Back & Body Wellness

Date:

First Name:	Last Name:	Date of Birth:
Address:	City:	State: Zip:
Email (for receipts & statements):	Cell Phone: ( )	
Occupation:	Emergency Contact:	Phone: ( )
Language Preference: ◯ English ◯ other: _____	Will you require an interpreter? ◯ Yes ◯ No	
Have you seen a chiropractor before? ◯ Yes ◯ No	If yes, for what reason?	When was last visit?
How did you hear about us? ◯ friend/family ◯ internet ◯ Yelp ◯ other:	Can we send text reminders to your phone for future appointments? ◯ Yes ◯ No	

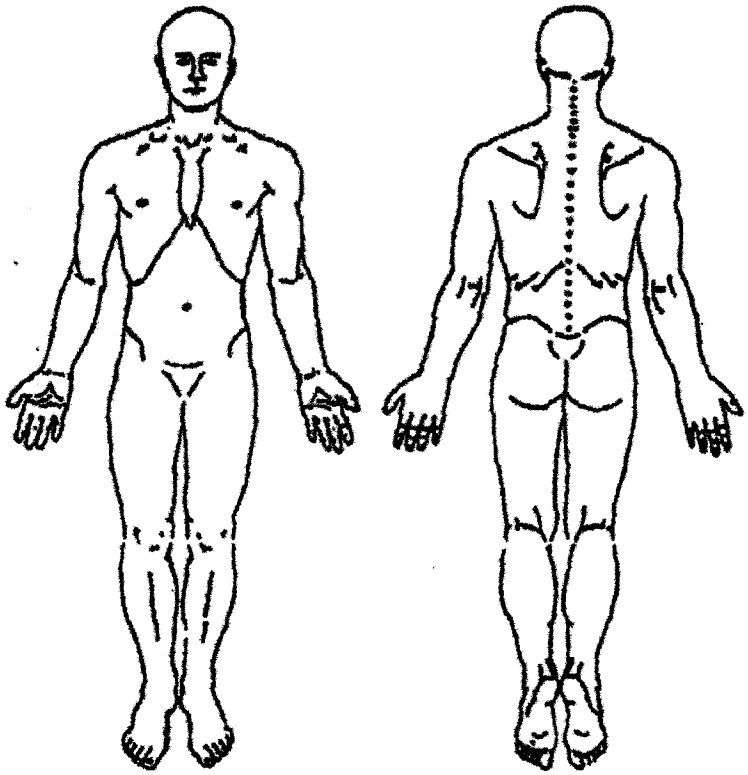
***Please list your PRIMARY personal health insurance here. ONLY your primary insurance will be accepted

Insurance:_____ Member ID:_____ Group No. (Only for United Health) _____

I agree to authorize the release of medical or other information requested by my insurance for claim processing.

Sign: Date:

Please mark on the diagram below the location of your symptoms you are currently experiencing.



Please circle your level of pain when it's at its worst: 10=highest 1=lowest

1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

How many days a week do you exercise? _____ For how long? _____

List type of exercise or activity: _____

Have you been treated for any illness/conditions in the last 3 years? ◯ No ◯ Yes

If yes, please describe: _____

What medications are you taking and for what conditions: _____

Have you ever:		Briefly explain and when?
Broken bones?	◯ No ◯ Yes	
Been hospitalized?	◯ No ◯ Yes	
Had sprains/strains?	◯ No ◯ Yes	
Had surgery?	◯ No ◯ Yes	

Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) osteoporosis
( ) arthritis
( ) scoliosis
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) varicose veins
( ) headaches/migraines
( ) epilepsy
( ) pregnancy
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) stroke
( ) atherosclerosis
( ) blood clots/ deep vein thrombosis
( ) phlebitis
( ) depression
( ) cancer
( ) diabetes
( ) numbness/decreased sensation
( ) back/neck problems
( ) sciatica
( ) Tendonitis/bursitis
( ) Spinal disc problems
( ) carpal tunnel syndrome
( ) tennis elbow

FAMILY HISTORY

List here present & past major health conditions of your immediate family members (heart disease, cancer, arthritis, etc.)

Office Policies

24 HOUR CANCELLATION

$25.00 fee will be assessed for no-shows or late cancellations (less than 24 hour prior to appointment)

We understand that circumstances arise that do not allow you to keep your appointment. Please call or text us at least 24 hours prior to your appointment if you need to reschedule. You can also email or leave a voicemail.

No-show/Late Cancellation fee will be increased to $50 after multiple instances.

We may terminate our relationship with clients who frequently reschedule and/or cancel at our discretion.

initial _____

LATENESS

We request that you arrive 5 minutes early for your appointment. If you arrive late for your appointment, your treatment time may be reduced and the time left will be used to its best advantage at our discretion. If you arrive 15 mins or later without calling, you will be considered a no show and charged our late cancellation/no-show fee.

initial _____

INSURANCE BILLING

WE ONLY ACCEPT AND BILL YOUR PRIMARY HEALTH INSURANCE. We DO NOT bill secondary insurances. (exception given for auto accident injuries when auto insurance coverage is used.)

