Cockrell Family Chiropractic

New Patient Introduction

Please complete this packet as thoroughly as possible. We will also need a copy of your drivers license and any insurance cards.

Contact Information

Full Name:			Date:	
Street Address:		City:	State:	Zip Code:
Cell Phone #:	Home Phone #:		Work Phone #:	
Email Address:		Social Security Number:		
What is the best way to contact you? May we contact you by: ___ Text Message ___ Email				

Tell us a little more about you

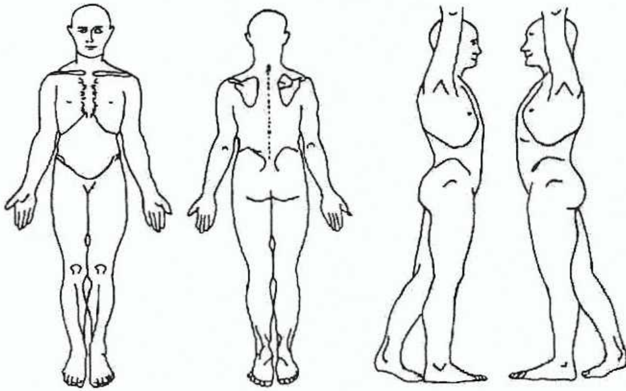
Age:	Birthdate:	Gender:	Height:	Weight:
Marital Status:	Spouse's Name:		Please list your children and ages: 1. 2. 3. 4.	
Occupation:				
Employer's Address:				
What does your daily work entail?				
Primary Doctor:		City:	Phone #:	
Have you seen any other specialists:				
What is your previous chiropractic experience:				
Allergies:				
Please tell us about your hobbies and interests:				

Insurance Information

Insurance Company:		Address:	
Effective Date:	Name of subscriber:		Phone #:
Member ID #:		Group #:	Plan Code:
Additional Information:			

WHY ARE YOU HERE TODAY?

Your Name________________________________ Date________________



It is important that the doctor gets a clear, detailed picture of what is going on with you.

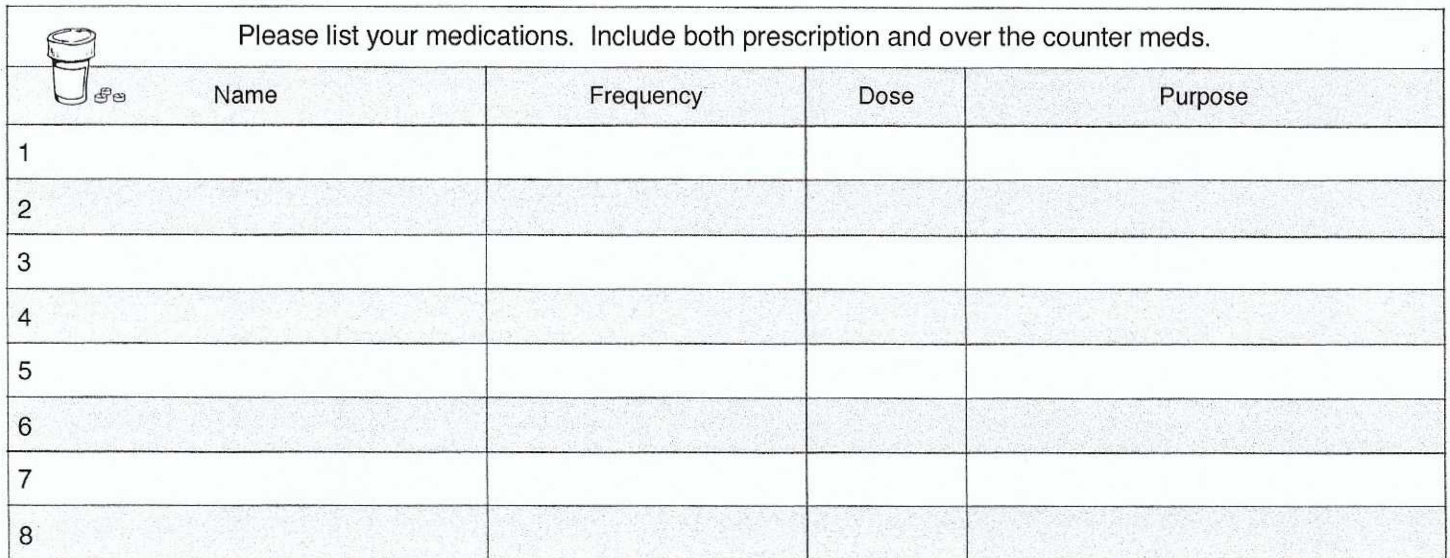
In the diagram to the left, please sketch the problems you are having. Please feel free to shade in areas of problems and write as needed. The more specific you can be the better.

