Asher Chiropractic Clinic

Registration & Account Information

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

confidential health information

File #	Date

1 PATIENT INFORMATION

last name	first name	m.i.

age	date of birth	email address	gender ☐ male ☐ female

status ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced

street	city	state	zip

work phone	extension	home phone	cell phone	e-mail

spouse or guardian last name	first name	m.i.	date of birth

2 EMERGENCY CONTACT

last name	first name	relationship	home phone	work phone	cell phone
last name	first name	relationship	home phone	work phone	cell phone

3 PATIENT EMPLOYMENT

employer name	occupation

address street	city	state	zip

4 QUESTIONS

Who referred you to us?	
How did you hear about our clinic?	
Are you here because you were involved in a vehicle collision?	☐ yes ☐ no
Are you here because you were injured at your place of employment?	☐ yes ☐ no
Are you here because you were involved in another type of accident?	☐ yes ☐ no
Are you related to a Parker Student? **Name:** **Relationship:**	☐ yes ☐ no
Will you be using health insurance to supplement payment to our office*? * If YES, please complete the I[illegible] SURA[illegible] CE COVERAGE and I[illegible] SURED I[illegible] FORMATIO[illegible] sections of this form.	☐ yes ☐ no

5 INSURANCE COVERAGE

types of insurance

☐ employee group health plan ☐ personal health insurance ☐ health savings account ☐ Medicare ☐ Medicaid

☐ personal injury ☐ Work's Compensation ☐ TRICARE/CHAMPS ☐ CHAMPVA ☐ FECA

primary insurance company	primary ins. ID #	primary ins. group #
secondary insurance company	secondary ins. ID #	secondary ins. group #

I understand and agree to the following:

- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional services may be recommended and I will be advised of applicable costs
- There is no guarantee that my health insurance will pay for all or any part of my care
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred for services rendered
- All payments are due at the time services are rendered

patient or guardian signature

Date

I understand there is a *$25 MISSED APPOINTMENT fee* for appointments missed or canceled w/o 24 hrs notice. _____

6 INSURED'S INFORMATION

last name	first name	m.i.

street	city	state	zip

employer	age	date of birth	social security #	gender ☐ male ☐ female

Relationship to patient

☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

7 BENEFITS ASSIGNMENT & INFORMATION RELEASE

I authorize the payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

_____

Patient or guardian signature

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

_____ _____

Patient or guardian signature Date

OFFICE USE ONLY:

Patient: last name first name m.i. date of birth

FILE # INTERN NAME & # DOC # POD#

INSURANCE VERIFICATION

Person's name that you spoke to?

Last: First:

ID # Extension:

Does the plan have a **deductible?** ☐ yes ☐ no

Amount for an individual: _____

Amount for the family: _____

Amount currently met: _____

After deductible, what % of services do you cover? _____

When does the deductible renew? _____

Does the patient have a **co-pay?** ☐ yes ☐ no

Amount for the co-pay: _____

What is the max. yearly **benefit?** ☐ yes ☐ no

Does the company **assign benefits** to the doctor? ☐ yes ☐ no

What is the **yearly visit cap?** _____

Are any **special forms** required to file claims? ☐ yes ☐ no

Auto Collision or **Personal Injury** case? ☐ yes ☐ no

Reported to the insurance company? ☐ yes ☐ no

Has an application for benefits been filed? ☐ yes ☐ no

Did the police write a report? ☐ yes ☐ no

Is auto or PI insurance primary? ☐ yes ☐ no

Agent name and contact info: _____

_____

Workers' Comp case? ☐ yes ☐ no

Has the injury been reported? ☐ yes ☐ no

Name:

Title:

Is patient currently employed at place of injury? ☐ yes ☐ no

Name of person authorizing care: _____

_____

Does the plan cover the following **services?**

Chiropractic Adjustments ☐ yes ☐ no

Modalities by a Chiropractor ☐ yes ☐ no

X-rays: _____ ☐ yes ☐ no

Therptc. Exercise, Therptc. Activity & Neuro Myo Reedu. ☐ yes ☐ no

Orthotics, supports, pillows and Nutritional supplements? ☐ yes ☐ no

Other: _____ ☐ yes ☐ no

Address to send claims:

Asher Chiropractic Clinic

Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

1 PATIENT INFORMATION

Preferred name	date

last name	first name	m.i.

