NEW PATIENT APPLICATION

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ Zip: _____
Social Security#: _____ Email: _____
Home Phone: _____ Cell: _____ Work: _____
Occupation: _____ Employer: _____
Male ☐ Female ☐ Marital Status: M S W Sep.

Spouse Name: _____ Spouse Birthdate: _____ (for insurance purposes)
Referred By? _____ **Purpose of this appointment or primary complaint:**
_____

MEDICAL HISTORY: Please print clearly and fill in as completely as possible.

Have you used any medications or treatments for this problem(s): _____
Patient's Primary Physician: _____
Current drugs or medications: _____
_____

PLEASE ANSWER CAREFULLY THE LIST BELOW AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CHIROPRACTIC CARE **(circle those that apply if you have experienced in the last 6 months).**

Pneumonia	Mumps	Influenza	**INTAKE**
Rheumatic Fever	Small Pox	Pleurisy	Coffee
Polio	Chicken Pox	Arthritis	Tea
Tuberculosis	Diabetes	Epilepsy	Alcohol
Whooping Cough	Cancer	Mental Disorders	Cigarettes
Anemia	Heart Disease	Lumbago	White Sugar
Measles	Thyroid	Eczema	Vitamins

HAVE YOU BEEN TESTED HIV POSITIVE YES / NO

Height: _____ Weight: _____ Are you happy with your current appearance/abilities? Y / N
Do you feel refreshed after waking up? Y / N How old is your mattress? _____ How old is your pillow? _____
Which position(s) do you sleep? _____ Do you exercise regularly? Y / N
How many hours do you spend on an electronic device? _____ Have you ever had surgery? Y / N
How many hours do you work? _____ How much water do you consume in a day? _____
Have you ever been in an auto accident? Y / N Date: _____ Age: _____ Details: _____
_____
Date: _____ Age: _____ Details: _____
Were you evaluated and treated after each? Y / N
Have you had any non-vehicle accidents or falls? Y / N Date: _____ Age: _____ Details: _____
_____

As a patient or legal guardian of minor patient I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to paid directly to Claremont Chiropractic & Wellness. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

I have read and agree to comply with the office policy stated in the patient information sheet.

SIGNED _____

Claremont Chiropractic

"You deserve to have a doctor who treats you as whole person and gets results"

CHECK ANY YOU HAVE EXPERIENCED IN THE LAST 6 MONTHS

MUSCULO-SKELETAL

- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Lower Back Pain
- ☐ Arm Pain
- ☐ Joint Pain
- ☐ Walking Problem
- ☐ Difficulty Chewing
- ☐ General Stiffness

NERVOUS SYSTEM

- ☐ Nervousness
- ☐ Numbness
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Convulsions
- ☐ Paralysis
- ☐ Cold/Tingling Extremities

GENERAL

- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Headaches
- ☐ Fever
- ☐ Allergies

GASTRO-INTESTINAL

- ☐ Poor/ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Weight Trouble
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver/Gall Bladder Problem
- ☐ Abdominal Cramps
- ☐ Gas/ Bloating
- ☐ Heartburn
- ☐ Black/Bloody Stool

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Pain/Excessive Urination
- ☐ Discolored Urine

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Lung Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Strokes

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Stuffy Nose
- ☐ Hearing Difficulty

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

Family History

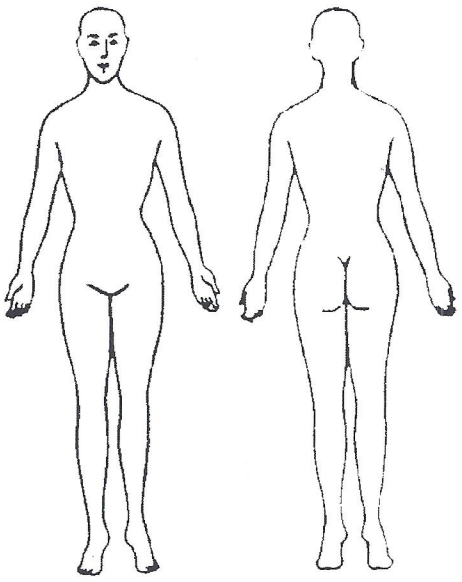
The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

FEMALES ONLY:

When was your last period?_____

Are you pregnant? (circle one)



YES NO UNSURE

Please outline on the diagram the area of discomfort.

Pain Rating1-10: (10 being the worst you feel today) _____

How many days per week can you commit to in order for you to get better? _____

What days are you available for treatment? M W F

Why Chiropractic? People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of pain discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptom corrected and relieved (Corrective Care). Dr. will weigh your needs and desires when recommending your treatment program. Circle the one(s) you desire most: Relief Care / Corrective Care / Doctors Recommendation

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYIS:_____

DIAGNOSIS: _____

PATIENT ACCEPTED YES OR NO

SIGNED_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, 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 health care 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 two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. 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 opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, 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 content, and by signing below, I agree with the current or future recommendation to receive chiropractic 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 chiropractic care from this office.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

IN ADDITION PLEASE SIGN THE ARBITRATION AGREEMENT PROVIDED

PATIENT NAME:

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 California and federal law provide 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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, as to whether this agreement is unconscionable, and any procedural disputes, 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 healthcare 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 healthcare provider and/or other licensed healthcare providers, preceptors, or 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

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 equal 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, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

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 healthcare 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

IN ADDITION, PLEASE SIGN THE INFORMED CONSENT PROVIDED

CLAREMONT CHIROPRACTIC
E. Mark Waterman
5405 Arrow Hwy Ste. 104
Montclair, CA 91763
(909) 670-2225

CLAREMONT CHIROPRACTIC FINANCIAL POLICY

If you have medical insurance, we are available to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved by our staff. We accept cash, checks and major credit cards.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You should realize that:

1. Your insurance is a contract between you, your employer and the insurance company.

2. Payments for co-pays and deductibles are due as treatment is rendered. If you wish to know your benefits in advance, please call the number on the back of your insurance card.

3. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up, to the maximum allowance determined by each carrier. If this is not the case, the patient is still liable for the remaining balance.

4. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, thereby making the patient completely responsible for the charge.

We must emphasize that as medical care provider, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered, unless the contract between our office and the insurance company states otherwise. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Date: _____

Patient Name_____ Patient Signature _____

CLAREMONT CHIROPRACTIC

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of [Practice's] Notice of Privacy Practices effective [Date].

Name (please print): _____
Signature: _____
Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of [Practice's] Notice of Privacy Practices effective [Date].

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: _____
Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective [date] given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

Cancellation/ No Show Policy for Claremont Chiropractic

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If you are unable to keep your Scheduled appointment, Kindly give 24 hours prior notice. Otherwise we reserve the right to charge $25 missed appointment fee. This fee will not be covered by your insurance company.

I have read and understand your Cancellation/No show Policy:

Print Name_____

Signature_____

Date_____