PATIENT INFORMATION & MEDICAL HISTORY

First Name _____ Last Name _____ Middle Initial ____ Sex (M / F)

Address _____
(number) (street) (city) (state) (zip code)

Social Security# _____-_____-_____ Birth Date ____ / ____ / _____ Age _____

Phone # (_____) _____ - _____ Cell # (_____) _____ - _____Email_____

Married ( ) Single ( ) Other ( ) _____ Spouse's Name _____

Occupation _____ Employer _____ Work Address_____

IN CASE OF AN EMERGENCY, CONTACT_____
Name Relationship Phone #

Have you ever had chiropractic care before? (YES / NO) If yes, when was your last treatment? _____

Have you ever had a professional massage before? (YES / NO) If yes, when was your last massage? _____

What are your health goals? (Check one of the following)

( ) Reduce symptoms only ( ) Reduce symptoms and show me how to prevent flair-ups ( ) Reduce symptoms, prevent flair-ups and maintenance care

Do you have any type of health insurance? (YES / NO) Primary Insurance _____ Secondary Insurance_____

Is this injury work related? (YES / NO) Is this injury due to a motor vehicle accident? (YES / NO)

*** IF YOU ANSWERED YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, PLEASE NOTIFY THE FRONT DESK ***

PAST YEAR MEDICAL HISTORY

*Check any of the following symptoms you are **currently experiencing or have experienced within the past 12 months.***

Musculoskeletal
__Low Back Pain
__Pain Between Shoulders
__Neck Pain
__Headaches
__Arm Pain/Numb/Tingling
__Leg Pain/Numb/Tingling
__Joint Pain/Stiffness
__Walking Problems
__Difficulty Chewing
__Weakness

EENT
__Vision Problems
__Dental Problems
__Sore Throat
__Ear Pain/Ringing
__Hearing Difficulty

General
__Allergies
__Loss of Sleep
__Fever/Night Sweats
__Eczema (skin rash)
__Weight Loss/Gain

Genitourinary
__Bladder Trouble
__Painful Urination
__ Excessive Urination
__Discolored Urine

Male Specific
__Difficulty Urinating
__Impotence
__Sterility

C-V-R
__Chest Pain
__Short of Breath
__Blood Pressure
__Heart Problems
__Wheezing
__Lung Problems
__Varicose Veins
__Arm/Leg Swelling
__Asthma
__High Cholesterol
__Bruise Easily

Female Specific
__Menstrual Irregularity
__Menstrual Cramping
__Sterility
__Breast Pain

Nervous
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion
__Depression
__Fainting
__Convulsions
__ADHD/Hyperactivity
__Anxious
__Tremor/Shaking

Gastrointestinal
__Gas/Bloating
__Heartburn
__Poor Appetite
__Excessive Appetite
__Excessive Thirst
__Decreased Appetite
__Colitis
__Vomiting
__Diarrhea
__Constipation
__Black/Bloody Stool
__Hemorrhoids
__Liver Problems
__Abdominal Pain
__Frequent Nausea

*****ARE YOU PREGNANT? (YES / NO)*****

Name of your family physician _____Last appointment with your physician _____Phone # _____
Do you give us permission to send your medical doctor an updated report on your health status? (YES / NO)
Have you been hospitalized in the past? (YES / NO) If yes when and why? _____
Please list any surgeries you have had and when.

