PERFORMANCE CHIROPRACTIC & REHABILITATION CENTER

PATIENT'S PRESENT COMPLAINTS

Name ______________________ Date ____________

Address ____________ City ____________ State ______ Zip ______

Telephone ____________ Social Security# ____________ Driver Lic.# ____________

Age ______ Birthdate ____/____/____ Sex M / F Status M S W D No. Children ______

Occupation ____________ Employer ____________ Years Employed ______

Address ____________ City ____________ State ______ Zip ______

Spouse's Name ____________ Occupation ____________ Employer ____________ Soc. Sec.# ____________

Person Responsible for this Account ____________ Health Plan ____________

Subscriber's Name ____________ ID# ____________ Group# ____________

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Please describe your problem and how it began. Date problem began: ____/____/____ ____________

____

____

How bad is your pain? (Circle a number)	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Describe your current pain/symptoms: ☐ Sharp/Stabbing ☐ Dull ☐ Numbness ☐ Burning ☐ Throbbing ☐ Soreness ☐ Shooting ☐ Tingling ☐ Aches ☐ Weakness ☐ Gripping ☐ Other ______

Since it began, is your problem: ☐ Improving ☐ Getting Worse ☐ No Change

What makes the problem better? ☐ Nothing ☐ Standing ☐ Exercise ☐ Lying Down ☐ Sitting ☐ Inactivity/rest ☐ Walking ☐ Movement ☐ Other ______

What makes the problem worse? ☐ Nothing ☐ Standing ☐ Exercise ☐ Lying Down ☐ Sitting ☐ Inactivity/rest ☐ Walking ☐ Movement ☐ Other ______

Can you perform your daily home activities?	☐ Yes	☐ Yes, only with help	☐ Not at all
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all
Describe your job requirements:	☐ Mainly sitting	☐ Light Labor	☐ Heavy Labor
Can you perform your daily work activities?	☐ Yes, all activities	☐ Only some	☐ Not at all
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High

What treatment have you had for this condition in the past? (surgery, medications, injections, therapy, chiropractic)

____

____

Have you had X-rays, MRI or other tests for this condition? What tests and When? ____________

____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING

Patient Signature: ______________________ Date: ____________

PATIENT'S HEALTH QUESTIONNAIRE

Patient Name ______________________________ Patient ID# ____________________

If you have *ever* had a listed symptom in the *past*, please check that symptom in the *Past Column*. If you are *presently* troubled by a particular symptom, check that symptom in the *Present column*. **KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

Past	Present	Condition
☐	☐	Neck Pain
☐	☐	Shoulder Pain (R_____ L_____)
☐	☐	Pain in Upper Arm or Elbow (R_____ L_____)
☐	☐	Hand Pain (R_____ L_____)
☐	☐	Wrist Pain (R_____ L_____)
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R_____ L_____)
☐	☐	Pain in Lower Leg or Knee (R_____ L_____)
☐	☐	Pain in Ankle or Foot (R_____ L_____)
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstral Flow
☐	☐	Profuse Menstral Flow
☐	☐	Breast ☐Soreness ☐Lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Past	Present	Condition
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (date) ____________
☐	☐	Stroke (date) ____________
☐	☐	Asthma
☐	☐	Cancer, Explain____________
☐	☐	Tumor, Explain____________
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver / Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other____________

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other____________
☐ High Blood Pressure	____________

Yes	No	
☐	☐	Do you have a permanent disability rating? Location ____________
☐	☐	Date rating received ____/____/____
☐	☐	Rating Percentage__________%

Present Weight _______pounds **Height** _______feet _______inches

Please check any of the following that apply to you

Past	Present	
☐	☐	Pregnancy, # births____________
☐	☐	Birth Control Pills, type____________
☐	☐	Medications (list if not listed elsewhere) ____________ ____________
☐	☐	Hospitalizations/Surgical Procedures (list if not described elsewhere)____________

Past	Present	
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffinated Soft drinks: cups/cans per day____________

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

Patient's Signature: ______________________________ Date: ____________

PATIENT HISTORY

Name:______________________________ Referred By:______________________________

Address:______________________City:______________State:________Zip:____________

Phone:__________Birthdate:__________Sex:_____Age:_____Marital Status:________# of Children:________

Employer:________________Occupation:________________Work Phone #____________

Social Security #:____________________ California Driver's License #____________________

Email address: ____________________ (YOUR EMAIL ADDRESS WILL **NOT** BE SHARED WITH ANYONE.)