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐ yes ☐ no

What services interest you? (mark all that apply)

- ☐ injury prevention
- ☐ balance and coordination training
- ☐ range of motion, mobility, or flexibility therapy
- ☐ treatment for pain
- ☐ spinal and body alignment
- ☐ strengthening and stamina exercise
- ☐ patient education classes
- ☐ body composition counseling
- ☐ nutritional and supplement counseling
- ☐ other: _____

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning ☐ cold

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1	2	3	4	5	6	7	8	9	10
no pain or discomfort	slight discomfort	pain that does not affect my activity	pain that affects my daily activities	pain that prevents performing my daily activities	pain that limits my work schedule	pain that prevents working at all	pain that prevents working and all personal activity	pain that keeps me bed ridden	pain that causes thoughts of suicide

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

List other health complaints (2-5) on the following lines.

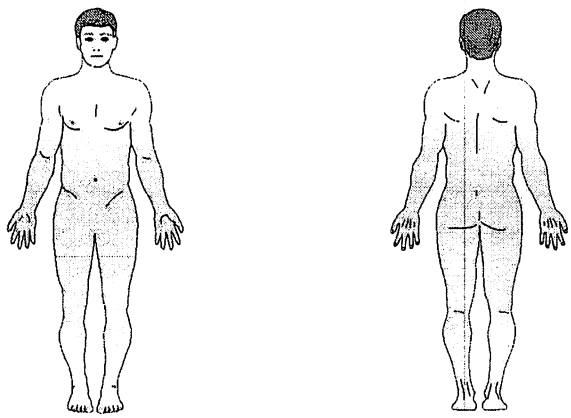
2 _____ 4 _____

3 _____ 5 _____

Do you have any other condition other than what brings you here? ☐ yes ☐ no
If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.

N = numbness
T = tingling
P = pain
W = weakness



3 LIFESTYLES & HABITS

Patient

How many hours of television do you watch a day? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

Do you usually snack while watching television? ☐ yes ☐ no

How many hours per day do you use a computer at work or home? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How many hours per day do you ride in a car or other vehicle? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How often do you exercise? ☐ daily ☐ 3x's/week ☐ 2x's/week ☐ 1x/week ☐ I don't exercise

How long do your exercise work outs last? ☐ >1 hour ☐ 1 hour ☐ 30 minutes ☐ < 30 minutes ☐ NA

What are your exercise activities? (mark all that apply) ☐ I don't exercise

☐ walking ☐ swimming ☐ weight lifting

☐ stretching/flexibility ☐ yoga/Pilates ☐ resistance bands

☐ running/treadmill/rowing/climbing ☐ group exercise classes ☐ other_____

Do you take a multi-vitamin? ☐ yes ☐ no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

Have you ever used tobacco? ☐ never ☐ daily ☐ weekly ☐ monthly ☐ yearly

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
heart problems	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
kidney problems	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
cancer	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
headaches	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
back pain	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
obesity	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
poor conditioning	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	☐ yes ☐ no	epilepsy	☐ yes ☐ no	low back pain	☐ yes ☐ no	polio	☐ yes ☐ no
anemia	☐ yes ☐ no	goiter	☐ yes ☐ no	measles	☐ yes ☐ no	rheumatic fever	☐ yes ☐ no
appendicitis	☐ yes ☐ no	heart disease	☐ yes ☐ no	mental disorder	☐ yes ☐ no	tuberculosis	☐ yes ☐ no
arthritis	☐ yes ☐ no	HIV positive	☐ yes ☐ no	mumps	☐ yes ☐ no	venereal infection	☐ yes ☐ no
cancer	☐ yes ☐ no	influenza	☐ yes ☐ no	pleurisy	☐ yes ☐ no	whiplash	☐ yes ☐ no
		diabetes	☐ yes ☐ no	pneumonia	☐ yes ☐ no	whooping cough	☐ yes ☐ no

