



PATIENT'S PRESENT COMPLAINTS

Work Telephone

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 Throbbing Aches
 Dull Soreness Weakness
 Numbness Shooting Gripping
 Burning Tingling Other _____

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

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

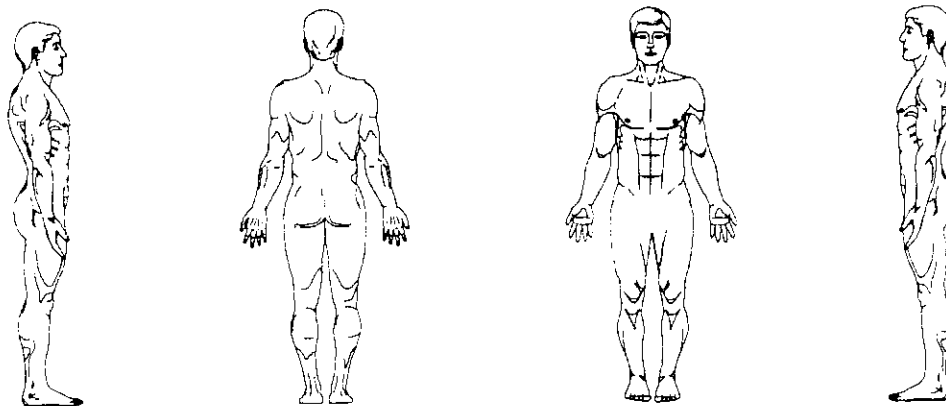
What makes the problem worse? Nothing Lying Down Walking
 Standing Sitting Movement
 Exercise Inactivity/rest Other _____

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.**

<table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> <th style="text-align: left;">Condition</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Neck Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Shoulder Pain (R_____ L_____)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pain in Upper Arm or Elbow (R_____ L_____)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hand Pain (R_____ L_____)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Wrist Pain (R_____ L_____)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Upper Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Low Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input 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If a family member has had any of the following, please mark the appropriate box:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> High Blood Pressure	

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a permanent disability rating?
		Location _____
<input type="checkbox"/>	<input type="checkbox"/>	Date rating received ____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Rating Percentage _____%

Present Weight _____ pounds Height _____ feet _____ inches

Please check any of the following that apply to you

<table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> <th style="text-align: left;">Condition</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pregnancy, # births _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Birth Control Pills, type _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Medications (list if not listed elsewhere)</td></tr> <tr><td colspan="3">_____</td></tr> <tr><td colspan="3">_____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hospitalizations/Surgical Procedures (list if not described elsewhere)</td></tr> <tr><td colspan="3">_____</td></tr> </table>	Past	Present	Condition	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # births _____	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills, type _____	<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere)	_____			_____			<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures (list if not described elsewhere)	_____			<table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">Past</th> <th style="text-align: left;">Present</th> <th style="text-align: left;">Condition</th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tobacco</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Alcohol</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Drug or Alcohol Dependence</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Coffee/Tea/Caffinated Soft drinks:</td></tr> <tr><td colspan="2"></td><td>cups/cans per day _____</td></tr> </table>	Past	Present	Condition	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffinated Soft drinks:			cups/cans per day _____
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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: _____

PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? () Yes () No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: () Driver () Passenger () Front Seat () Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? () North () East () South () West
on (name of street) _____
5. What direction was other vehicle headed? () North () East () South () West
on (name of street) _____
6. Were you struck from: () Behind () Front () Left side () Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? () Yes () No If yes, for how long? _____
9. Were police notified? () Yes () No
10. In your own words, please describe accident: _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No If yes, please describe in detail: _____

12. Please describe how you felt:
- a. DURING the accident: _____
 - b. IMMEDIATELY AFTER the accident: _____
 - c. LATER THAT DAY: _____
 - d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

14. Do you have any congenital (from birth) factors which relate to this problem? () Yes () No If yes, please describe:

15. Do you have any previous illnesses which relate to this case? () Yes () No If yes, please describe:

16. Have you ever been involved in an accident before? () Yes () No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? () Yes () No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

19. Since this injury occurred, are your symptoms: () Improving () Getting Worse () Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? () Yes () No If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? () Yes () No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? () Yes () No If yes, please describe, in detail:

23. Other pertinent information: _____

DATE

PATIENT'S SIGNATURE

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

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 _____

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: _____

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.

NOTICE OF DOCTOR LIEN

Patient: _____ Attorney: _____

Date of Accident: _____

I do hereby authorize Eric R. Belusa D.C. to furnish you, my attorney, with a full report of treatment of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due owing for chiropractic service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the inquiries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by Eric R. Belusa D.C. for service rendered me and that this agreement is made solely for said Doctor to give additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said Doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to Eric R Belusa D.C. I have been advised that if my attorney does not wish to cooperate in protecting said doctors interest, the doctor will not await payment but may declare the entire balance due and payable. I further understand the cost of my chiropractic treatment and believe his charges to be a reasonable and necessary expense. I also direct my attorney to pay said doctor the full cost of treatment in my case.

Date _____ Patient's Signature _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Date _____ Attorney's Signature _____

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Dr. Eric R. Belusa D.C.
4425 Treat Blvd., Suite B
Concord, CA 94521
(925) 687-5515

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 all deductibles and co-payments of my care. I further understand that it is my responsibility to know my own insurance benefits and that Performance Chiropractic is not responsible for any discrepancy between what my coverage is and what was reported to us. 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.

I have read and fully understand the above financial terms and prices.

Signed _____ Date _____.