We cannot accept secondary insurances due to their very untimely processing and the immense amount of extra work placed on our office.

If you erroneously give us your secondary insurance to bill, your claim will be denied by your insurance company and you will be responsible for the full cost of your visit at the time of your denied claim. Failure to promptly paying this bill within 30 days will be forwarded to our debt collection service.

We will bill your health insurance and perform any necessary follow-up that is within normal and customary procedures. Any outstanding balance unresolved greater than 6 months from the billing date is the responsibility of the client.

Any remaining balance 9 months from the date of service will be forwarded to a debt collection agency.

initial _____

TIPPING

Tips for your massage sessions are never required or expected, but accepted with great appreciation. The greatest "tip" we can receive is your referrals to friends and family, honest feedback, and your online reviews on various websites. Any tip you wish to leave will be forwarded to your massage therapist of that session at 100%. Tips for chiropractic services are not allowed and will not be accepted. Thank you for your support!

initial _____

SANITATION AND HYGIENE

Massage therapy involves close physical contact for an extended amount of time. Coming to your massage therapy session with a clean body is imperative for the health and safety of both the client and massage therapist. Personal hygiene is mutually respected on both parties. Should either party fail to uphold their hygiene responsibilities, services for that session will be postponed. The client will inform the therapist of any breaks in the skin and these areas will be avoided. Foot massages are not performed for hygienic reasons.

Uncleanliness, strong body odor, obvious contagious conditions, or suspicions of alcohol or drug influence are reasons for termination of session. We reserve the right to refuse treatment to any person for violation of any of these conditions at our discretion.

All linens that come in contact with clients will be cleaned after each use.

Before and after each massage, the therapist's hands and forearms will be washed with water and soap. Any breaks in the skin of the therapists will be covered with protective coverings.

initial _____

MASSAGE ROOM

Massages are performed 1 on 1 with no other guests in the room. Exceptions are granted when client is a child or when client will need assistance with language translation. Children of clients may also be in the room. Any companion allowed in the room should not be disruptive during treatment or session maybe terminated.

initial _____

Consent

You are consenting to an examination and treatment at Back & Body Wellness. You do not have to submit to any examination or treatment procedures. All procedures are performed at your comfort and to tolerance.

Privacy will be assured as you have the right to undress only to your comfort level and treatment requirements. Draping techniques will be used to expose only those body parts that require treatment and/or as you choose to ensure comfort during treatment. If at any time you feel uncomfortable with the treatment for any reason, you have the right to request an immediate stop or request modifications to the treatment, regardless of prior consent given.

Soft tissue therapy, or "massage" is performed at this clinic for the purpose of relieving muscular pain and tension and facilitating range of motion to improve overall function. It may also be performed to release entrapment of "pinched" nerves. If you experience any pain or discomfort during your treatment, you should immediately inform the therapist so that pressure or joint motion will be modified. It is NEVER "no pain, no gain".

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures as well. When providing an adjustment, we use our hands or an instrument to manipulate anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation, reducing pain, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of healthcare interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in cervical adjustments.

It is also important that you understand there are options available for your condition other than chiropractic procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other options about your circumstances and health care as you see fit.

Because some treatments should not be performed under certain medical conditions, you affirm that you have stated all known medical conditions, and answered all questions honestly. You agree to update the office with any changes in your medical profile and understand that there shall be no liability on Back & Body Wellness should you fail to do so.

By signing below, I am stating that I have read the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its consent, and by signing below, I agree with the current or future recommendation to receive chiropractic and massage therapy care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

Print Name _____ Signature _____ Date _____

Health Information Privacy Notice

This notice describes how medical information about you maybe used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care with Dr. Chui, Back and Body Wellness, or one of their associates, your personal and health related information about you may be disclosed in the following ways:

- Your personal information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if the employer is responsible for the payment of your services).
- Your name, address, phone number and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not home to receive an appointment reminder, a message may be left on your answering machine or voicemail. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use ro disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive health care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to use in writing.

We are required by the state and federal law to maintain the privacy of your patient file and the health protected information therein. We are also required to provide you with this notice of your privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your health information in our files.

Information that we use to disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect or our privacy activities, you should direct your complaint to Dr. Les Chui, DC. if you would like further information about our privacy policies and practices, please contact Dr. Les Chui, DC.

This notice is effective as of 08/03/2018. This notice and any alterations or amendments made hereto will expire in seven years after the date upon the record was created.

My signature acknowledges that I have read and understand the contents of this notice.

Name (printed)	Signature	Date

If the patient is a minor, or if the patient is being represented by another party:

Personal Representative Name (Printed)	Personal Representative Signature	Date

Description of the authority to act on behalf of the patient