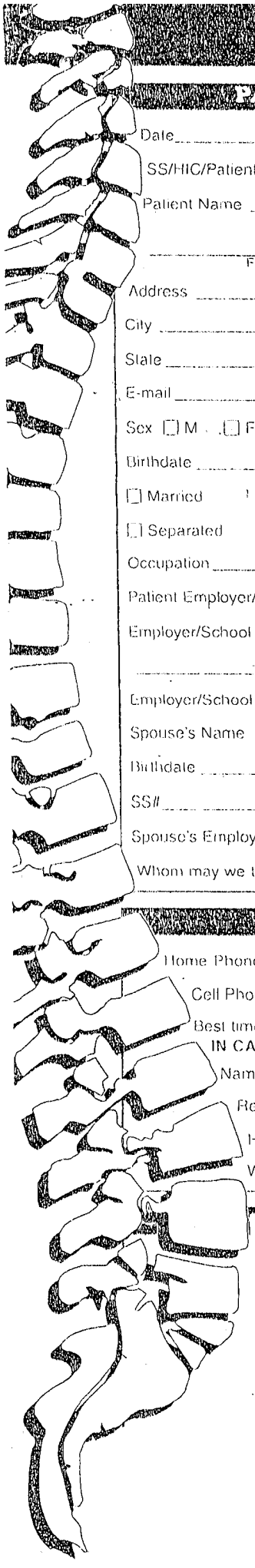
WELCOME



PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

Attorney Name (if applicable)

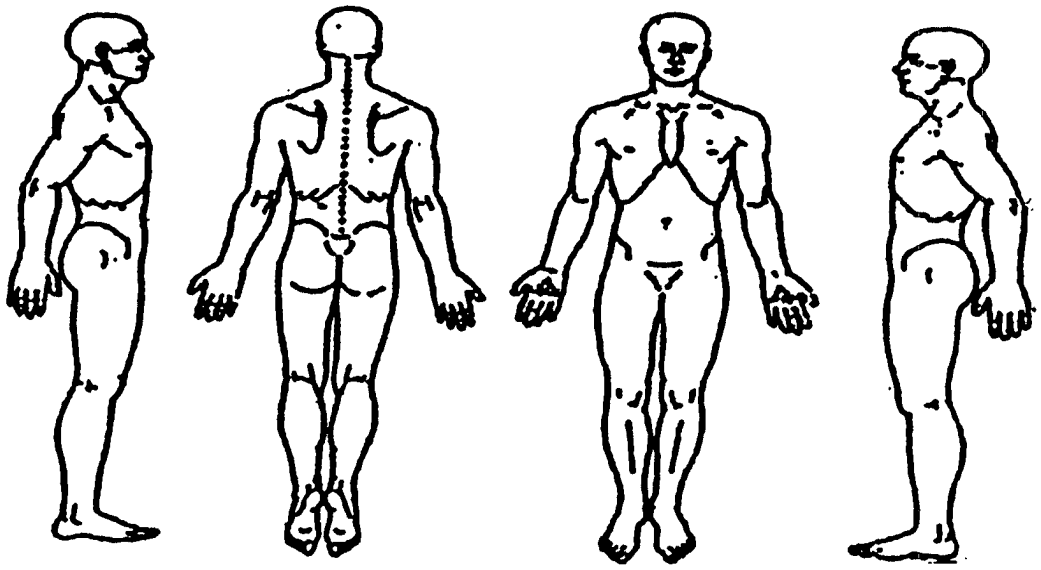
_____

Avicenna™
Laser Therapy Centers of Excellence
Revolutionizing Pain Management

PATIENT INTAKE FORM

Is today's problem caused by: □ Auto Accident □ Work Injury □ N/A

Indicate on the drawings below where you have pain/numbness/tingling symptoms:



Do you suffer from pain or numbness or tingling? __ Pain __ Numbness ___Tingling

How long have you been suffering with your pain/numbness/tingling?

_____

What treatments or surgeries have you already tried?

_____

_____

When do you suffer the most pain/numbness/tingling? (e.g. AM, PM, after walking, after activities, during sleeping, after sleeping)

_____

_____

Are you presently taking any medications for your condition? ____ yes ____ no
If so, what?

_____

_____

Patient Name: _____ **Date:** _____

How often do you experience your symptoms?

□ **Constantly** (76-100% of the time) □ **Occasionally** (26-50% of the time)
□ **Frequently** (51-75% of the time) □ **Intermittently** (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ Numb □ Dull □ Tingly □ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion □ Burning □ Stabbing with motion
□ Shooting □ Stiff □ Electric like with motion □ Other:_____

How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

How do you think your problem began?_____
_____
_____

Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

What aggravates your problem?_____
_____

What alleviates your problem?_____
_____

What concerns you the most about your problem; what does it prevent you from doing?_____
_____

Do you have x-rays and/or an MRI of the area of pain or numbness? ___ Yes ___ No
If yes, please bring them or the written report at your earliest convenience.

