SimpleHEALTH
ACUPUNCTURE & CHIROPRACTIC

Simple Health Chiropractic
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SIMPLE HEALTH NEW PATIENT INTAKE

Today's Date:_____

Name:_____ Date of Birth _____ Age_____

Address _____ City_____ Zip _____
Phone ( )_____ Email _____

Occupation _____ Employer _____

Marital Status: M S W D Children Y / N #_____
Name of Spouse _____ Occupation _____
Spouse's Employer_____ Work Phone _____

Emergency Contact _____ Contact Phone _____
Relationship of emergency contact (Parent/ Other Relative/ Friend) _____

Referred By (circle): Internet / Provider Manual / Other Physician / Friend or Relative
Name _____

Reason for visit today? _____
Is your visit the result of an auto or work injury? Y / N If yes, which _____
_____

Are you currently taking any medications/supplements prescribed or over the counter? (If more than three provide list): _____
_____
_____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

For individuals utilizing medical insurance, the patient or patient's representative agrees and understands that verification of medical eligibility/benefits is not a guaranty of payment from insurance company to licensed practitioner and/or Simple Health. Patient or patient's representative agrees to pay Simple Health for services rendered by licensed practitioner in accordance with the regular rates and terms if the insurance company for any reason denies the billed charges for services rendered to the patient. Patient or patient's representative agrees to be liable and responsible for all non-reimbursed costs to licensed practitioner and/or Simple Health from the insurance company.

Patient's Signature: _____ Date _____

Guardian's Signature Authorizing Care: _____

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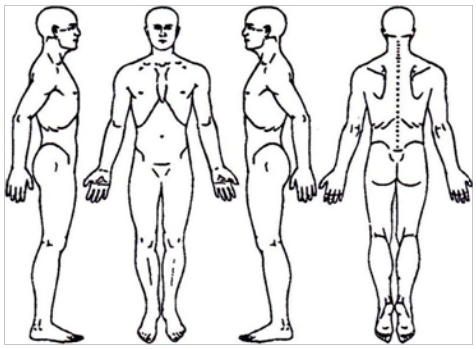
Name: _____

DETAILS OF CHIEF COMPLAINT: Please answer all questions that apply to your condition.
List illnesses and/or symptoms in order of importance to you.

1. _____

2. _____

3. _____



On the diagrams above, mark where you currently have pain. Include pain, numbness, tingling, etc..

4. Have you had spine x-rays, MRI or CT Scan related to chief complaint? ☐ Yes ☐ No

Date(s) Taken:_____
What areas were taken? _____

Please check all of the following that apply to you: ☐ None Apply

Yes	No	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use (Steroid inhaler)
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date)
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma
☐	☐	Allergies:_____

_____

Yes	No	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births_____
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	History of Low/Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use: #_____day/wk
☐	☐	History of Tobacco Use:#_____day/wk
☐	☐	Surgeries/Implants: _____

_____

_____

Have you received any previous treatment for your complaints: ☐ No ☐ Yes

If yes please describe_____

Allergies:_____

Exercise Habits: ☐ None ☐ Regular Program ☐ Semi-regular program (Describe) _____

_____

I certify that the above information is complete and accurate. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature: _____ Date: _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice , including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful l death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees , or other expenses incurred by a party for such party's own benefit.
Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1),the limitation on recovery for non-economic losses (Civil Code 3333.2) , and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim , if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE : BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION , AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT .

(Date)

(Indicate relationship if signing for patient)

(Date)

AAC-CA

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SIMPLE HEALTH INFORMED CONSENT

Acupuncture: I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of acupuncture on me (or the patient named below for whom I am legally responsible) by the licensed acupuncturist(s) who now or in the future work at the clinic or office listed below or any other office or clinic. I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Oriental Massage), Oriental herbal medicine, and nutritional counseling. I will immediately notify the licensed acupuncturist of any unanticipated or unpleasant effects associated with the consumption of herbal pills or formulas.

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising (especially on the face), numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the licensed acupuncturist uses only sterile single use disposable needles. Burns and/or scarring are a potential risk of cupping and moxibustion. I understand that while this document describes the more common risks of treatment, other side effects may occur. The herbs and nutritional supplements which are from plant, animal, and mineral sources, that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, rashes and tingling of the tongue. I will notify the licensed acupuncturist if I become or suspect I have become pregnant.

