

Have occupational stress? Y _____

Please rate your occupational stress: *0 (no stress) 1 2 3 4 5 6 7 8 9 10 (unbearable stress)*

Have physical stress? Y _____

Please rate your physical stress: *0 (no stress) 1 2 3 4 5 6 7 8 9 10 (unbearable stress)*

Have mental stress? Y _____

Please rate your mental stress: *0 (no stress) 1 2 3 4 5 6 7 8 9 10 (unbearable stress)*

Sleeping posture – side–stomach–back _____

Current Health Condition

Date of Last Physical _____/ _____/_____ Location: _____

Present Complaint / Reason For Your Visit Today_____

Other _____

_____

Pain or Problem started on_____

Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Does the pain radiate to other parts of the body Yes No If yes, where? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Does this condition wake you up at night? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

- ❒ Headaches
- ❒ Neck Pain
- ❒ Sleeping Problems
- ❒ Back Pain
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Chest Pains
- ❒ Dizziness
- ❒ Face Flushed
- ❒ Neck Stiff
- ❒ Pins & Needles in Legs
- ❒ Pins & Needles in Arms
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Shortness of Breath
- ❒ Fatigue
- ❒ Depression
- ❒ Light Bothers Eyes
- ❒ Loss of Memory
- ❒ Ears Ring
- ❒ Fever
- ❒ Fainting
- ❒ Cold Sweats
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Diarrhea
- ❒ Feet Cold
- ❒ Hands Cold
- ❒ Stomach Upset
- ❒ Constipation
- ❒ Loss of Balance
- ❒ Buzzing in Ear

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? _____ What? _____ When?_____

What side effects have you experienced from the drugs and surgery? _____

Have you experienced unexplained weight loss or weight gain over the last 12 months? (Y) (N)

Have you had any of the following studies preformed within the last 12 months?

Spinal X-Rays:(Y)/(N) **MRI**: (Y) / (N) **CAT Scan**: (Y) / (N) **Mammogram**: (Y) / (N) **Bone Density Test:** (Y) / (N)

Family History

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Lifestyle History

Please rate your current lifestyle components on the scale of 1 (poor) to 10 (excellent)											**Doctor Comments**
Nutrition	1	2	3	4	5	6	7	8	9	10	_____
Exercise	1	2	3	4	5	6	7	8	9	10	_____
Rest	1	2	3	4	5	6	7	8	9	10	_____
Overall Health	1	2	3	4	5	6	7	8	9	10	_____

Chiropractic History

Date of last chiropractic visit _____ Reason for care_____

How long were you under care? _____Are other family members under chiropractic care? Yes No Who? _____

What do chiropractors treat?_____ Your preferred chiropractic technique? _____

Why our Wellness Center? People come to us for many reasons. Some simply come 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). Others embrace chiropractic to help the nervous system function at its optimal potential allowing them to experience health at its fullest (WELLNESS CARE). In addition, our wellness center offers a variety of services that can help you and your family to THRIVE in optimal health and wellness!

As a result of my care, I would like to:

Please check all that apply

- □ Feel better quickly
- □ Have a healthier spine
- □ Have a healthier body by keeping my nervous system healthy
- □ Live a healthier lifestyle
  - □ Learn about disease prevention
  - □ Receive Weight Management Coaching
  - □ Receive Stress Management Coaching
  - □ Receive Lifestyle/Empowerment Coaching
  - □ Pre and postnatal Coaching
  - □ Stop Smoking

_____ _____

Signature Date