History of your Primary Complaint
Please describe what the problem you are experiencing:
How and when did this begin?
Is this a recurring problem through the years?
What seems to exacerbate the symptoms?
How do the symptoms change through the day, weeks, months?
How have you treated this so far?
Please indicate your pain severity on a scale of 1-10. (1 is slight and 10 is incapacitating/debilitating.)
[At this moment: 0 1 2 3 4 5 6 7 8 9 10] [At it's worst: 0 1 2 3 4 5 6 7 8 9 10] [At its best 0 1 2 3 4 5 6 7 8 9 10]

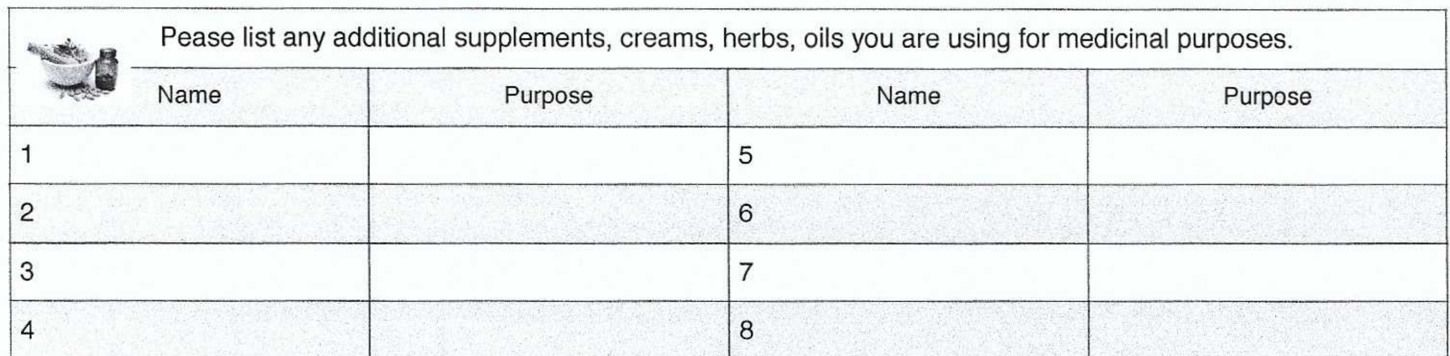
History of your Other Complaint(s)
If you are experiencing multiple symptoms or injuries, please provide similar details in the lines below. Be sure to include the pain history, locations, timing and severity of 0-10

Just a little more information please

Your Name____________________________ Date__________________



Please list your medications. Include both prescription and over the counter meds.			
Name	Frequency	Dose	Purpose
1			
2			
3			
4			
5			
6			
7			
8			



Pease list any additional supplements, creams, herbs, oils you are using for medicinal purposes.			
Name	Purpose	Name	Purpose
1		5	
2		6	
3		7	
4		8	

Restoring your Quality of Life

Please take a moment and answer the following questions as honestly as you can.

How does your problem affect your ability to enjoy things in life?

How does your problem interfere with your relationship or parenting?

If your problem was resolved or better managed, what would you do that you couldn't before?

Do you feel that this problem has changed who you are? If so, how?

Is there anything else the Doctor needs to know?