Patient Name: _____ **Date:** _____

What is your: Height_____ **Weight** _____ **Age** _____

Occupation _____

How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

Indicate if you have any immediate family members with any of the following:

□ **Rheumatoid Arthritis** □ **Diabetes** □ **Lupus** □ **Heart Problems** □ **Cancer**
□ **ALS**

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Upper Leg Pain	□	□ Bladder Control	□	□ Dermatitis/Rash
□	□ Hip Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		
□	□ Jaw Pain	□	□ Abdominal Pain		
□	□ Joint Pain/Stiffness	□	□ Ulcer		
□	□ Arthritis	□	□ Hepatitis		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ General Fatigue	□	□ Cancer		
□	□ Muscular coordination	□	□ Tumor	**For Females Only**	
□	□ Visual Disturbances	□	□ Asthma	□	□ HRT
□	□ Chronic Sinusitis	□	□ Dizziness	□	□ Birth Control
□	□ Other: _____			□	□ Pregnancy

Patient Name: _____ **Date:** _____

How have you taken care of your health in the past?

Medications
Routine medical
Exercise
Diet and Nutrition
Holistic
Vitamins
Chiropractic
Other: _____

How did the previous methods work for you? _____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel?

_____

_____

How does this problem interfere with the following areas in your life?

Work: _____
Family: _____
Hobbies: _____
Life: _____

Where do you picture yourself being in the next 3-5 years if this problem is ***NOT*** taken care of? Please be specific _____

_____

_____

Where do you picture yourself being in the next 3-5 years if this problem is taken care of? Please be specific (include anything that is part of your happiness: health, family, work, finances, travel, bucket list etc...)

_____

_____

_____

What potential barriers do you foresee that would prevent you from starting & finishing a treatment program?

_____

_____

_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____

_____

_____

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!

Patients Rights and Responsibilities

To comply with new federal regulations (HIPAA), this office has established procedures to make your identity and medical records more secure. Our only use of your personal information is for billing purposes and for proper medical treatment. We must have on record, a signed acknowledgement that you have read your rights and responsibilities as patients and that you understand them. Please contact the office staff if you have any questions.

Patients Rights:

* To receive service within a reasonable period of time.
* To receive medically necessary services.
* To be treated with respect and courtesy.
* To receive all available information about your care and treatment, including risks and options.
* To have your medical coverage explained to you.
* To have all medical and personal records treated as confidential.
* To participate in treatment decisions.
* To refuse treatment.
* To receive impartial access to treatment.
* To receive a second opinion regarding any treatment plan.
* To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges.
* To be given information on how to file a complaint/grievance.
* To formulate an advance directive if you have a life threatening illness or injury.
* To provide, or have provided for you, an interpreter in your primary language.

Patients Responsibilities:

* Having appropriate identification, insurance membership cards, coverage stickers, etc. at the time of appointment.
* Keeping appointments or contacting this office in advance to cancel an appointment.
* Fulfilling financial obligations at the time of service such as deductible or co-pay fees.
* Providing complete and accurate information.
* Following the health plan you and the physician agree on.
* Being considerate of others.
* Providing legal documentation of guardianship of a minor being treated.
* Providing a list of persons who may receive medical information about you, on your behalf, in an emergency.

Please sign and return this form to the front desk:

Patients Name _____ Date _____

Rappe Chiropractic, Inc.
78-474 Hwy 111 Suite C
La Quinta, CA 92253
760-777-4177 fax 760-777-4174

Informed Consent

Dear Patient,

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called INFORMED CONSENT.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, X-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc.

Stroke: Stroke is the most serious problem associated with Chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The result can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebrae artery stroke is called the "Extension-rotation-thrust atlas adjustment". ***We DO NOT do this type of adjustment on patients.*** Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol 37, No. 2, June 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average Chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally Chiropractic treatment (adjustments, traction etc.) will aggravate the problem and rarely surgery may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc. may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

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Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your X-rays. We adjust all patients very carefully, and especially those who have osteoporosis on the X-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heath and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for Chiropractic adjustments, traction, massage therapy, exercise etc. to result in temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change, it is not dangerous, but please tell your doctor about it.

Other problems: There may be other problems or complications that might arise from Chiropractic treatment other than those noted above. These problems occur so rarely that there are no available statistics to quantify their probability.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

_____ _____

Patients name printed Today's Date

_____ _____

Patients Signature Parent or Guardian
Signature if patient is a minor

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ (name of individual) consent to Rappe Chiropractic Inc's ("the practice's) use and disclosure of my protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this consent, "Protected Health information" means any information, including my demographic information, created or received by the practice, that relates to my past, present or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have a right to request a restriction on the use and disclosure of my protected health information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

Date _____

Rappe Chiropractic, Inc.

78-474 Hwy 111 Suite C
La Quinta, CA 92253

760-777-4177 fax 760-777-4174

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, (patients name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Rappe Chiropractic, Inc., which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received or maintained by the Practice.

_____ Date

_____ Signature

_____ Print Name

Standard Publicity Release Agreement

We have many success stories in our office and often patients wish to share these stories with other people. If you would like to share your story with others please read below:
I hereby grant you, Rappe Chiropractic Inc, all rights with this my irrevocable explicit approval to use my likeness, voice etc. as captured or edited, recorded and rendered in various audio, visual and written medium, to be used in commercial, instructional and promotional activities as Rappe Chiropractic Inc see fit. Rappe Chiropractic Inc. shall own 100% rights, titles and interest in resulting product and shall have the right to sell rights and transfer rights of the resulting product at their discretion.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and publicity release agreement. I have been told about the risks and benefits of Chiropractic, Laser treatment, Spinal Decompression and other procedures, and have had an opportunity to ask questions. 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.

_____ Patient Name

_____ Date

_____ Signature of Patient, Parent or Guardian