SUMMERFIELD CHIROPRACTIC
NANCY ROCKS, DC
ANDREA FURST, DC

PATIENT REGISTRATION

NAME______________________________ DATE______________

ADDRESS______________________ CITY______________ ZIP________

HM PHONE____________ CELL PHONE:____________ EMAIL ______________

DATE OF BIRTH________ Age _____ GENDER: Male ( ) Female ( ) Other _____Preferred Pronoun __________

MARITAL STATUS: M S W D Domestic Partner NAME: __________ NUMBER OF CHILDREN________

OCCUPATION__________________EMPLOYER______________________

ADDRESS______________CITY/ZIP____________ TELEPHONE____________

NAME OF SPOUSE or EMERGENCY CONTACT______________TELEPHONE____________

ADDRESS______________________CITY/ZIP______________________

NEAREST RELATIVE (Not living with you)______________________________

ADDRESS______________CITY/ZIP____________TELEPHONE____________

REFERRED BY: ◻ INTERNET ◻ WEBSITE ◻ YELP ◻ NEXT DOOR ◻ FACEBOOK ◻ GOOGLE

EXISTING PATIENT______________ OTHER ______________

INSURANCE INFO (Medicare patients OR Auto Accident only)

INSURANCE NAME________________ADDRESS______________________

CITY/ZIP______________________ PHONE (______) ____________

MEMBER ID#____________CLAIM#____________ ADJUSTOR NAME____________

ARE YOU WORKING WITH AN ATTORNEY? YES / NO NAME:______________ PH:__________

ADDRESS:______________________ CITY____________ ZIP____________

TELL US WHAT BRINGS YOU IN TODAY

WERE YOU HURT: AT WORK________AUTO ACCIDENT______OTHER______________

MAJOR PAIN OR PROBLEM TODAY______________________________

TODAYS PAIN OR PROBLEM BEGAN______________________________

HOW DID IT HAPPEN?______________________________________

____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?______________________

WHAT ACTIVITIES LESSEN YOUR CONDITION?________________________

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?________________

IS CONDITION GETTING PROGRESSIVELY WORSE?______________________________

OTHER DOCTORS SEEN FOR THIS CONDITION______________________________

PREVIOUS SERIOUS ILLNESS:(Please list & describe) CANCER__________ FRACTURES________________

OTHER____

WHAT MEDICATIONS ARE YOU TAKING? ______________________________________

____

ARE YOU PREGNANT ? Y / N WHEN WERE YOU LAST X-RAYED__________ BY WHOM ____________

FAMILY HISTORY OF: □ HEART DISEASE □ CANCER □ DIABETES □ ARTHRITIS □ BACK PROBLEMS □ DISC PROBLEMS □ OTHER_______________________________