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):

MAJOR COMPLAINT______________________________

How long have you had this condition?______________________________

Have you lost work days because of this condition? Yes ( ) No ( ) How many?____________

Is the injury related to: Work accident ( ) Auto accident ( )

When have you last seen a chiropractor?____________________ Dr.:____________________

Why did you see this chiropractor?____________________Were you helped?____________

What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

____

Did you follow the program?__________ If not, why?____________________

Why are you changing chiropractors?______________________________

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?)____________

____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?____________________

________Temporary Relief (Help the symptom but do not fix the cause of the problem)

________Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US?

____

What are your favorite activities or hobbies to do now?____________________

Are your current problems affecting these activities or hobbies?____________________

What activities are you looking forward to doing in retirement?____________________

On a scale of 1 – 10 (10 being the most, and 1 being the least):

____How committed are you to being at your maximum health potential?

____How important is it for your family to be at their maximum health potential?

____How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had?______________________________

List drugs or supplements you now take (prescription & non prescription):____________________

____

Name other doctors you have seen for this condition: What was done, and for how long?____________

____

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Signature:______________________________**Date**____________________

INFORMED CONSENT

It is our responsibility to fully inform you of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. It, however, has one of the safest records of the wide range of treatments that can be used for spinal disorders. Please feel free to ask the Doctor if you need any clarification.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on nerve tissue, fractures in weakened bones such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasm or tightening are common but usually brief reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications versus the relative frequency of the complications of the other typical treatments which may be used for a spinal disorder.

DISC INJURY from manipulation causing spinal cord pressure
1 per 100 million cases
1 per 400 million (cmt)

ARTERY INJURY from manipulation causing stroke
1 per 1 million

NEUROLOGICAL complication from
Neck Surgery 1 per 64 (cases)
Back Surgery 1 per 333 (cases)

DEATH RATE from neck surgery
1 per 145

Perhaps the most common alternative to spinal manipulation is the use of anti-inflammatory drugs or NSAIDs. These drugs cause fairly common and can also potentially cause serious complications.

COMPLICATIONS ASSOCIATED WITH ANTI-INFLAMMATORY DRUG USE	
Serious stomach or intestinal bleeding	1-4 per 100 users
Hospitalizations from complications	20,000 per year
Deaths from complications	2,600 per year

I have read the above and understand the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Eric Belusa, DC or any DC at Performance Chiropractic.

________________________ Signature

________________ Date

PERFORMANCE CHIROPRACTIC CENTER
NOTICE OF PRIVACY PRACTICES

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.

Performance Chiropractic Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Performance Chiropractic Center."*

> *"It is our policy to provide a substitute health care provider, authorized by Performance Chiropractic Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Performance Chiropractic Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

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office at 925-687-5515 If Eric Belusa, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ______/______/_______

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Performance Chiropractic Center with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

_______________________________________ ______________
Patient's Signature Date

_______________________________________ ______________
Authorized Facility Signature Date

If you would like the complete document (4 pages), please ask the front desk. Thank you.

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Health and Medical Information Release Form

I, ________________________________, give permission to Dr. Eric Belusa, his staff, associates, and employees of Performance Chiropractic to share private and medical information with my medical doctor, ____________________________________, as well as his or her staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Belusa and his staff.

Signature: ________________________________ Date: ______________________

Patient Info

Name: ____

Address: ____

City, State, Zip: ____

Phone: ______________________________ Date of Birth: _________________

Medical Doctor Info

Name of Doctor: ____

Address: ____

City, State, Zip: ____

Phone: ____

Disclosure of Fees/ Payment Policy

99201	Brief Initial History and Consultation		60.00
99202	Brief Initial History and Exam		75.00
99203	Intermediate Initial History and Exam		100.00
99204	Comprehensive History and Exam		140.00
99211	Min. Office Visit/ Re-evaluation (not needing doctors presence)		35.00
99212	Brief Office Visit/ Re-evaluation		45.00
99213	Limited Office Visit/ Re-evaluation		55.00
99214	Intermediate Office Visit/ Re-evaluation		80.00
97026	Infrared Hot/ Cold		35.00
97035	Ultrasound/ Iontophoresis 15 minutes or less		45.00
97032	Muscular Stimulation 15 minutes or less		55.00
97124	Vibromassage		15.00
97124	Massage Therapy 15 minutes or less		30.00
97250	Myofascial Release 15 minutes		50.00
99012	Mechanical Traction		30.00
98940	Manipulation 1-2 Areas		60.00
98941	Manipulation 3-4 Areas		75.00
98943	Extra Spinal Manipulation		60.00
98940-52	Office Visit/ Manipulation		55.00
98940-52	Family Wellness Plan		
98940	Medicare	Spinal Manipulation 1-2 Areas	29.48
98941	Medicare	Spinal Manipulation 3-4 Areas	41.12
98942	Medicare	Spinal Manipulation 5 Regions	52.82
72040	X-rays	Cervical 2 Views	90.00
72050	X-rays	Cervical 5 Views	130.00
72100	X-rays	Lumbar 2 Views	100.00
72070	X-rays	Thoracic 2 Views	100.00
99070	Brace and Supports		Varies
	Supplements		Varies

I have read the above codes and fees and understand and know the cost of my care with my treating doctor. I understand that I am responsible for payment of <u>all deductibles and co-payments of my care.</u> I further understand that it is my responsibility to know my own insurance benefits and that <u>Performance Chiropractic is not responsible for any discrepancy between what my coverage is and what was reported to us.</u> I understand that if I have a balance for medical services not paid, I will make a minimum payment of $50.00 each month or 20% (auto debit) of the outstanding balance whichever is greater. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of the case. I understand that if a check or debit is returned for insufficient funds, I will be charged a $25.00 service charge.

<u>I have read and fully understand the above financial terms and prices.</u>

Signed____Date____________________.