_____
Please list any medications you are taking.

_____

PATIENT SIGNATURE _____ **DATE** _____

SUBJECTIVE COMPLAINTS / INTENSITY / FREQUENCY

Name _____ **(Complete sections 1-6)** Date _____

1. What is your **WORST** complaint or symptom? _____

When and **How** did this condition begin? _____

Rate your pain/discomfort on the scale. (circle) (no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (severe pain)

What % of the day or **Frequency** of this symptom experienced? (circle below)

0-5 6-10 11-15 16-20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70 71-75 76-80 81-85 86-90 91-95 96-100

Is this condition and symptom changing? (circle) **Improving** **Not Changing** **Worsening**

2. What is your **SECOND WORST** complaint or symptom? _____

When and **How** did this condition begin? _____

Rate your pain/discomfort on the scale. (circle) (no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (severe pain)

What % of the day or **Frequency** of this symptom experienced? (circle below)

0-5 6-10 11-15 16-20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70 71-75 76-80 81-85 86-90 91-95 96-100

Is this condition and symptom changing? (circle) **Improving** **Not Changing** **Worsening**

3. What is your **THIRD WORST** complaint or symptom? _____

When and **How** did this condition begin? _____

Rate your pain/discomfort on the scale. (circle) (no pain) = **0 1 2 3 4 5 6 7 8 9 10** = (severe pain)

What % of the day or **Frequency** of this symptom experienced? (circle below)

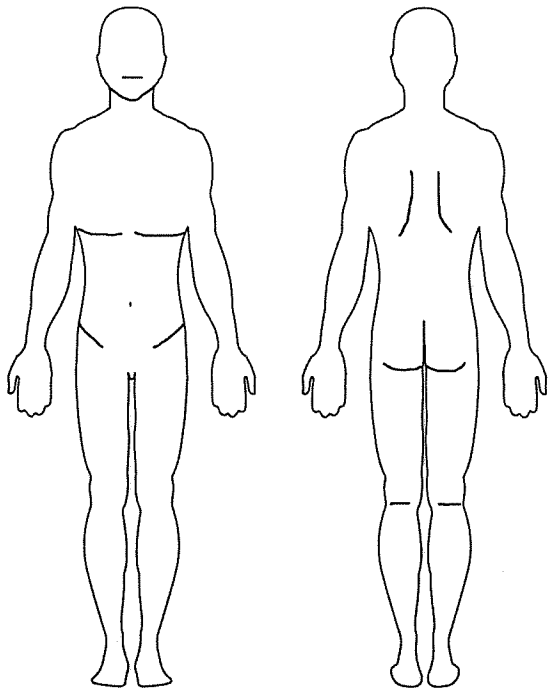
0-5 6-10 11-15 16-20 21-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66-70 71-75 76-80 81-85 86-90 91-95 96-100

Is this condition and symptom changing? (circle) **Improving** **Not Changing** **Worsening**

4. Please indicate on the diagram to the right where you experience your symptoms using the key below.

KEY: Pain XXX Numbness OOO Tingling √ √ √

Stiffness / / / Burning + + + Stabbing SSS



5. Include additional symptoms using the same format as above. For each symptom, please rate your pain/ discomfort 1-10, % frequency, & if improving, not changing or worsening:

4th Complaint/ Symptom: _____

_____

5th Complaint/ Symptom: _____

_____

6th Complaint/ Symptom: _____

_____

6. **Patient Signature:** _____

NEW PATIENT CURRENT COMPLAINTS & PAST HISTORY

Name _____ **(Complete #1-5)** Date _____

1. **CURRENT COMPLAINTS:** Please describe how your **CURRENT** condition(s) or symptom(s) began:

_____

_____

_____

2. Who have you seen for these **CURRENT** symptoms? (If Yes, check below which apply and continue section)

___No One ___Medical Doctor ___Chiropractor ___Physical Therapist ___Other (Describe)_____

Please list any names of providers seen for this current complaint: _____

What treatment(s) did you receive and when? _____

Circle any diagnostic testing have you had for your symptoms?