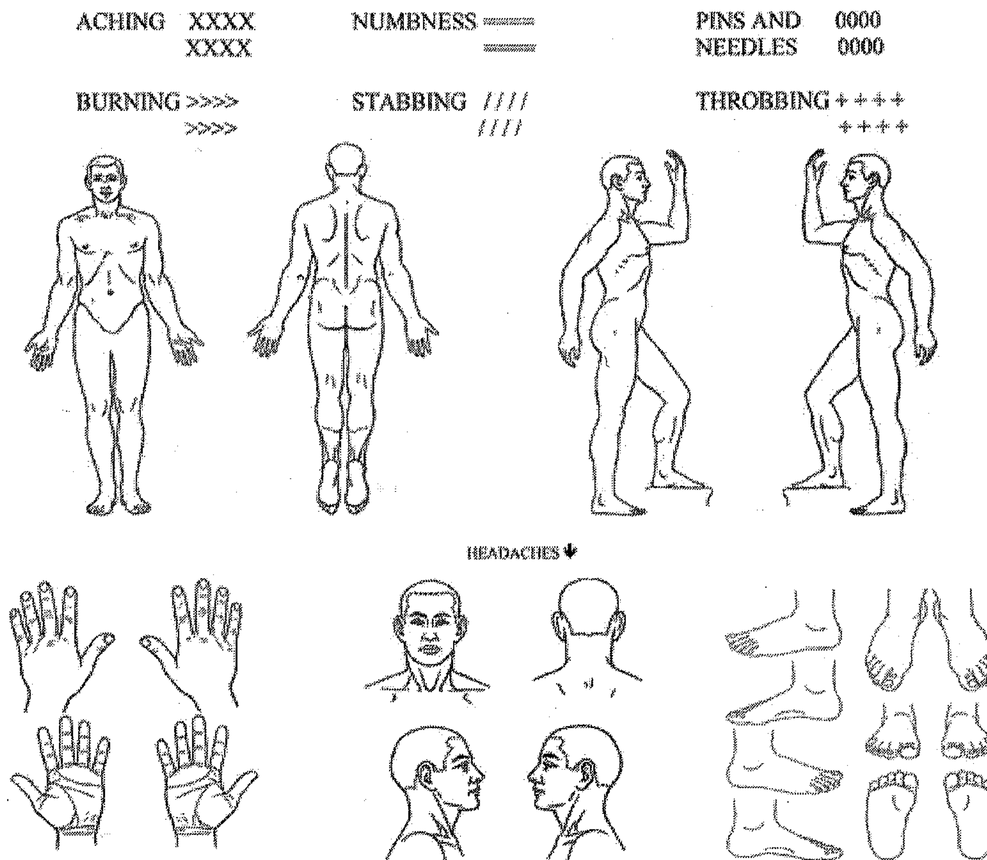
Check symptoms you have noticed: Use **N** if problem **Now** Use **P** if problem in the **Past** Leave **blank** if **OK**

( ) Headaches
( ) Head feels heavy
( ) Light headed
( ) Loss of balance
( ) Dizzy
( ) Nervous
( ) Fatique
( ) Loss of hearing
( ) Blurred vision
( ) Chest pain

( ) Pain in shoulder
( ) Muscle spasm in shoulder
( ) Pain in neck
( ) Stiff neck
( ) Muscle spasms in neck
( ) Pain in arm and hand
( ) Pins and needles in arms/hands
( ) Loss of grip strength
( ) Mid back pain
( ) Pain between shoulders

( ) Low back pains
( ) Low back muscle spasm
( ) Pain into buttock
( ) Pain into thigh
( ) Pain down leg
( ) Pain in ankle
( ) Pain in foot

Using the key below please indicate location of pain using the symbol that best describes your current discomfort.



Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your neck and/or back problems has affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0 ______ 1 ______ 2 ______ 3 ______ 4

No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain

2. Sleeping

0 ______ 1 ______ 2 ______ 3 ______ 4

Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0 ______ 1 ______ 2 ______ 3 ______ 4

No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly assistance | Moderate pain; need some 100% assistance | Severe pain; need

4. Travelling (driving, etc.)

0 ______ 1 ______ 2 ______ 3 ______ 4

No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on short trips

5. Work

0 ______ 1 ______ 2 ______ 3 ______ 4

Can do usual work plus unlimited extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work

6. Recreation

0 ______ 1 ______ 2 ______ 3 ______ 4

Can do all activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activity

7. Frequency of Pain

0 ______ 1 ______ 2 ______ 3 ______ 4

No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day

8. Lifting

0 ______ 1 ______ 2 ______ 3 ______ 4

No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight

9. Walking

0 ______ 1 ______ 2 ______ 3 ______ 4

No pain; any Distance | Increased pain after 1 mile | Increased pain after 1/2 mile | Increased pain after 1/4 mile | Increased pain with all walking

10. Standing

0 ______ 1 ______ 2 ______ 3 ______ 4

No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after 1/2 hour | Increased pain with any standing

Total Scre

______ / 40

For Providerse Only

Summerfield Chiropractic
4765 Hoen Avenue
Santa Rosa, CA 95405
(707) 523-3020

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose you or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Use and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information
that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:______________________________

Signature:______________________________

Date:____________________

Summerfield Chiropractic
Dr. Nancy Rocks, D.C.
Dr. Andie Furst, D.C.