60 Ridge Rd., Ste G. Sutter Creek, CA 95658 (209) 267-0330

Personal and Family Medical History

	Current this year	Past >1 year	Family History
Right Arm and Hand			
Pain			
Numbness or tingling			
Weakness			
Surgery or hardware			
Other________			
Left Arm and Hand			
Pain			
Numbness or tingling			
Weakness			
Surgery or hardware			
Other________			
Right Leg and Foot			
Pain			
Numbness or tingling			
Weakness			
Surgery or hardware			
Other________			
Left Leg and Foot			
Pain			
Numbness or tingling			
Weakness			
Surgery or hardware			
Other________			
Emotional			
Nervousness			
Irritability			
Anxiety			
Anger			
Depression			
Forgetfulness			
Fear			
Diagnoses:________			
Neurological			
Fainting			
Seizures			
Paralysis			
Stroke			
Vertigo (spinning sensation)			
Dizzy (lightheaded/disconnected)			
Clumsiness			
Drowsiness			
Bone & Joint			
Osteoporosis/Osteopenia			
Arthritis			
Joint Stiffness			

	Current this year	Past >1 year	Family History
Heart and Lungs			
Known heart condition			
Chest pain			
High blood pressure			
Low blood pressure			
Irregular heart beat			
Poor circulation			
Swelling in legs/ankles/feet			
Varicose veins			
Cough (wet / dry)			
Shortness of breath			
Wheezing			
Gastrointestinal/Urinary			
Urinary burning			
Urinary urgency or frequency			
Urinary incontinence			
Nausea			
Heartburn/Acid reflux			
Constipation or Diarrhea			
Yellow eyes or skin			
Ears/Nose/Throat			
Stuffiness/Congestion			
Difficulty swallowing			
Discharge			
Sinus pain			
Ear pain			
Allergies			
Nosebleeds			
Dry mouth			
Sore throat			
Eyes/Visual			
Glasses/Contacts			
Color Blind			
Nystagmus			
Cataracts			
Other			
Headaches			
Headaches			
Migraines			
Other Conditions and Surgeries			
1			
2			
3			
4			
5			
6			
7			

Please Print Name________________________ **Sign**________________________ **Date**____________

Informed Consent to Care

Cockrell Family Chiropractic
60 Ridge Rd., Ste G. Sutter Creek, CA 95685

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 typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1,219 events per one million persons/year and risk of death has been estimated as 104 per one million users.

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.

Patient Name: ______________________ Signature: ____________________ Date: ______________

Parent or Guardian: ____________________ Signature: ____________________ Date: ______________

Witness Name: ______________________ Signature: ____________________ Date: ______________

HIPAA Notice of Privacy Practices

Cockrell Family Chiropractic

We are required by law to maintain the privacy of protected health information, to give you the notice of your legal duties and privacy practices regarding health information about you and to follow the terms of our notice that is currently in effect. It is our desire to communicate to you that we are taking the new Federal HIPAA (Health Insurance Portability and Accountability Act) written to protect the confidentiality of your health information seriously. We do not want you to delay care because you are afraid your personal health history might be unnecessarily made available to others outside our office. We will ONLY use and communicate your health information for the purposes of providing your care, obtaining payment and conducting health care operations. Your Health Information will NOT be used for other purposes unless we have been asked for and been given your written permission unless superseded by law as stated below in rare cases.

How we may use and disclose health information:

Described as follows are the way she may use and disclose health information that identifies you ("Health Information"). Except of the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practices privacy officer.

- **Treatment:** We may use and disclose health information for your treatment and to provide you with treatment-related personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care such as an independent massage therapist.

- **Payment:** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

- **Health Care Operations:** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the chiropractic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

- **Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services:** We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

- **Individual Involved in Your Care or Payment for Your Care:** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

- **Research:** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations:

- **As Required by Law:** We will disclose Health Information when required to do so by international, federal, state or local law to avert a serious threat to health of safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure however, will be made to someone who may be able to help provide treatment.

- **Business Associates:** We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company or independent contractor to perform billing services on our behalf. All of our associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

- **Military and Veterans:** If you are a member of the armed forces we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers Compensation:** We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risk:** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; informs a person who may have been exposed to a disease or may be at risk for contracting or

spreading a disease or condition; and report to the appropriate government authorities if we believe a patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required by law.

