Back on Track
upper cervical care

DR. AUTUMN MONT...

CONFIDENTIAL PATIENT INFORMATION

The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date: _____

Name: _____

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

Age: _____ Birth Date: _____ Marital Status: M S W D No. of Children _____

Referred by: _____ E-mail Address: _____

Please Check Type of Payment: ☐ Cash ☐ Check ☐ MasterCard/Visa

Home Phone: _____ Cell Phone: _____ Your SS#: _____

Name of Spouse or Parent: _____ Birth Date: _____

Spouse's SS#: _____

Describe The Major Complaints That Bring You To Our Office: _____

_____

_____

Is Your Condition Due To An Accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident? ☐ Auto ☐ Work/Job ☐ At Home ☐ Other: _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand that I am personally responsible for payment of any and all services. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ *Date:* _____

Guardian's Signature (For Minors): _____ *Date:* _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

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HEALTH HISTORY

Name: _____ Date: _____

List All Current Health Problems: _____

_____

_____

List Any Other Doctors Seen, Treatments And Results Obtained: _____

_____

_____

Your Current Physician(s)/Therapist(s): _____

_____

List All Surgeries And Their Dates: _____

_____

_____

List Any Medications You Are Taking: 12/01

_____

_____

List Any Traumas And Their Dates: _____

_____

_____

Please Check The Conditions You Have Or Have Had:

( ) AIDS
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Chronic fatigue
( ) Depression
( ) Diabetes
( ) Epilepsy
( ) Fibromyalgia
( ) Hypoglycemia
( ) Multiple sclerosis
( ) Parkinson's disease
( ) Polio
( ) Rheumatic fever
( ) Rheumatoid arthritis
( ) Tuberculosis
( ) Venereal disease

Please Check All Present Symptoms::

CARDIOVASCULAR
( ) General swelling
( ) Swelling in legs
( ) Swelling in face
( ) Swelling around eyes
( ) Chest pain
( ) Pounding heart beat
( ) Rapid heart beat
( ) Irregular heart beat
( ) Blue or purple skin
( ) Blue or purple nail beds
( ) Cold hand/feet

VERTEBROBASILAR
( ) Double vision
( ) Loss of coordination
( ) Loss of memory
( ) Rringing in ears
( ) Heart attack
( ) High blood pressure
( ) Muscle weakness
( ) Dizziness
( ) Blurred vision
( ) Stroke
( ) Hypertension
( ) Inability to form words
( ) Burning sensations
( ) Blindness
( ) Previous head injury
( ) Previous neck injury
( ) Taking birth control pills
( ) Family history of stroke
( ) Blood vessel disease
( ) Check if you smoke
( ) Fainting
( ) Area of numbness

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DR. AUTUMN MONTEIRO

MUSCULOSKELETAL SYSTEM

Please Check All Present Symptoms:

Head
( ) Frequent headaches
( ) Severe headaches
( ) Head feels heavy
( ) Vertigo
( ) Dizziness
( ) Light headedness
( ) Loss of taste
( ) Loss of smell
( ) Loss of hearing
( ) Loss of balance

Neck
( ) Pain in neck
( ) Pain with movement
( ) Swelling in neck
( ) Stiffness in neck
( ) Pinched nerve in neck
( ) Neck feels out of place
( ) Muscle spasms in neck
( ) Grinding sounds in neck
( ) Popping sounds in neck
( ) Limited neck movement

Mid-Back
( ) Mid-back pain
( ) Pain between shoulder blades
( ) Sharp stabbing pain
( ) Dull ache
( ) Pain from front to back
( ) Pain over kidney area
( ) Muscle spasms

Lower Back
( ) Lower back pain
( ) Lower back feels out of place
( ) Muscle spasms

Shoulders
( ) Pain in shoulders
( ) Pain across shoulders
( ) Muscle spasms
( ) Can't raise arm
( ) Above shoulder
( ) Above head

Arms & Hands
( ) Pain in upper arm
( ) Pain in forearm
( ) Pain in hands
( ) Pain in fingers
( ) Pins & needles
( ) In arms
( ) In fingers
( ) Fingers go to sleep
( ) Cold hands
( ) Swollen fingers
( ) Loss of grip strength

Hips, Legs & Feet
( ) Pain in buttocks
( ) Pain in hip
( ) Pain down leg
( ) Knee pain
( ) Leg cramps
( ) Pins & needles in legs
( ) Numbness in legs
( ) Numbness in toes
( ) Cold feet
( ) Swollen ankles
( ) Swollen feet

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PAIN DRAWING

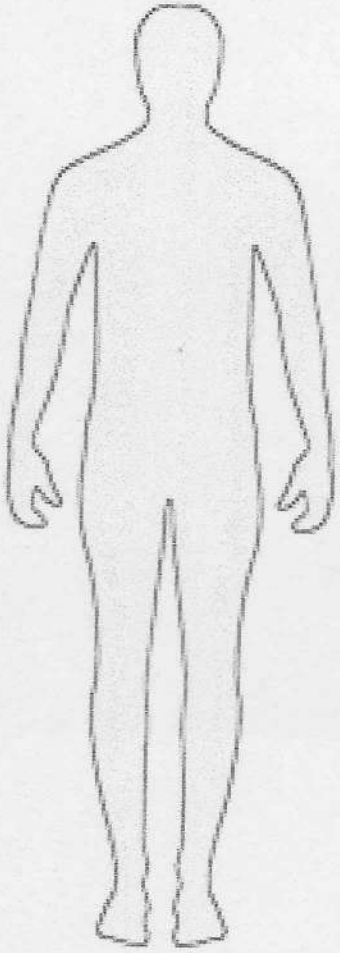
Patient Name: _____ Date: _____

Attending Dr.: _____

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face.

A = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing

R L



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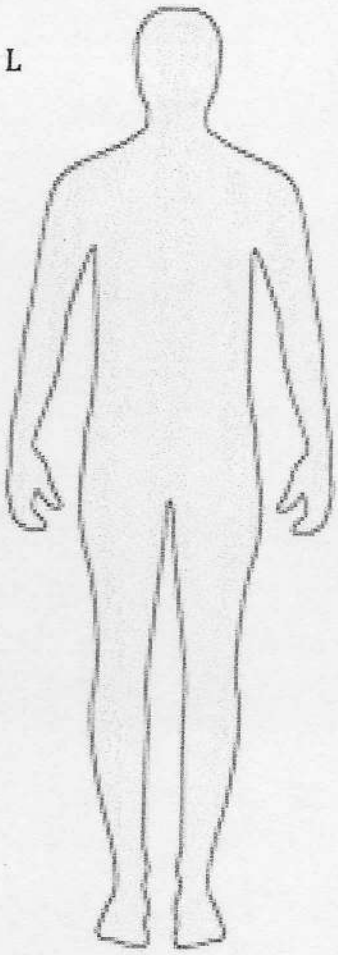

BACK

Patient Signature: _____

Date: _____

SUBJECTIVE and OBJECTIVE NUMERICAL OUTCOME MEASURE ASSESSMENT

6090 S. Fort Apache #100
Las Vegas, NV 89148
702.834.5777

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our Practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of 01/01/07, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any Changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health care Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we can not use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquires as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voice mail, postcards, or letters).

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of the Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you no more than $.75 for each page, and postage if you you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before July 1, 2009.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative locations(e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must proved satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding, the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Contact: Dr. Autumn Monteiro, DC

Telephone: 702-834-5777 **FAX:** 702-442-0755

Email: drautumn@seeonedoc.com

Address: 6090 S. Fort Apache #100 Las Vegas, NV 89148

PRIVACY ACT FORM

You have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in your care, payment of your bills, or in the performance of healthcare operations of this Chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice Of Privacy Practices also describes the rights and duties of the Chiropractor with respect to your protected health information. You are hereby giving permission to Dr. Autumn Monteiro Dorini to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS

You are hereby giving permission to Dr. Autumn Monteiro Dorini to use your address, phone number, email, and clinical records to contact you appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.

If Dr. Autumn Monteiro Dorini's office contacts you by phone, you are giving them permission to leave a phone message on your answering machine or voicemail. Specific details will not be left on your machine.

By signing this form you are giving Dr. Autumn Monteiro permission to use and disclose your Protected Health Information in accordance with the directives listed above. The use of this format is intended to make your experience at Dr. Autumn Monteiro Dorini's office more efficient and productive as well as to enhance your access to quality Chiropractic Care and health information. This authorization will remain in effect for the duration of your care with Dr. Autumn Monteiro Dorini plus 7 years or until you revoke it.

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. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Dr. Autumn Monteiro Dorini. The written notice must contain the following information: Your name, social security number, and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request; And your signature. The revocation is not effective until it is received y Dr. Autumn Monteiro Dorini. This AUTHORIZATION is requested by Dr. Autumn Monteiro Dorini for its own use/ Disclosure of PHI. (*Minimum necessary standards apply.)*

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Dr. Autumn Monteiro Dorini will provide care; however, it will not be possible for Dr. Autumn Monteiro Dorini to reschedule your appo9intments since she will be unable to contact you regarding your care.

You have the right to inspect or have copies made, with boundaries, the Protected Health Information to be used/ disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided at your request.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of the Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Name (Print): _____ Date of Birth:_____

Signature:_____Today's Date: _____

Name of Personal Representative (If someone other than yourself is designated to act on your behalf)

Name (Print): _____Signature: _____

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upper cervical care

DR. AUTUMN MONTEIRO

Informed Contest to Chiropractic Treatment

I hereby request and contest to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Back On Track Upper Cervical Care
Autumn Monteiro, D.C.
6090 S. Fort Apache Rd. #100 Las Vegas, NV 89148
702-834-5777

Date of Signature_____

_____
Printed Name of Patient

_____
Signature of Patient/or patient's representative

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upper cervical care

DR. AUTUMN MONTEIRO

TERMS OF ACCEPTANCE

When a patient seeks Upper Cervical health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Upper Cervical care has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Correction: An upper cervical correction is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments to the upper cervical 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 a vertebral subluxation. However, if during the course of an upper cervical examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services 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 PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjustments to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

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.

_____ _____

(signature) (date)

ELECTRONIC RECORDS/REMINDERS

Would you like to receive email or text message appointment reminders? Emails are sent 24 hours prior to your next appointment. You will receive a text 2 hours prior. You may opt in to BOTH services.

_____ **Yes.** I would like to receive electronic appointment reminders via **EMAIL.**

Please provide the email that you would prefer your reminder sent to.

_____

_____**Yes,** I would like to receive electronic appointment reminders via **TEXT.**

Please provide your cell phone carrier. _____

_____**No,** I would **not** like to receive electronic appointment reminders.

Patient Signature _____ Date_____