Dr. Rebecca Bomgaars, Doctor of Chiropractic

4019 Westerly Place, Suite 101, Newport Beach, CA 92660

Phone: 562-774-4197 **Fax:** 562-438-1222 **Email:** drrebecca@440chiro.com

Today's Date:_____

Patient's First Name:_____ Last Name:_____

Guardian's First and Last Name: _____

PHONE# _____ Alternative Phone: _____

Address:_____

City/State/Zip _____

Email address: _____@_____
Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: ___/___/_____ Gender: ( ) Male ( ) Female ( ) Other (please specify) _____

Emergency Contact:
1) Name:_____ Phone:_____
2) Name:_____ Phone:_____

Patient's Employer:_____ Occupation: _____

Preferred Language: _____ Current Height:_____ Current Weight:_____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer Type here:

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer Type here:

OF CHILDREN (of patient) _____ MARITAL STATUS S M D W Type here:

Spouse or Partner's NAME

_____

PERSON RESPONSIBLE FOR PAYMENT _____

HOW WERE YOU REFERRED TO OUR OFFICE? Ex: FRIEND'S NAME _____

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? _____

IF YES, WHEN?_____

Are you currently taking any medications? _____

Medication Name Dosage and Frequency (i.e. 5mg once a day, etc.)(Please include regularly used over the counter medications) _____
*If more than 3 medications, please continue list on back of page If typing, use top margin.
Do you have any medication allergies? _____
Medication Name Reaction Onset Date Additional Comments _____
HAVE YOU EVER HAD ANY SURGERIES?_____

DRUGS YOU NOW TAKE: ___ASPRIN ___PAIN KILLERS ___ TRANQUILIZERS ___INSULIN

___BIRTH CONTROL PILLS___ OTHER (PLEASE LIST) _____

_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked Type here:

Do you drink alcohol? _____ If yes, how much, what kind, and how often? _____

Do you have any problems with the following list? (please check and write additional information in the notes at the bottom of list)

<u>Eyes/Ears/Nose/Throat</u>

Any blurry vision? ____ Corrected with glasses or contacts?___ Glaucoma____ Cataracts_____

Headaches?___ how often?_____where?_____

Ringing in the ears? ____ how often?____ when did it start?____

Difficulty swallowing ___

Any issues with…

Shoulders___ Hips___ Temperature changes in arms or legs___

Elbows___ Knees___ Numbness in arms or legs, hands or feet___

Wrists___ Ankles___ Tingling in arms or legs, hands or feet___

Hands___ Feet___

Digestion___

Bowl function___

Bladder function___

Night sweats___

Notes:_____

_____

_____

_____

_____

Any history of any accidents or surgeries?

_____

_____

Family History

Mom's side medical conditions (please specify relative)

_____

_____

_____

Dad's side medical conditions (please specify relative)

_____

_____

_____

WHAT IS YOUR MAJOR COMPLAINT?

_____

IS THIS CONDITION DUE TO AN A) AUTO ACCIDENT B) WORK INJURY C) OTHER ACCIDENT
D) UNKNOWN CAUSE E) ILLNESS Type here:

ARE THE SYMPTOMS: A) IMPROVING B) GETTING WORSE C) ABOUT THE SAME
D) INTERMITTENT (COME AND GO) Type here:

DATE SYMPTOMS APPEARED _____

CIRCLE ANY ACTIVITIES WHICH AGGRAVATE YOUR CONDITON:

A) STANDING B) WALKING C) SITTING D) LYING E) BENDING F) LIFTING G) TWISTING
H) COUGHING I) OTHER (please specify)_____ Type here:

IS THERE ANYTHING YOU CANNOT DO THAT YOU WERE ABLE TO DO BEFORE THIS ISSUE?

_____

HAVE YOU HAD THESE SYMPTOMS BEFORE? _____ IF SO, WHEN? _____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION? A) M.D. B) CHIROPRACTOR
C) OSTEOPATH D) ACUPUNCTURIST E) DENTIST F) PODIATRIST Type here:

DR.'S NAME _____ DATE CONSULTED _____

DIAGNOSIS_____

TREATMENTS _____

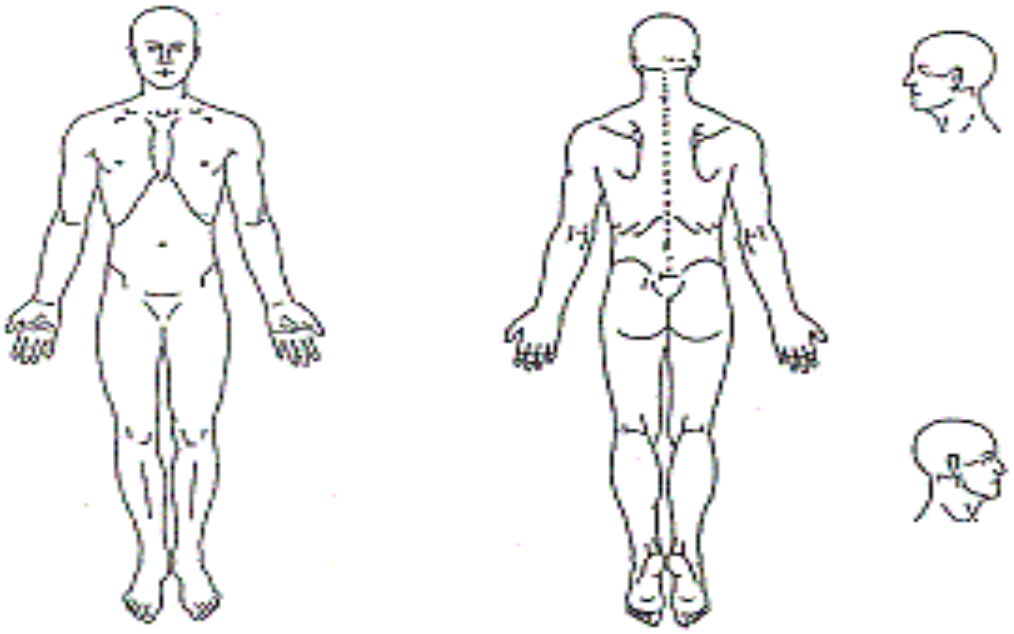
IS THERE ANYTHING THAT HAS HELPED IMPROVE YOUR SYMPTOMS? Examples: Rest, Ice, Heat, lying down, sitting up, not doing a certain movement?

_____

DO YOU HAVE ANY LIMITS IN YOUR RANGE OF MOTION IN THE AREAS OF COMPLAINT?

IF YOU ARE IN PAIN, PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW. ALSO DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN, AS WELL AS ANY ACTIVITY WHICH BRINGS ON OR AGGRAVATES THE PAIN. FOR EXAMPLE, DULL, SHARP, CONSTANT, OFF & ON, WHEN STANDING, WHEN SITTING, ETC.

COMPLETE THESE DIAGRAMS



On a Scale of 0-10, what number would you give your pain? Please specify each area:

_____

_____

_____

What is your main goal in seeking treatment? _____

PATIENT
SIGNATURE:_____Date:_____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, soreness (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, bruises, fractures, disk injuries, strokes, dislocations, burns and sprains. I understand most of these possible complications will resolve within 48 hours and are part of the healing process. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. 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.

Please answer the following questions to help us determine possible risk factors. Check mark if yes (at anytime in your life), leave blank if answer is no.

I am possibly pregnant. ___
I have been diagnosed with a heart condition ___
Someone in my family died of a heart condition under the age of 30 ___
I have a headache or neck pain that is the worst I have ever felt. ___
I have become dizzy or lost consciousness when turning my head. ___
I have sudden weakness in my arms or legs ___
I have numbness in the genital area ___
I have recent inability to urinate or lack of control when urinating ___
I have been diagnosed with osteoporosis ___
I take corticosteroids (e.g. prednisone) ___
I have been diagnosed with cancer ___
I have metal implants ___
I take aspirin or other pain medications on a regular basis ___ How much and often? __
I take blood thinners (e.g. Warfarin, Coumadin, Heparin) ___ How much and often? __
I have been diagnosed with any of the following: Rheumatoid arthritis, Reiter's syndrome, Cauda Equina Syndrome, Ankylosing Spondylitis, Psoriatic Arthritis, Giant Cell Arteritis (temporal arteritis), Osteogenesis Imperfecta, Ligamentous Hypermobility (such as with Marfan's Syndrome), Ehlers-Danlos syndrome, Medial Cystic Necrosis (cystic mucoid degeneration), Bechet's Disease, Fibromuscular Dysplasia, spinal stenosis, spondylolisthesis. Type here:
I have had spinal surgery _____ When and please describe_____

I have answered the above questions and read or have had read to me, the above consent, and hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical

therapy and instrument adjusting, including but not limited to: electric stimulation, ultrasound, rapid release technology, blocking, activator technique, traction, Gua Sha therapy, heat, ice, low level laser therapy, nutritional recommendations and rehabilitave procedures on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Rebecca Bomgaars.

