NORTH COUNTY FAMILY CHIROPRACTIC
10175 Rancho Carmel Drive, Ste 116
San Diego, CA 92128
Tel: 858.674.6400
Fax: 858.674.6498

Name ____ Date ___/___/______
Date of Birth ___/___/______ Age_____

Personal History

Address____________________________________
City ______________ State ____ Zip____________
Phone (H) ________________ (C)______________
Parent Name/Mother:_________________________
Parent Name/Father: _________________________
Referred By_________________________________

Primary Care Physician Information:

Name: ____________________________________
Phone # ___________________________________
Clinic Name:________________________________
Location: ___________________________________

Personal Health History

I. BIRTH HISTORY: *Please circle Y for Yes and N for No. If Yes please provide additional information about the child's birth process.*

1. Long Delivery? Y / N ______________________________
2. Difficult Delivery? Y / N ______________________________
3. Forceps/Vacuum? Y / N ______________________________
4. Caesarian? Y / N ______________________________
5. Breach/Cephalic? Y / N ______________________________
6. Home Birth? Y / N ______________________________
7. Induced Labor? Y / N ______________________________
8. Mother given drugs during delivery Y / N ______________________________

II. GROWTH AND DEVELOPMENT

1. Was the child Breast fed? Y / N (if Yes) Up to what age? ________
2. Was the child Formula fed? Y / N (if Yes) Age first formula fed? ____
3. Does/Has the child had
   i. Frequent ear infections Y / N
   ii. Colic Y / N
   iii. Allergies Y / N
   iv. Asthma Y / N
   v. Surgeries Y / N *(Please specify type of surgery and year performed)*
   ____
   ____
   ____
4. Has the child ever taken
   i. Prescription medication Y / N
   ii. Non-Prescription medication Y / N
   Please list all medications the patient has taken
   ____
   ____
   ____
5. Immunization History
   i. Has the patient been immunized? Y / N ____________
   ii. Has the patient shown side effects form immunization? Y / N ____________
   iii. Has the patient ever had a flu vaccine? Y / N Year: ____________
   iv. Is the patient scheduled for booster shots? Y / N ____________
   v. Have you, the parent, tracked vaccine maker/type/stock number? Y / N

6. Nutrition / Diet

Please estimate an average number of servings of each food per day that your child consumes:

i. Water	_____ glasses/day	vi. Juice	_____ glasses/day
ii. Fruit	_____	vii. Soda	_____ glasses/day
iii. Vegetables	_____	viii. Milk	_____ glasses/day
iv. Meat	_____	ix. Nuts	_____
v. Fish	_____	x. Sweets	_____

Does your child take:

i. Multi vitamins? Y / N Brand: _____________ Dose ____________

ii. Omega-3 FA supplements? Y / N Brand: _____________ Dose ____________

Does your child have any:

i. Food Allergies Y / N Food type: _____________________________

ii. Food Intolerance Y / N Food type: _____________________________

7. Activity Level *(please circle one)* Minimal Moderate Very Active

III. CURRENT HEALTH CONCERN

Date of last Spinal Check up ____ / ____ / _____ Location: ___________________________________

Reason for your visit today: ____

____

Pain/Problem first started on _________________________ Prior History of this complaint Y / N

What activities aggravate the child's condition? ____

What activities lessen the child's condition? ____

Have you seen other health providers for this complaint/ Y / N

i. Who? ____

ii. Working diagnosis ____

iii. Recommended treatment ____

Home remedies? ____

Is the condition getting *(please circle one)*? Better Worst Same _______________________________

Does this condition wake the child up at night? Y / N _______________________________

Have you noticed unexplainable weight gain of more than 5-10lbs in the last 30 days? Y / N

Have you noticed unexplainable weight loss of more than 5-10lbs in the last 30 days? Y / N

Has the child had recent bouts of:

i. Flu	Y / N	vi. Loss of Appetite	Y / N	xi. Shortness of Breath	Y / N
ii. Fever	Y / N	vii. Loss of Balance	Y / N	xii. Face Flushed	Y / N
iii. Constipation	Y / N	viii. Cold Sweats	Y / N	xiii. Irritability	Y / N
iv. Diarrhea	Y / N	ix. Tremors	Y / N	xiv. Yellowing of hands	Y / N
v. Vomiting	Y/ N	x. Fatigue	Y / N	xv. Yellowing of eyes	Y / N

Other: ____

IV. FAMILY HISTORY

Please check all that apply:

□ Cancer □ Diabetes □ Heart Disease □ Arthritis □ Immune Disorders Other: _________________

Parent Name: _________________________________ 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:_________

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 (Parent or guardian) Date

____ ____________
Authorized Facility Signature Date

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-the counter 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 Parent Signature Date

________________________ ____________
Authorized Facility Signature Date