6 INJURIES

Patient

List any **auto collisions** that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any **job injuries** that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any **sports injuries** that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any **other injuries** caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

7 HOSPITAL / MEDICINE

Have you had breast implant surgery? ☐ yes ☐ no

Have you had knee or hip replacement surgery? ☐ yes ☐ no

Do you have a pacemaker? ☐ yes ☐ no

Do you have any other implantable medical devices in your body? ☐ yes ☐ no

Mark all of the following procedures as they pertain to you.

vaccinations	☐ yes	☐ no	tubes in ears	☐ yes	☐ no	rectal surgery	☐ yes ☐ no
tonsillectomy	☐ yes	☐ no	appendectomy	☐ yes	☐ no	sinus surgery	☐ yes ☐ no
gall bladder removal	☐ yes	☐ no	female/male surgery	☐ yes	☐ no	hernia surgery	☐ yes ☐ no
back surgery	☐ yes	☐ no	_____			thyroid surgery	☐ yes ☐ no
						stomach surgery	☐ yes ☐ no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory? ☐ yes ☐ no Were you ever knocked unconscious? ☐ yes ☐ no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection? ☐ yes ☐ no

8 SYSTEM REVIEW

Patient

Mark the following conditions that are **currently** a cause of significant concern for you.

General

☐	consistent fainting	☐	chills	☐	convulsions	☐	depression	☐	dizziness
☐	loss of weight	☐	fatigue	☐	fever	☐	headache	☐	loss of sleep
☐	weight gain	☐	neuralgia	☐	night sweats	☐	wheezing	☐	nervousness

Gastro-Intestinal

☐	constipation	☐	diarrhea	☐	gall bladder problems	☐	hemorrhoids	☐	jaundice
☐	liver problems	☐	nausea	☐	stomach pain	☐	poor appetite	☐	poor digestion
☐	rectal bleeding	☐	vomiting	☐	vomiting blood				

Eye/Ear/Nose/Throat

☐	asthma	☐	crossed eyes	☐	deafness	☐	earache	☐	ear discharge
☐	ear noises	☐	enlarged thyroid	☐	frequent colds	☐	hay fever	☐	hoarseness
☐	nasal obstruction	☐	nose bleeds	☐	pain in eyes	☐	poor vision	☐	sinusitis
☐	sore throat	☐	tonsillitis						

Respiratory

☐	chest pain	☐	chronic cough	☐	difficulty breathing	☐	spitting blood	☐	spitting phlegm

Muscles/Joints/Bones

☐	backache	☐	foot problems	☐	pain bet. shoulders	☐	painful tailbone	☐	stiff neck
☐	spinal curvature	☐	swollen joints	☐	tremors	☐	twitching	☐	weakness

Cardio-Vascular

☐	ankle swelling	☐	high blood pressure	☐	low blood pressure	☐	heart trouble	☐	pain over heart
☐	poor circulation	☐	rapid heart	☐	slow heart	☐	strokes		

Skin or Allergies

☐	bruise easily	☐	dryness	☐	eczema	☐	hives	☐	itching
☐	sensitive skin								

Women

☐	cramps	☐	excessive flow	☐	hot flashes	☐	irregular cycle	☐	painful periods

9 PREGNANCY — WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? ☐ yes ☐ no On what date did your last period begin?

Do you want to take a pregnancy test now? ☐ yes ☐ no

OFFICE USE ONLY
result of clinic pregnancy test: + -

Mark the following situations as they pertain to you.

tubal ligation	☐ yes ☐ no	complete or partial hysterectomy	☐ yes ☐ no	partner had a vasectomy	☐ yes ☐ no
less than 10 days since the start of my last period	☐ yes ☐ no	taking birth control pills	☐ yes ☐ no		

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) can be ordered and supplied upon payment of reproduction fees.

patient or guardian signature

date

Patient Name_____

Asher Chiropractic Clinic
15079 Goldenwest St.
Huntington Beach, CA 92647
(714) 891-0999

Today's date_____

Activities of Daily Living

Please indicate on a scale from 1 to 10, with 10 being the worst pain, each activity which you have difficulty performing and/or can perform only with pain.