(X-Rays) date:_____ (CT Scan) date:_____ (MRI) date:_____ (Other) _____

3. **PAST HISTORY:** Have you had similar symptoms in the **PAST or SIGNIFICANT injuries**? (YES / NO) (If Yes, continue section)

If Yes, what symptom or condition did you have in the past: _____

Was this past condition due to an accident or injury? (YES / NO) If yes, describe injury and approximate date: _____

_____

When was the last time you experienced those symptoms? _____

How long did those past symptoms last for? _____

Did you condition require any surgeries? (YES / NO) If Yes, When was the surgery: _____

Did your symptoms and condition(s) resolve? (YES / NO) If No, what condition remained: _____

Did you see a medical provider / chiropractor or other specialist for that past condition? (YES / NO)

If Yes, who did you see? (Please list names of providers)

Name: _____ Specialty: MD / DC / PT Name: _____ Specialty: MD / DC / PT

Name: _____ Specialty: MD / DC / PT Name: _____ Specialty: MD / DC / PT

4. What is your occupation? _____ Are you required a disability note for your employer / teacher? (YES / NO)

5. **Family History:** Does anyone in your immediate family (including your grandparents) have any of the conditions listed?
(Circle all that apply) **Arthritis, Asthma, Birth Defects (i.e. heart defects), Cancer, Diabetes, Genetic Conditions (i.e. Cystic Fibrosis), Heart Disease, Mental Illnesses (i.e. Alzheimer's, Parkinson's), Obesity, Osteoporosis, Seizures**

DOCTORS NOTES: _____

Kyle Tetz Chiropractic Inc.—410 S. Melrose Dr. Ste 200, Vista, CA 92081—Ph: 760.630.8060

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.

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

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

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

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.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGEMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES AND PATIENT'S FREEDOM OF CHOICE

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules and different treatment techniques. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Patients are free to choose any doctor or organization that may be recommended by our doctors. You do not have to use the facilities at our office for treatments and we can assist you on finding an alternative locations or sources.

KYLE TETZ CHIROPRACTIC INC. (CURRENT CUSTOMARY FEE SCHEDULE OF OUR MOST COMMON FEES)

You may request a statement or receive an insurance explanation of benefits (EOB) which will reflect services provided and the associated insurance billing codes which are shown below. According to (California Business and Professions Code 657), we offer a "Pay at Time of Service Discount" which you may qualify for. If you have any questions, please discuss them with our office manager. All fees may change without notice.

Initial Exam *(New Patient)*	99201 Limited	$70.00	**Re-Exam** *(Established Patient)* *(Treated within 3 years)*	99211 Minimal	$35.00
	99202 Expanded	$120.00		99212 Limited	$70.00
	99203 Detailed	$170.00		99213 Expanded	$120.00
	99204 Comprehensive	$260.00		99214 Detailed	$170.00

Chiropractic Adjustments	98940	$45.00 1-2 regions	**Manual Therapies**	97140	$45.00			
	98941	$65.00 3-4 regions				**Electrical Muscle Stimulation**	97014	$25.00
	98942	$83.00 5 regions	**Therapeutic Exercises**	97110	$50.00 / Unit			
	98943	$43.00 Extremities						
			Therapeutic Activities	97530	$65.00 / Unit	**Ultrasound**	97035	$22.00
Massage	97124	$45.00 / Unit						
	Ex. 30 min = $90.00		**Mechanical Traction**	97012	$25.00	**Neuromuscular Ed**	97112	$55.00

X-Rays	**Cervical Spine**		**Thoracic Spine**			**Lumbar Spine**		
	72040	$110.00 2-3 views	72070	$110.00	2 views	72100	$120.00	2-3 views
	72050	$145.00 4 views	72072	$125.00	3 views	72110	$145.00	4 views
	72052	$170.00 5 views				72114	$170.00	6 views

Summary Reports ($50 per page- typically 3-6 pages) **All X-ray fees are not listed such as extremities. Ask the front desk for these fees.

PRINT NAME _____ SIGNATURE _____ DATE _____

ProRehab Integrated Healthcare Specialists LLC

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of _____**ProRehab Integrated Healthcare Specialists LLC.**

I understand that the Notice describes the uses and disclosures of my protected health information by **ProRehab Integrated Healthcare Specialists LLC** and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*