CHULA VISTA
PHYSICIANS
GROUP

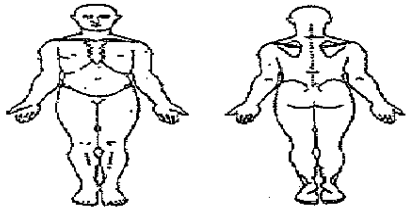
INTAKE FORM

First Name_____ Last Name_____ Sex: M/F Age_____
Birth Date _____ Social Security #_____ Drivers License #_____
Address_____ City_____ State_____Zip_____
Home Tel _____ Cell Tel_____ Work Tel_____
Sex: M / F Email address_____
Employer Name_____ Occupation_____
Employer Address_____ City_____ State____Zip_____

Spouse's Name_____ Spouse's Employer_____
Address_____ Spouse's Date of Birth_____
Emergency Contact_____ Tel #_____

How or who referred you to our office?_____
Do you have health insurance? Y / N If yes, Insurance ID/Med #_____
Health Insurance Company Name_____
Is this your own coverage or through another person? ◯ Yes, my own ◯ Spouse ◯ Other If other,
Name of Insurer_____ Date of Birth _____
Health Insurance Company Name_____
Insurer Social Security _____ Medical ID #_____

Current Health Problems – Why are you here to see us?
1._____
2. _____
3._____
4. _____



What are these problems related to? ◯ Work Injury ◯ Auto Accident ◯ Other _____

Please list all doctors that you have seen for these problems:
1._____ 2. _____
3._____ 4._____

Diagnosis _____ _____ _____ _____
_____ _____ _____ _____

I hereby authorize and assign Chula Vista Physicians Group and their doctors my rights to receive payment from negligent parties or from insurance companies. I authorize Chula Vista Physicians Group to release any information to any insurance carrier, adjuster, attorney, or government agency that will assist in the payment for services rendered by Chula Vista Physicians Group and its doctors/therapists. I agree that if my insurance company does not reimburse Chula Vista Physicians Group, I am responsible for the balance.

Signature: _____ Date: _____

PATIENT HISTORY

NAME:_____ DATE:_____

1. Where is the location of your pain?_____
   _____
2. When did this start? _____
   _____
3. How did you receive your injury?_____
   _____
4. Describe the pain…sharp, dull, burning, throbbing, etc. _____
   _____
5. Since you received your injury, has the pain gotten better or worse? (circle one)
   BETTER WORSE
6. Is the pain constant or does it come and go? If it comes and goes, when and how often does it hurt? _____
   _____
7. Have you ever had this pain before? If so, when? _____
   _____
8. Do you have any pain in the shoulders, arms or legs? Any tingling or numbness?_____
   _____
9. Can you find a comfortable position which seems to relieve your symptoms? If so what is it?_____
10. Have you done any of the following for your pain?
    Heating pad___ Did this help: YES NO
    Ice ___ Did this help: YES NO
    Asprin, Advil, Tylenol?_____ Did this help: YES NO
    Bengay, Deep Heat, Icy hot?_ Did this help: YES NO
11. What seems to aggravate your pain? _____
    _____
12. Have you ever seen a medical doctor about this condition? If so, what was the diagnosis? What was the treatment? Drugs? _____
    _____
13. Are you on medication now? If so, what and what for?_____
    _____
14. Have you ever had any surgery? If so, what? _____
    _____
15. Have you ever been to a chiropractor before? When was the most recent time? What for? What did he or she do (treatment)? _____
    _____
16. What do you do for a living or during the day?_____
    _____

17. Is this so bad you cannot work? YES NO
Does it slow you down at work? YES NO
Does it keep you from doing anything that you want to do? YES NO
Does it keep you from sleeping? YES NO
How does this affect you?_____
_____

Assignment of Benefits Form

Practice Name _____ Date _____
Address _____ Patient _____
City, State, Zip _____ ID# _____
Phone _____ Group# _____

I, _____ , understand that services rendered to me by **Chula Vista Physicians Group** are my financial responsibility and that the Provider will bill my insurance company, _____ as a courtesy. I authorize my insurance company to pay my benefits directly to Chula Vista Physicians Group and I understand that I will be fully responsible for any outstanding balance on my account.
ins. name

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____.
ins. company

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to **Chula Vista Physicians Group** within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize **Chula Vista Physicians Group** to facilitate payment utilizing the credit card number on file to resolve the balance.

I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____
Signature of Policyholder Patient / Guardian Printed Name

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Chula Vista Physicians Group
690 Otay Lakes Rd. Ste. 110
Chula Vista CA 91910

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third- party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:

_____

Relationship to patient

_____

Signature:

_____

Date:

_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below.

DATE: INITIALS: REASON:

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form whether electronically on paper, or orally, are kept properly confidential. This Act gives you the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

INFORMED CONSENT

I hereby request and consent to the performance of procedures, which may include but is not limited to various modes of physical therapy, diagnosis, x-rays, medical doctor, and/or chiropractic adjustments on me (or the patient named below, for whom I am legally responsible) by the doctor named below and/or other license doctors who now or in the future treat me while employed by, working or associated with or serving as back up for Chula Vista Physicians Group, including those working at the center or office listed below or any other office or center.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and/or other procedures.

I understand and am informed that in the practice of medicine and in the practice of chiropractic there are some risks to treatments including but not limited to, fractures, disk 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 on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name: _____ Signature: _____

PLEASE PRINT

Date Signed: _____ Witness or Patient's Guardian Signature: _____

TO BE COMPLEDTED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name: _____ Signature of Patient: _____

PLEASE PRINT

Date Signed: _____ Signature of Representative: _____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office: Chula Vista Physicians Group
Address: 690 Otay Lakes Rd. Ste. 110 Chula Vista, CA 91910
Name of Doctor's treating this patient: Dr. McCown