

Patient Name _____ Birthdate _____ Sex: M / F
Address _____ City _____
State _____ Zip _____ Phone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

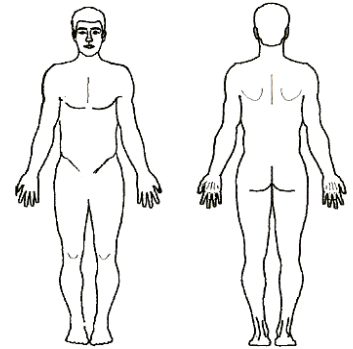
- Headache Neck Pain Mid-Back Pain Low Back Pain
 Other _____

Is this? Work Related Auto Related N/A

Date Problem Began _____

How Problem Began

Current complaint (how you feel today):
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain



How often are your symptoms present?

- (Occasional) 0 – 25% 26 – 50% 51 – 75% 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:

- Excellent Very Good Good Fair Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently Pregnant, # Weeks _____ |
| <input type="checkbox"/> Stroke (Date) _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tobacco Use - Type _____ |
| <input type="checkbox"/> Epilepsy/Seizures | Frequency _____/Day |
| <input type="checkbox"/> Other Health Problems (Explain) _____ | <input type="checkbox"/> Medications _____ |

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ Date _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I understand and I am informed that in the practice of chiropractic, as in the practice of medicine, there are some risks to treatment. Including but not limited to fractures, disc injuries strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment based on the facts known at the time of service based on my best interests, during the course of treatment.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below, I agree to the above named procedures. I consent to this 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:

_____ Date: _____
Patient's Name (Print) Patient's Signature

To Be Completed By Patients Representative If Patient Is A Minor Or Incapacitated:

_____ Date: _____
Parent or Legal Guardian's Name Parent or Legal Guardian's Signature

Female Patient's Only:

This is to certify that to the best of my knowledge, I am **NOT** pregnant and that Dr. Kelly Lucas **DOES** have my permission to take x-rays. (Please enter the first day of your last period): _____ / _____ / _____

_____ Date: _____
Patient's Signature

This is to certify that to the best of my knowledge, I **AM** pregnant and that Dr. Kelly Lucas **DOES NOT** have my permission to take x-rays. Please enter how many months/weeks pregnant you are: _____

_____ Date: _____
Estimated Due Date Patient's Signature

Name and Address of Clinic:
Coast Rehabilitation
1500 E. Katella Ave., Ste. G
Orange, CA 92867

Doctors Treating this Patient:
•Kelly K. Lucas, D.C.
Homa Bakhtar, D.C
John R. Kole, D.C

Financial Agreement

We would like you to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, we would like to explain how your medical bills will be handled. All patient portions of charges for treatment in this office are due and payable at the time the service is performed. The first visit is to be paid in full at the time of service for all patients with or without insurance benefits (except workman's compensation or personal injury). **Please Initial where it applies.**

Payment Plans

_____ **PRIVATE PAY:** I agree to pay for each visit at the time of service or I will agree to prepay for visits on a weekly/monthly basis. *Discounts are offered with prepaid visit plans. *

_____ **PRIVATE/GROUP INSURANCE:** I understand that the terms of my insurance policy are between the insurance company and myself. Should my insurance company deny any charges incurred, I will be personally responsible for payment for those services in full. I agree to pay my yearly deductible amount and my co-insurance amount at the time of service or prepay on a weekly/monthly basis. I will pay for the first visit in full at the time of service. That payment will be applied toward my yearly deductible, co-insurance amount or will be fully refunded if my insurance pays 100%. * As a courtesy our staff will verify your health insurance benefits but we cannot guarantee payment or the accuracy of benefits quoted.*

_____ **MEDICARE:** I understand that my Medicare insurance policy only covers 80% of allowed charges for spinal manipulation procedures performed by a chiropractor. Any and all other charges are considered not covered by Medicare. I agree to be personally responsible for payment of my deductible amount, my co-payment amount for covered services and for all non covered services such as: x-rays, vitamins/supplements, pillows or supports.

_____ **PERSONAL INJURY:** I agree to allow Dr. Kelly Lucas to submit all charges incurred for this accident to my automobile medical payment policy. I further agree that if no medical coverage is available with my auto insurance or if I exhaust my benefits, that I will be personally responsible to pay for all charges incurred. If medical coverage is not available on my auto insurance policy my private health insurance may be billed.

_____ **ATTORNEY LIEN:** I understand that Dr. Kelly Lucas has agreed to carry the balance of any unpaid charges on a lien with my attorney. I further understand that if I change attorneys or release this attorney prior to the settlement of my claim this agreement is void and I agree to pay the full balance due immediately.

_____ **3rd PARTY CLAIM (No Attorney):** I understand that I am making a claim against a 3rd party insurance policy and that this policy does not reimburse the doctor directly for any services incurred as a result of my claim. I agree that I am personally responsible to pay charges incurred on a daily/weekly/monthly basis or at the time of settlement of my claim.

