Patient Information

Date_____ Male / Female

Name_____

Address_____

_____

City_____State_____Zip_____

Birthdate_____Age_____

Marital Status:

□Single □Married □Widowed □Divorced □Dom. Partnership

Occupation_____

Employer_____

Spouse's

Name_____

Whom May We Thank For Referring You?

_____

Contact Telephone Information

Home(_____)_____
Work (_____)_____Ext_____
Cell (_____)_____
Email_____

Insurance

Insurance Company _____
Phone # (_____)_____
ID #_____
Group #_____ PPO or HMO?
Insured Name _____
Insured DOB _____/_____/_____
Relationship to You _____
Supplemental Insurance? □Yes □No

I, _____, certify that I (or my dependant) have insurance coverage with _____and assign directly to *Dr. Scott Neubauer* all insurance benefits, if any. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature _____
Date _____/_____/_____

Accident Information

Is condition due to an accident? □Yes □No
Type of Accident: □Auto □Home □Other □Work

Patient Condition

1. Reason for Visit:

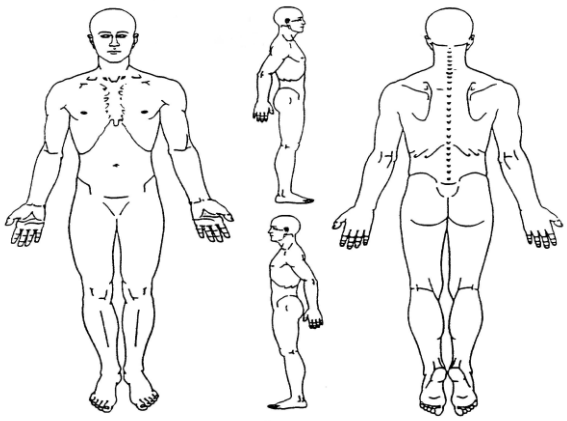
_____

_____

_____

2. When did your symptoms start? _____
Your symptoms are: □decreasing □increasing □no change
3. Description of symptoms: □sharp □dull □ache □numb □weak □shooting □burning □throbbing □tingling
4. Frequency of symptoms: □constant □frequent □occasional □intermittent
3. Rate the severity of your condition:
0 (least) to 10 (worst) _____
Symptoms are worse in the: □morning □afternoon □night
7. Have you had these symptoms before? □Yes □No
If yes, when? _____
8. What makes it better?
□nothing □rest □walking □standing □sitting □exercise □heat □ice
9. What makes it worse?
□nothing □rest □walking □standing □ sitting □exercise □heat □bending □lifting □sneezing □coughing
10. Does it interfere with:
□work □sleep □exercise □daily routine □recreation

11. Put an X on the picture where you are experiencing your symptoms



12. Activities that are difficult to perform

_____

Current Medications (please list dose and frequency): _____

_____

_____

What type of care have you already received for your condition?

☐Chiropractic ☐Massage ☐Medication ☐Surgery ☐Other _____

Names of other Doctor(s) who have cared for you _____

Last Date of Spinal Examination, X-ray, MRI, CT, or Bone Scan _____

CIRCLE any conditions you *currently* suffer from; ***CHECK*** any conditions you *previously* suffered from:

AIDS/HIV	Alcoholism	Allergy Shots	Anemia	Anorexia
Appendicitis	Arthritis	Asthma	Bleeding	Breast Lump
Bronchitis	Bulimia	Cancer	Cataracts	Chemical Dependent
Chicken Pox	Diabetes	Emphysema	Epilepsy	Fractures
Glaucoma	Goiter	Gonorrhea	Gout	Heart Disease
Hepatitis	Hernia	Herniated Disc	Herpes	High Cholesterol
Kidney Disease	Liver Disease	Measles	Headaches	Miscarriage
Mono	MS	Mumps	Osteoporosis	Pacemaker
Parkinson's	Pinched Nerve	Pneumonia	Polio	Prostate problem
Prosthesis	Psychiatric care	Rheumatoid Arth	Rheumatic fever	Scarlet fever
Stroke	Suicide attempt	Thyroid problem	Tonsillitis	TB
Tumors, growths	Typhoid fever	Ulcers	Vaginal infections	Venereal disease
Whooping cough	Colds	Flu	Viral infections	Vision problems
Fibromyalgia	Migraines	Other_____		

EXERCISE

□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY

□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS

□ Smoking Packs/Day_____
□ Alcohol Drinks/Week_____
□ Coffee/Sodas Cups/Day_____

For Women Only: Are you pregnant? □Yes □No Due Date_____ Last menstrual period_____

Injuries/ Surgeries You've Had

	Description	Date
Falls		
Head Injuries/Whiplash		
Broken Bones/Dislocations		
Surgeries		
Cancer		
Other		

Please List Any Known Allergies

_____

_____

_____

CONSENT FOR TREATMENT

Patient's Name_____ Date_____

All Patients in the State of California are required to approve of all services rendered by their doctor before any services are performed. Refusal to comply with California Law releases your doctor of all liabilities and his/her right to refuse treatment.