- **Health Oversight Activities:** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary of the government to monitor the health care system, government programs and compliance with civil rights laws.

- **Lawsuits and Disputes:** If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement:** We may release Health Information if asked by a law enforcement official if the information is 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises, and; 6) in an emergency to report a crime to the location of the crime victims, or the identity description or location of the person who committed the crime.

- **National Security, Protective Services and Intelligence Activities:** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Your Rights

- **Right to Inspect and Copy:** You have the right to inspect and copy Health Information that we may have used to make decisions about your care or payment for your care. This includes medical and billing records. To inspect and copy this information , you must make your request in writing to our Privacy Officer.

- **Right to Amend:** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request and amendment for as long as the information is kept by or for our office. To request an amendment you must make your request in writing to our Privacy Officer.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment of your care like a family member or friend. For Example, you can ask that we do not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request a confidential communications, you must make your request in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

- **Right to a Paper Copy of this Request:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to this Notice:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page.

Complaints:

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing my name below, I acknowledge I may receive a copy of this notice, I understand this notice and I agree to it's terms.

______________________________	______________________________	______________
Patient Signature (or legal guardian)	Printed Name of Patient	Date

Financial Policy
For Payment at Time of Service

Cockrell Family Chiropractic
60 Ridge Rd. Ste G. Sutter Creek, CA 95685

Our Policy is that payment is due at the time of service. At your request we may courtesy bill your insurance to allow you to receive your insurance benefits which will be sent to you. Due to the many different insurance industry policies, we can neither call to verify your benefits, nor guarantee in any way that the care we provide will be reimbursed for you. We are not contracted providers with any insurance company. Should your insurance company deny reimbursement, you are still responsible for any unpaid amounts. If a situation arises that may involve a fee for service that is not listed, it will be discussed prior to the service.

Regular Patient Fees at Time of Service*

Regular Chiropractic Appointment and Adjustment (Ages 18+)	$50
Pediatric/Child/Youth Adjustment (Ages 1 day thru 17)	$40
New Patient Examination (Standard)	$100
Progress Exam During Active Care Phase	$50

Medicare Fees at Time of Service*

As stated on the ABN form, Medicare does not consider examinations to be reimbursable but does consider them necessary. If you are under active treatment and seeking reimbursement, these examinations may be necessary every 30 days to demonstrate medical necessity or lack there of. If not, adjustments are considered maintenance or preventative care which they do not cover according to their policy.

Medicare New Patient Examination and Intake	$100
Medicare 30 day evaluation to assess medical necessity	$50
Medicare Chiropractic Appointment and Adjustment (1-2 Region 98940)	$32
Medicare Chiropractic Appointment and Adjustment (3-4 Region 98941)	$40

Massage Therapy Fees at Time of Service*

Our massage therapists are professional independent contractors and not employees of Dr. Cockrell. If you are late for your appointment you may still be charged the full amount and the missed time forfeit, as it cannot be made up without interfering with the next patient's care.

(Our massage therapists are independent contractors. As a result, should you miss an appointment or cancel less than 24 hours prior, you may be charged a fee not to exceed $35)

Massage Therapy Session (per hour)	$60

Personal Injury Cases

Patients who are seeking treatment following a motor vehicle accident or other accident are required to pay at the time of service unless there is verified MedPay on the policy that can be billed or there is an active Lien signed with an attorney. The acceptance of any Lien or payment by Med-Pay is at the discretion of Dr. Cockrell. You are responsible for complete payment of the final bill including unpaid portions unless other arrangements are made.

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*All listed fees represent our cost reduction for payment at time of service. If payment is not received at the time of service, our normal fee schedule is implemented which is 150% of the fees listed on this schedule unless other arrangements have been made with Dr. Cockrell.

I have read, understand and am in agreement with the financial policies including both the Standard Financial Policy and the Payment at the Time of Service Policy. Any questions that I have had have been answered and I understand that payment is due at the time of service unless other arrangements have been made with Cockrell Family Chiropractic. This Financial Policy is subject to change at any time and you will be notified of any changes prior to receiving services related to the change.

*Your Signature*____________________________ *Today's Date*________________