Financial Policy

We are committed to providing you with the best possible care, which is why your clear understanding of our Financial Policy is important to our professional relationship. We are glad to answer any questions you have.

Private or Group Insurance: We are a "**fee for service**" practice and do not bill personal insurance.Therefore, payment is due at the time of service. We are happy to generate a "superbill" that you can use to submit to your insurance plan for potential partial reimbursement. Please contact your personal insurance company to determine if your plan includes **out of network** chiropractic coverage.

Medicare: We do not accept Medicare assignment. However, we will courtesy-bill Medicare for you. Medicare covers spinal manipulation (CMT) only. If Medicare deems your treatment medically necessary they will reimburse you directly at the Medicare allowed amount – once your deductible is met. You are responsible for the full office visit charge at the time of your visit. Because we do not collect directly from Medicare, we are unable to bill your secondary insurance. In most cases, Medicare will forward information to your secondary insurance.

Workers' Compensation: We are not participating with any Workers' Compensation MPN's (Medical Provider Network). If you are approved to see the provider of your choice, regardless of MPN, prior authorization is required before treatment can be rendered. Approval for these case types are on a case by case basis. Consult with the Office Manager for more information.

Lien Cases: We will accept lien cases by prior approval only. A lien form must be completed and signed by you and your attorney prior to the second visit. You are responsible for all charges not paid when your case is complete. Liens are accepted on a case-by-case basis. If you are not working with an attorney, we can make a referral. Consult with the Office Manager for more information.

Personal Injury: We will gladly bill the Medpay (Medical Payments Coverage) portion of your auto insurance. **Please understand that you are responsible for any charges not paid by your insurance company as well as any deductibles that may apply to your policy.** If you do not have Medpay on your policy, please note 'third party' (or at fault party) insurance will not directly pay claims from our office. You will be responsible for payment at each date of service. A third-party insurance will reimburse you at the end of treatment if they agree to fault. Consult with the Office Manager for more information.

Private Pay: Payment is due at the time of your visit.

Missed Appointments: We require 24 hours notice if you cannot keep an appointment. Last minute cancellations and "no shows" are subject to a $65.00 charge for which you are responsible. We cannot bill your insurance company or attorney for this fee. **We offer courtesy text or email reminders one day in advance of your scheduled appointment. Please choose your preferred method of delivery below.**

[ ] Text reminder: Cell (_______)_______-__________

[ ] Email reminder: Email address____________________________________

[ ] Opt in to receive quarterly Newsletter

Patient's Signature:____________________________________ **Dated:**_____________________

Note: Your signature states you have read and understand this policy.

SUMMERFIELD CHIROPRACTIC
NANCY ROCKS, D.C.
ANDREA FURST, D.C.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

The State of California Board of Chiropractic Examiners requires we gain your informed consent to treat you. Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before signing.

The nature of the chiropractic adjustment.

The primary treatment used by a Doctor of Chiropractic is spinal manipulative therapy. A chiropractor may use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. While rare, we are required by our state board to inform you. 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. Some patients will feel some stiffness and /or soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and possibly X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options may be available for your condition.
You should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary carel physician. Be advised there may be risks and dangers to leaving your condition untreated.

Analysis / Examination / Treatment

By initialing below, I hereby request and consent to the performance of the following modes of analysis, examination and treatment.

___spinal manipulative therapy
___range of motion testing
___muscle strength testing
___palpation
___ Hvolt massager
____ IASTM
___ultrasound
___vital signs
___orthopedic testing
___electric muscle stimulation
___ Cupping
___impulse/activator
___postural analysis
___basic neurological testing
___supplement recommendation
___therapeutic exercise recommendation
___ Kinesiotaping
___ All

I have read 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 have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

______________________________ Patient's Name

______________________________ Today's Date

______________________________ Signature (Parent or Guardian If a minor)

Tel: 707-523-3020

Email: info@summerfieldchiropractic.com