Welcome to
The Neck Pain Doctor
Physical Therapy & Chiropractic
906 Sycamore Ave Ste 210
Vista, CA 92081
(760) 940-0500

Patient Information

Full Name: _____
Address: _____City: _____State: _____ Zip: _____
Date of Birth: ____/____/____ Sex: ____ Age: ____ Marital Status: ____ SSN: _____
Cell Phone: _____ Email: _____
Occupation: _____Employer: _____Work Phone: _____
In Case of Emergency, who may we contact? _____
Relation: _____ Phone: _____
How did you hear about us? _____
Were you referred by someone? If so, please let us know who: _____

Insurance Information

Do you have insurance? _____ if yes, name of primary insurance company _____
ID/Member number: _____ Group number: _____
Name of primary insurer (if different) _____
Name of secondary insurance company (if any) _____
ID/Member number: _____ Group number: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I understand that The Neck Pain Doctor will prepare any necessary reports and forms to assist in making collection from the insurance company, and that any amount authorized to be paid directly to The Neck Pain Doctor will be credited to my account upon receipt. However, I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. The information I have provided is true and correct to the best of my knowledge.

Patient Signature_____ Date _____

Please fill in the appropriate space: information gathered is confidential

Major complaint: _____
_____
_____

Is this the result of work? **Yes / No** If so, explain: _____
_____
Did you notify your employer? ____ Claim: _____ Date of injury: _____
Name of treating doctor (if any): _____
Loss of work? ____ Dates out of work: _____
Name of treating doctor (if any) _____Continued…

Is this the result of a car accident? **Yes / No** If so, Claim #: _____
Date of auto accident: _____ Do you have an attorney? _____ If so, we will need your attorneys address and phone number: _____
_____
_____

If none of the above, what caused the current condition? _____
_____
Have you been treated previously for this condition? _____
If yes, where and by whom? _____
Is there a possibility that you could be pregnant? _____

Please check **ALL** conditions you have suffered from either in the past or present:

___ HEADACHES	___ DIABETES	___ HEART TROUBLE	___ DIGESTIVE DISORDERS
___ BACKACHES	___ NUMBNESS	___ TUBERCULOSIS	___ RHEUMATIC FEVER
___ DIZZINESS	___ NEURITIS	___ NERVOUSNESS	___ SINUS TROUBLE
___ ARTHRITIS	___ ASTHMA	___ CANCER	___ ANEMIA

Please list other significant information needed to help evaluate your current condition such as previous surgeries, fractures, accidents, or medications

Major Surgeries: _____
_____
_____
Pins or Plates? _____ if so, where: _____
_____
Artificial Joints? _____ if so, where: _____
_____
Fractures? _____ if so, when: _____ Where? _____
_____

_____

Current Medications:

_____
_____
_____

Please answer the following questions to help us determine possible risk factors:

GENERAL	YES	NO
Have you had an adverse (i.e bad) reaction to or following chiropractic care?	_____	_____
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	_____	_____

Continued…

	YES	NO
Do you take corticosteroids (e.g. prednisone)?	_____	_____
Have you been diagnosed with a compression fracture(s) of the spine?	_____	_____
Have you been diagnosed with cancer?	_____	_____
Do you have any metal implants?	_____	_____
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	_____	_____
If yes, about how much do you take daily? _____		
Do you take warfarin (coumadin), heparin, or other similar "blood thinners" ?	_____	_____
Have you ever been diagnosed with any of the following disorders/diseases?		
Rheumatoid arthritis	_____	_____
Reiter's syndrome, ankylosing spondylitis or psoriatic arthritis	_____	_____
Giant cell arteritis (temporal arteritis)	_____	_____
Osteogenesis imperfecta	_____	_____
Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	_____	_____
Medical cystic necrosis (cystic mucoid degeneration)	_____	_____
Bechet's disease	_____	_____
Fibromuscular dysplasia	_____	_____
Have you ever become dizzy or lost consciousness when turning your head?	_____	_____
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	_____	_____
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	_____	_____
Have you been diagnosed with spondylolisthesis?	_____	_____
Have you had any of the following problems?	_____	_____
Sudden weakness in the arms or legs?	_____	_____
Numbness in the genital area?	_____	_____
Recent inability to urinate or lack of control when urinating?	_____	_____

PLEASE **DO NOT** SIGN THIS FORM UNTIL AFTER YOUR TREATMENT PLAN HAS BEEN REVIEWED WITH YOU BY YOUR DOCTOR

I have read the information regarding the risk of chiropractic care and my doctor has verbally explained my risk (if any) to me and suggested alternatives when those risk exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

_____ _____

PATIENT or PARENT/GUARDIAN SIGNATURE DATE

_____ _____

FRONT OFFICE STAFF SIGNATURE DATE

_____ _____

DOCTOR'S SIGNATURE DATE

Informed Consent Form Chiropractic

The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involving the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest intervention available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatments, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medial physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:
Common 1,2

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolved within 48 hours

Rare 3,4

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns sur to some therapies
- Disc herniation
- Cauda equina Syndrome (2) (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar arty (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustment [manipulation]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older then 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have every felt (3)

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen, and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risk.
- Surgical risks may include unsuccessful outcome, complication such as infection, pain, reactions to anesthesia, and prolonged recovery (5)
- Potential risk of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation and worsening of my condition (6)

Neck and back pain generally improve in time, however, recurrence us common. Remaining active and positive improve your chances of recovery.