I do not expect the licensed acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the licensed acupuncturist to exercise careful judgment during the course of treatment, which the licensed acupuncturist believes, based on the facts then known is in my best interest. I understand results are not guaranteed.

Chiropractic: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures within the scope of practice of the practitioner, including but not limited to therapeutic exercises, electric stimulation, and hot/cold therapy, on myself (or on the patient named below, for whom I am legally responsible), by the doctor(s) of chiropractic who now or in the future work at this or any other clinic or office of Simple Health.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. 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 fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I understand that massage and stretching therapy is often performed as an adjunct treatment to acupuncture and chiropractic, and may be performed by either the licensed acupuncturist, chiropractor, a certified massage therapist, or a trained stretch therapist. I understand that massage and stretching is basically for the purpose of stress management, relief of muscle tension, and to promote flexibility and wellness. I also understand that massage therapists do not diagnose mental or physical illnesses nor do they prescribe medication for treatment of disease. Massage and stretching works on soft tissue and the therapist may integrate gentle range of motion exercises to the joints but will not administer spinal manipulations.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment(s); have been told about the risks and benefits of all procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment(s) for my present condition and any future condition(s) for which I seek treatment.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

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SIMPLE HEALTH FINANCIAL AGREEMENT AND CANCELLATION POLICY

At Simple Health, we understand that unanticipated events happen occasionally in life. While truly sympathetic, the clinic cannot absorb the financial responsibility of last minute cancellations. In our desire to be effective and fair to all clients, the following policies are in effect.

All appointments require a 24-hour notice for cancellation. This allows the opportunity for someone else to schedule an appointment. Any late cancellations or no-shows within less than 24 hours of appointment time are subject to a fee of **$25**.

Pre-Paid Package Appointments:

If you have a Pre-Paid package for any service and you are unable to give us 24-hours advance notice to cancel your appointment, you will be billed a fee of $25. If you do not have a credit card on file, you have 3 business days to pay the cancellation fee, otherwise a session will be deducted from your package equal to the missed appointment time.

We have tried to make this information clear and understandable. Should you have any additional questions, please feel free to discuss this with our reception.

Financial Agreement

1. The patient or patient's representative agrees to pay Simple Health for services rendered in accordance with the regular rates and terms. When this agreement is executed by the patient or the patient's representative, all shall by jointly and individually liable for the patient. Should accounts be referred to an attorney or collection agency, reasonable attorney's fees and collection expenses incurred shall be payable in addition to the other amounts due.

2. Returned Checks will incur a $25 returned check fee plus the amount of the check.

☐ I have read the following information above and have been informed of the policies and procedures regarding cancellations.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have the right to refuse to sign this acknowledgment.

I,_____, have received a copy of the Notice of Privacy Practices
(PLEASE PRINT NAME)
for the above referenced practice.

Signature:_____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgment of Receipt of our Notice of Privacy Practices from the above individual, but acknowledgment could not be obtained because:

- ☐ The individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other reason, as follows:_____
  _____
  _____

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PATIENT RIGHTS PRIVACY NOTIFICATION

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the purposes listed in this document. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Compliance Officer.

Right to a Paper Copy: You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION
Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our business associates, such as our computer service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you to all the other health care providers who participate in your insurance plan.

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Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign in sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification / communication with family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Marketing: We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

Required by law: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public health: We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health oversight activities: We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Judicial / administrative proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law enforcement: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners: We may, and are often required by law, to disclose health information to coroners in connection with their investigations of deaths.

Public safety: We may, and are sometimes required by law, to disclose your health information to, appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized government functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Workers' Compensation: We may disclose your health information as necessary to comply with workers compensation laws. For example, to the extent your care is covered by workers compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers compensation insurer.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information / record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Research: We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

YOUR HEALTH INFORMATION RIGHTS

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy: You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances.

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Right to Amend or Supplement: You have aright to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health Information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1(treatment), 2(payment), 3(health care operations), 6(notification and communication with family) and 16(specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.