I,_____, hereby request and give consent to my doctor to perform all necessary chiropractic examinations, adjustments, therapy and rehabilitation. I understand that my doctor will consult with me before any procedures are performed, at which time, I will give him /her permission to perform all necessary procedures to treat my condition. I understand I have an opportunity to discuss with the doctor and/or with the office staff the nature and purpose of my chiropractic care before any treatment is rendered.

Patient Signature_____ Date_____

IF THE PATIENT IS A MINOR, THE BOTTOM PORTION MUST BE SIGNED BY PARENT OR GAURDIAN.

CONSENT TO TREATMENT OF A MINOR

I hereby authorize Dr. Scott Neubauer and whomever he may designate as assistants to administer treatment as deemed necessary to my son/daughter.

PRINT NAME_____Date_____

Signed_____(Parent or Guardian, please circle one)

Informed Consent to Chiropractic/Physiotherapy Treatment

The nature of spinal manipulation: The doctor may use his hands or a mechanical device in order to move your joints.You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as Active Release Techniques® (ART®) soft-tissue therapy, hot or cold packs, rehabilitative exercises or electric muscle stimulation may also be used.

Possible Risks: As with any health care procedure, complications are possible following a spinal manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, bruising, or minor complications.

Probability of risks occurring: The risks of serious complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million. The probability of a serious adverse reaction due to ancillary procedures is also considered "rare", except as described in the following section regarding ART®. Risks associated with Active Release Techniques (ART®) soft-tissue therapy include bruising, skin irritation, and increased sensitivity of the injured tissues. These risks are common and not usually serious. ART® is an aggressive form of treatment designed to break-up scar tissue and is often performed to the patient's tolerance of pain.

Risks of remaining untreated: ***Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes***. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have had the risks of my case explained to me. I have read the explanation above of chiropractic/physiotherapy treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Patient Name (print)_____

Patient Signature_____ Date_____

Doctor Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

Coastal Health and Fitness
Dr. Scott Neubauer
22706 Aspan Street #400
Lake Forest, CA 92630
949-933-7789

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.

Coastal Health and Fitness 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. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Coastal Health and Fitness. It is our policy to provide a substitute health care provider, authorized by Coastal Health and Fitness to provide assessment and or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence, or by assignment. We utilize and open filing system for patients' charts located in a secure area. Only staff members are allowed in secure areas.
Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Coastal Health and Fitness for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide and itemized billing to you upon request. This billing may contain medical information, possibly including diagnosis, date of injury or condition, and codes which describe the health care services received.
Worker's 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: As required by law, we may disclose you health information to public health authorities for purposes related to prevention or control of disease, injury or disability, reporting child 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.
Judicial and Administrative Proceedings: We may disclose you health information in the course of any administrative of judicial proceeding.
Law Enforcement: We may disclose you 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 or subpoena, and other law enforcement purposes.
Deceased Persons: We may disclose your health information to coroners or medical examiners.
Research: We may disclose your health information to researchers conducting research that has been approved by and Institutional Review Board.
Public Safety: It may be necessary 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 to the general public.
Specialized Government Agencies: We may disclose your health information for military, national security, prisoner and government benefits purposes.
Marketing: We may contact you for scheduling purposes. We may call your home prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we may leave a reminder message on your answering machine or with the person answering the phone. You may opt-in to be sent newsletters via mail or electronic means. We utilize a sign-in sheet which confirms a patient's appearance on a specific day/date.
Change of Ownership: In the event that Coastal Health and Fitness is sold or merged with another organization, your health information/record will become the property of the new owner.
Your Health Information Rights: You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Coastal Health and Fitness is not required to agree to the restriction that you requested. You have the right to have your health information received or communicated through and alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. You have the right to inspect and copy your health information. You have a right to request that Coastal Health and Fitness amend your protected health information. Please be advised, however, that Coastal Health and Fitness is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by Coastal Health and Fitness. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.
Changes to this Notice of Privacy Practices: Coastal Health and Fitness reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Coastal Health and Fitness is required by law to comply with this Notice. Coastal Health and Fitness is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Scott Neubauer by calling this office at (949) 933-7789. If Scott Neubauer is not available, you may make an appointment for a personal conference in person or by telephone within two working days.
Complaints: Complaints about your Privacy rights, or how Coastal Health and Fitness has handled your health information should be directed to Scott Neubauer by calling this office at (949) 933-7789. If Scott Neubauer is not available, you may make an appointment for a personal conference in person or by telephone within two 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.

I have read and understand the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Coastal Health and Fitness with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations and described in the Privacy Notice.

Patient's Name_____Signature_____Date_____

Authorized Facility Signature_____Date_____