1. Thiel HW, Bolton JE, Docherty S, Potlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. Spine Oct | 2007;32(21):2375-2378; discussion 2379.
2. Rubinstein SM. Leboeuf-Yde C, Knol DL, de Koekkoek TE Pfeifie CE, van Tulder MW. The benefits outweigh the risk for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. J Manipulative Physiol Ther. Jul-Aug 2007;30(6):408-418
3. Cassidy JD, Boyle E, Cote P, et al Risk of vertebrobasilar stroke and chiropractic care; results of a population-based case-control and case-crossover study. Spine. Feb 15 2008;33(4Suppl):S176-183
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar arty stroke in two Canadian provinces. Spine. Feb 15 2008;33(4 Suppl):S170-175
5. Carragee EI, Hurwitz EL, Cheng I, at al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders Spine. Feb 15 2008;33(4 Suppl):S153-169
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course abd prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 200-2010 Task Force on Neck Pain and Its Associated Disorders. Spine. Feb 15 2008;33(4 Suppl):S75-82

Cancellation and No-Show Policy

Thank you for choosing THE NECK PAIN DOCTOR to provide your chiropractic and physical therapy needs.

When a patient doesn't make it to a scheduled appointment, this is time another patient could have taken to receive the care they need. Please help us deliver the care our patients need as efficiently as possible. Read the following policies, and then sign and date at the bottom of the page.

CHIROPRACTIC CANCELLATION and NO-SHOW POLICY:

Please be courteous and call our office promptly if you are unable to attend your appointment, we require you give us at least **24-hour notice** so that we have the opportunity to offer your appointment to another patient.

A "No-Show" is someone who misses an appointment without notice. We have voicemail which is able to receive messages 24 hours a day. You can always respond to the text message reminder you receive prior to your appointment. No-Shows inconvenience patients that are in need of our services. A failure to cancel a scheduled appointment without 24-hour notice will be recorded in the patient's file and a cancellation fee of $25.00 will be charged. If you fail to be present for your scheduled appointment you will be charged a "No-Show" fee of $25.00. All fees will be due prior to seeing the doctor on future visits. Further multiple No-Shows may result in suspension of care with THE NECK PAIN DOCTOR.

CHIROPRACTIC LATE ARRIVALS

If you arrive late to your appointment, we will do our best to fit you into the schedule, however, it is likely we will reschedule your appointment for another time or day. I understand the terms of this form. I understand that these fees have nothing to do with my co-pay or deductible and in fact cannot be billed to my insurance company.

_____ _____

Print Name Date

Patient's Signature _____

Informed Consent for Infrared Laser Therapy

Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasm and promotes vasodilation. Adverse effects from the laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting hours, days, or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. **Always** wear the laser protective glasses provided.

The most common adverse effects are:

1. Temporary increase in pain during laser application.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

Please see front desk staff for pricing as infrared laser therapy is not covered by your insurance.

_____ _____

Patient Signature Date

HIPAA Release of Information MEDIA

RELEASE AUTHORIZATION FORM

I,_____hereby authorize The Neck Pain Doctor, its duly authorized employees or agents, to publish the following personal health information e.g., information relating to the diagnosis, treatment, and health care services provided or to be provided to me and which identifies my name and other personally identifiable information) to be used in print media, onthe radio, TV, the The Neck Pain Doctor website, blog and on the following social media platforms: Facebook, Instagram, and You Tube.

The following information about me will not be disclosed:
_____.

I understand that any personal health information or other information released via the social media platform(s) above may be subject to re-disclosure by such social media platform(s) and may no longer be protected by applicable Federal and State privacy laws.

This authorization is valid from the date of my/my representative's signature below shall not expire.

I understand that I have a right to revoke this authorization by providing written notice to The Neck Pain Doctor. However, this authorization may not be revoked if The Neck Pain Doctor, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient: _____

Signature of Patient/Guardian: _____

Date: _____

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HIPAA Notice of Privacy Practices

Our Obligations

We are required by law to:

-Maintain the privacy of protected health information

-Give you the notice of your legal duties and privacy practices regarding health information about you

-Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you. Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health care operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with our entities that have a relationship with you for their health are operating activities.

Appointment reminders, treatment alternatives, and health-related benefits and services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals involved in you care or payment for your care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To avert a serious threat to health and safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Military and veterans. If you are a member of the Armed Forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to appropriate foreign military authority if you are a member of a foreign military.

Worker's compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits or work-related injuries or illness.

Public health risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health oversight activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

_____Initials

Lawsuits and disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information required.

Law enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) In response to a court order, subpoena, warrant, summons, or similar process; 2) Limited information to identity or locate a suspect, fugitive, material witness, or missing person; 3) About the victim of a crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) About a death we believe may be the result of criminal conduct; 5) About criminal conduct on our premises; 6) In an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National security and intelligence activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or individuals in custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to inspect and copy. You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records. To inspect and copy this information, you must make your request in writing.

Right to amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing.

Right to an accounting of disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make you request in writing.

Right to request restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. To request a restriction you must make your request in writing. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to request confidential communications. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. To request confidential communications, you must submit your request in writing.

Write to a paper copy of this notice. You have the right to a paper copy of this notice. You may request a copy at any time from our office.

Changes to this notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or the Secretary of the Department of Health and Human Services. All complaints must be in writing. You will not be penalized for filing a complaint.

By signing my name below, I acknowledge receipt of a copy of the HIPAA Notice of Privacy practices, and my understanding and agreement to it's terms.

Patient Signature: _____ Date: _____