_____ **WORKMAN'S COMPENSATION:** I understand that I am filing a worker's compensation claim. I also understand that if I do not follow the doctor's recommendations for care or if I miss appointments my claim may be denied. If my claim is denied because of my failure to follow the doctor's recommendation for treatment or because I miss appointments I understand I will be responsible and liable for the balance of the bill.

_____ **MISSED APPOINTMENT FEE:** I understand and Agree to pay a fee of \$25.00 upon a missed appointment that I did not cancelled within a 24 hr notice. I understand that this fee includes a massage appointment as well, if I did not cancel within the 24 hr period.

I further understand that if I suspend or terminate my care with this office, my balance will be immediately due and payable.

I Have Read And I Agree To The Above:

_____ Date: _____
Patient's Signature

To Be Completed By Patients Representative If Patient Is A Minor Or Incapacitated:

_____ Date: _____
Parent or Legal Guardian's Signature

WE CARE ABOUT YOUR PRIVACY

Dr. Kelly K. Lucas, DC
1500 East Katella Ave. Unit G
Orange, CA 92867
714-639-7654

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need those records to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

*These privacy practices are currently in effect and will remain in effect until further notice.

2. Our Legal Duty

Law Requires Us To:

1. Keep your medical information private.
2. Give you this notice describing our legal rights, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have The Right To:

1. Change our privacy practices and the terms of this notice at any time, provided that the law permits these changes.
2. Make the changes and the new terms of our privacy practices effective for all medical information that we keep, including information previously recorded or received before the changes.

Notice of Change To Privacy Practices:

Before we make any important changes we will change this notice and have the new notice available upon request.

3. Use and Disclosure of Your Medical Information

We have listed all of the different ways we are permitted to use and disclose medical information, however, not every use or disclosure will be listed, but we will not use or disclose your medical information for any purpose not listed below without your specific written authorization.

For Treatment:

We may use your medical information to provide you with medical treatment or services. We may disclose your medical information to doctors, technicians or other people who are taking care of you. We may also share your medical information to other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to your insurance or directly to you and may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our

health care operations. This might include evaluating the performance of employees, measuring and improving quality, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use your medical information for the following purposes.

Notification:

We may use or disclose your medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share the information about your location, general condition, or death. If you are present we will give you the opportunity to give or refuse permission, if possible before we share any information. In case of an emergency, and you are not able to give or refuse permission, we will use our professional judgment and share only the health information that is necessary for your health care. We will also use our professional judgment to make decisions about allowing someone else to pick up any medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share your medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one our affiliated fundraising foundations to contact you for fundraising purposes only. We will limit our use and sharing to information that describes you in general and not personal as well as the terms and dates of your health care. We will also provide you with a description on how you may choose not to receive any future fundraising communications.

Research in Limited Circumstances:

We may use your medical information for research purposes in where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

We may share medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization to help them carry out their duties.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use medical information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:

We may use or disclose your medical information in response to a court or administrative order, subpoena, discovery request or other lawful process under certain circumstances. Under limited circumstances, such as a court order, warrant, or a grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning medical information of a suspect, fugitive, material witness, and crime victim or missing person. We may share medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:

As required by law, we may disclose medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. The Food and Drug Administration for purposes of reporting events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:

We may use and disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or possible victim of other crimes. We may share your medical information to prevent a serious threat to your health or safety or the health or safety of others. When necessary we may share your medical information to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:

When authorized or necessary we may disclose medical information to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:

We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, administrative, civil, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:

We may disclose medical information to law enforcement officials under certain circumstances. These include reporting required by certain laws (reporting certain types of wounds),

pursuant to certain court orders or subpoenas, reporting limited information concerning identification and location at the request of a law official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:

We may use your information for the purposes of sending you postcards, reminder calls or texts reminding you of your appointments.

Alternative and Additional Medical Services:

We may use your medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend alternative treatments.

4. Your Individual Rights

You Have The Right To:

1. Get copies or look at certain parts of your medical information. You must make the request in writing and you may request that we provide copies in a format other than photocopies and we will try to use the format you requested unless it is not practical for us to do so. There may be charges for copying and for postage if you want the copies mailed to you.
2. Receive a list of all the times we or our business associates have shared your medical information for purposes other than treatment, payment, health care operations or other specified exceptions.
3. Request to place additional restrictions on our use or disclosure of your medical information. We are not required to agree to the additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request in writing that we communicate with you about your medical information by different means or to different locations.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons, and provide you with a written explanation. If we accept your request we will make reasonable efforts to tell others of the change and to include the changes in any future sharing of that information.

Questions And Complaints

If you have any questions or if you believe that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. You may submit a written complaint to the U.S Department of Health and Human Services. We will provide you with the address and not retaliate in any way if you choose to file a complaint.

Signature Below Is Acknowledgement That You Understand And Have Received This Notice Of Your Privacy Practices

Patient's Name (Print)

Patient's Signature

Date: _____

To Be Completed By Patients Representative If Patient Is A Minor Or Incapacitated:

Parent or Legal Guardian's Name

Parent or Legal Guardian's Signature

Date: _____