I have had an opportunity to discuss with Dr. Bomgaars and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures as well as any concerns I may have. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Full Name (Please print) _____

Signature of Patient _____Date: _____

Guardian's full name (Please Print) _____ Date:_____

Signature of Guardian _____Date: _____

Missed Appointment Policy

At 440 Chiropractic, your scheduled appointment time is reserved just for you. We try not to overbook appointment times in order to provide excellent care and to be sure we have sufficient time to adequately examine you and to discuss your condition and treatment options in detail with you.

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time, and notifying us a minimum of twenty-four (24) hours in advance if you are unable to do so. When we receive advanced notice of cancellation, our day runs more efficiently and more importantly we are able to see other patients who need care. Failure to comply with this policy will necessitate the assessment of the following fees:

• 1st missed appointment - Our staff will call to ensure your wellbeing in addition to rescheduling your appointment.

• 2nd Missed Appointment - A missed appointment fee of $25 will need to be paid prior to receiving any new services. Additionally, all future exams will require pre-payment in order to secure the desired time.

Sincerely,

Dr. Rebecca Bomgaars D.C.

I understand and agree to the terms listed above.

Signed: _____ Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

PRACTICE'S REQUIREMENTS

The Practice:

• Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

• Is required to abide by the terms of this Privacy Notice.

• Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

• Will distribute any revised Privacy Notice to you prior to implementation.

• Will not retaliate against you for filing a complaint.

I have read and acknowledge the Notice of Health Information Privacy Practices. I understand that I have the option to obtain copies of this notice at any time.

I, _____ authorize 440 Chiropractic to release any information pertinent to my case to business associates for purposes of carrying out billing and back office duties.

Patient Signature:_____ Date: _____

Name Printed:_____

Insured Patients Instruction Sheet (Skip if Not Using Insurance)

IS THIS INJURY/ILLNESS WORK-RELATED? _____

HAVE YOU REPORTED IT TO YOUR EMPLOYER? _____

Employer's Address: _____

IS THIS INJURY/ILLNESS RELATED TO AN AUTOMOBILE ACCIDENT? _____

(IF YES, PLEASE GIVE FOLLOWING INFORMATION AND NOTIFY YOUR INSURANCE COMPANY THAT YOU ARE UNDER CARE AT THIS OFFICE)

AUTO INSURANCE CO. _____ POLICY# _____ CLAIM# _____

PHONE#_____

ADDRESS _____AGENT'S NAME _____

NAME OF ATTORNEY _____ ADDRESS _____

PHONE#_____

DO YOU HAVE ANY TYPE OF HEALTH INSURANCE? _____

MEMBER #_____ POLICY/GROUP# _____

INSURANCE COMPANY _____ ADDRESS _____

CUSTOMER SERVICE PHONE # (for providers)_____

INSURED'S NAME _____ RELATION _____

SOCIAL SECURITY#_____ DRIVER'S LICENSE#_____

ARE YOU COVERED UNDER ANY OTHER GROUP OR INDIVIDUAL HEALTH POLICY THROUGH YOURSELF OR SPOUSE? _____

INSURANCE COMPANY _____ ADDRESS_____

POLICY/GROUP# _____ INSURED SS# _____

TO ALL OUR INSURED PATIENTS: It is our policy to bill your insurance carrier(s) as a courtesy to you. However, your bill is always your responsibility because insurance is an agreement between you and your insurance carrier. The quotes they give are never a guarantee of payment. If we are out of network with your insurance, we will require the cash rate payment at the time of service. If the insurance pays us, we will reimburse you.

BALANCES UNPAID AFTER 60 DAYS WILL BE CHARGED AT A RATE OF 1.5% INTEREST PER MONTH. THE PATIENT WILL BE RESPONSIBLE FOR ANY LEGAL EXPENSES INVOLOVED IN COLLECTION OF PAST DUE ACCOUNTS.

The above is accurate to my knowledge and I HAVE READ AND UNDERSTAND THESE INSTRUCTIONS AS THEY APPLY TO ME

_____ _____

Patient's Signature **Date**