HOUSEWORK
_____ Doing Laundry
_____ Making beds
_____ Vacuuming
_____ Washing dishes
_____ Ironing
_____ Carrying groceries
_____ Caring for pets
_____ Cooking
_____ Other _____

YARDWORK
_____ Mowing lawn
_____ Shoveling dirt
_____ Raking leaves
_____ Gardening

GENERAL
_____ Walking
_____ Standing
_____ Running
_____ Sitting
_____ Lifting children
_____ Bending
_____ Climbing stairs
_____ Reading
_____ Lying in bed
_____ Chewing
_____ Swimming
_____ Sports: List: _____

PERSONAL GROOMING
_____ Combing hair
_____ Shaving
_____ In/out bathroom
___Brushing teeth
_____ Other _____

TRAVEL
_____ Driving
_____ Riding (Passenger)

Minutes per day
Type of vehicle
_____ Auto
_____ Train
_____ Bus
_____ Truck
_____ Airplane

_____ Getting in and out of auto
_____ Playing piano
_____ Using computer keyboard
_____ Kneeling
_____ Sexual intercourse
_____ Exercising
_____ Sleeping
_____ Using Telephone

Please list any other difficulties you are experiencing with activity:

_____

Notice of Privacy Practices
Asher 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. If you have any questions about this Notice please contact our Privacy Contacts: Dr. Roberta Blair-Thompson or Dr. Charlanne Gasper 714-891-0999

"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. We are required by law to maintain the privacy of protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices when you call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Treatment: We may use and disclose protected health information about you to provide, coordinate or manage your health care and related services

Payment: Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you by us or by another provider. For example, before you receive scheduled services, we may share information about these services with your health plan(s) to ask for coverage under your plan or policy and for approval of payment before we provide the services.

Healthcare Operations: We may use and disclose protected health information in performing business activities called "health care operations". Examples of the way we may use or disclose protected health information about you for "health care operations" include the following:

- *Appointment Reminders.* We may use and disclose health information to contact you as a reminder of your appointments.
- *Reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you*
- *Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks or assistants, etc.) to help them practice or improve their skills.*
- *Cooperating with outside organizations that assess the quality of the care we and others provide.* These organizations might include government agencies or accrediting bodies such as the Council on Chiropractic Education.
- *Reviewing activities and using or disclosing protected health information in the event that we sell our business, property or give control of our business or property to someone else.*

Written Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, we shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: We may use and disclose your protected health information if your Doctor or another health care provider in the clinic attempts to obtain consent from you but is unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization.

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to an appropriate government agency that is authorized by law to receive reports of abuse or neglect of a child, an elderly person or a disabled person. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in response to a subpoena, discovery request or other lawful process, subject to certain conditions.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

Workers' Compensation: Your protected health information may be disclosed by us to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your health care provider created or received your protected health information in the course of providing care to you.

Required Uses 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 45 C.F.R. Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. With limited exceptions, you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your health care provider and the clinic uses for making decisions about you.

You have the right to request a restriction of your protected health information. You may ask us to place additional restrictions on the use or disclosure of any part of your protected health information.

We are not required to agree to a restriction that you may request.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the reason for the request. Please make this request in writing to our Privacy Contact.

You have the right to ask us to amend your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Contact if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You may request a list of disclosures we have made after April 14, 2006. This list does not include disclosures for treatment, payment or healthcare operations, disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. 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 or treat you any differently for filing a complaint.

You may contact our Privacy Contact, Dr. Roberta Blair Thompson @ (714)891-0999 or Asherchiropractic@yahoo.com for further information about the complaint process.

This notice was published and becomes effective on **October 07, 2011**.

Asher Chiropractic Clinic

Welcome to our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

I have read/received a copy of the Privacy Practices for Asher Chiropractic Clinic
Your personal copy is available upon request

_____
patient initials

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed, as well as how you may have access to the information.

We may share your health information to:

- treat you
- collect payment
- run our office
- inform you about other services
- discuss your case with family
- do research
- include you in care classes
- thank you for referring other patients
- As a teaching institution, discuss your case with interns and consult with other colleagues

We may use your health information for:

- health and safety reasons
- reporting to law officials
- reporting victims of abuse
- court hearings and filings
- reporting to worker's compensation
- teaching / Instruction

You have the right to:

- request confidential communications
- request a list of entities with whom we share your information
- request a copy of your health record (an additional fee may be involved)
- advise our management if you believe your privacy rights have been violated
- ask us to limit information sharing
- amend your protected health information

_____
patient initials

These privacy practices are effective: October 7, 2011
For further information please contact: Dr Blair-Thompson @ 714-891-0999

Consultation & Exam

To begin today's visit, you will be asked to complete confidential health information for us to discuss with you. To learn more about your condition, we will perform preliminary examinations which may include a physical examination, x-rays, and laboratory tests.

If we believe that we may be able to help you, we will give you a report of our findings and recommend a treatment plan. As you advance through treatment, periodic progress evaluations will measure and compare your improvement. We will always inform you of associated fees before we perform any procedure or service.

_____
patient initials

Chiropractic is an alternative medical system. It takes a different approach from standard medicine in treating health problems. The basic concepts of chiropractic are:

- **Your body has a powerful self-healing ability**
- **Your body's structure (mainly the spine) and its function are related**
- **The goal of chiropractic therapy is to normalize this relationship**

Chiropractic professionals are doctors of chiropractic, or D.C.s. They use a type of hands-on therapy called an adjustment.

Office Use Only:

_____
Doctor's Signature # Date

I understand and agree to the above information:

_____
Date

_____
Print Name- patient or guardian

_____
Signature- patient or guardian

Asher Chiropractic Clinic

15079 Goldenwest St
Huntington Beach, CA 92647
714-891-0999

Informed Consent for Chiropractic Services

While chiropractic care is remarkably safe, you need to know the inherent risks involved with care before you can consent to treat. Please ask any questions before signing.

The nature of the Chiropractic Adjustment/Examination/Treatment

As a part of an examination and/or treatment you are consenting to the following procedures which may be performed by your doctor:

Spinal manipulative therapy, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, vital signs, neurological testing, radiographic studies, mechanical traction, therapeutic ultrasound, electric muscle stimulation, hot/cold therapy, soft tissue therapy and other procedures that the doctor deems necessary

The primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints and/or affect the tone of your muscles. This may cause an audible "pop" or "click" from gas releasing from your joints.

The material risks inherent in chiropractic adjustments.

As with any healthcare procedures, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, stroke, TIA, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Generally all complications described are extremely rare and do not result in a contraindication for chiropractic care. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between 1 in 1 million and 1 in 5 million cervical adjustments. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during your history, examination and radiographs. Your doctor 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 our attention, it is your responsibility to inform us.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- self-administered, over-the-counter analgesics and rest
- Physical therapy
- Medical care and prescription drugs
- Hospitalization
- Surgery

If you chose to use one of the above noted other treatment options, you should be aware that there are risks and benefits of such options, it is important to discuss them with your medical team.

- The risks and dangers attendant to remaining untreated.

I understand that remaining untreated can further increase severity of symptoms and/or spinal problems as well as complicating future treatment effectiveness.

I have read the above paragraphs. I have been informed of the nature of chiropractic treatment and its inherent risks as well as treatment options. I have had my questions answered to my satisfaction. I knowingly give the doctors of Asher Chiropractic Clinic my consent to proceed with chiropractic care and any treatments deemed necessary.

_____ _____

Patient's Name (printed) Date

_____

Patient'sSignature