CHIROPRACTIC NEUROLOGY CENTER

Dr. Shad J. Groves DC, DACNB, FACNB

Dr. Karin Kim DC

Cancellation Policy for first appointment only

Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients who may have an immediate need to our care. Of course we understand emergencies happen and will gladly accommodate any patient if we can. Your health and well-being is always our first priority.

There is a $50 cancellation fee if you are a no-show, or fail to reschedule more than 24 hours prior to your new patient appointment. Please note that appointment space is limited daily, therefore, we have a strict schedule. This means it is vital that you arrive for your appointment at the scheduled time. It is important for doctor to have the full appointment time with you, as our appointments are scheduled back-to-back.

If you are uncertain if you can make your appointment on time please call our office at 562-997-0966 and we will make other arrangements with you.

New Patients: Remember to arrive 10 to 15 minutes before your appointment time for paperwork and set-up.

Chiropractic Neurology Center
Dr. Shad J. Groves, DC, DACNB, QME / Dr. Karin Kim, DC

Date: _____ [For Office Personnel – Patient Acct #: _____]

Patient Name: _____ I preferred to be called: _____

Address: _____

Date of Birth: _____ Sex: Male or Female Age: _____

Social Security Number: _____

Marital Status: Single Married Separated Divorced Widowed Student Minor

Spouses Name: _____ Children / Ages? _____

Whom may we thank for referring you? (ie yellow pages, friend, online, insurance directory, etc..)

_____

Occupation: _____ Employer: _____

Employer Address: _____

Phone Numbers / Contact Information: Please indicate only the numbers and/or email address which our office is authorized to reach you at as required by the Federal HIPPA laws:

Home: (____) ____ - _____

Work: (____) ____ - _____

Cell: (____) ____ - _____

Email: _____

PATIENT CONDITION

Reason for your visit today: _____

Related to: (Circle One) Work Sport Auto Accident Trauma Chronic

Is this due to an accident? Y / N If so, when did accident occur? _____

When did your symptoms appear? _____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation?

If so, please explain: _____

Have you had this or similar conditions in the past? Yes / No

How often do you have this pain? _____

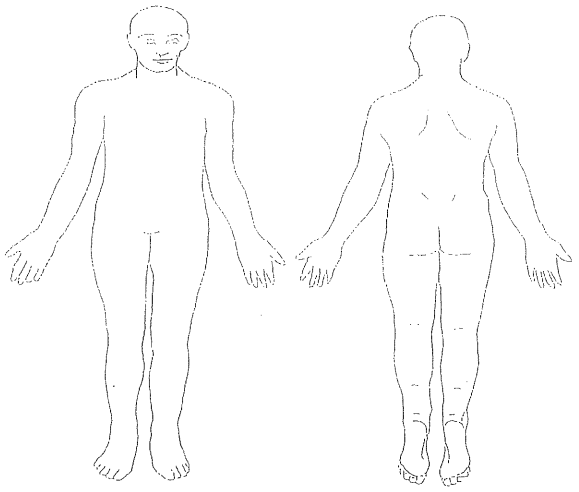
Activities and movements that are painful to perform?

☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Other: _____

Please indicate on the picture where your pain / symptoms appear using the following markings:

Circle any area of pain not represented by a symbol.

Description >>>	Numbness	Pins&Needles	Burning	Aching	Stabbing
	NNNN	PPPP	BBBB	AAAA	SSSS



HEALTH HISTORY

Have you been seen for this condition by another Healthcare Provider? ☐Yes ☐No

If so, please list the name of and address of other providers whom you have seen for your condition.

_____

Name Address Phone

Are you currently pregnant? ☐Yes ☐No Are you left or right handed? Please circle.

Do you exercise? ☐None ☐1-2 times per week ☐3-4 times per week or more

What type of work environment are you exposed to?
☐Standing ☐Sitting ☐Light Labor ☐Heavy Labor ☐Other_____

What is your stress level? ☐High ☐Moderate ☐Low ☐None

Do you smoke? Packs/Day_____

Do you consume alcohol? Drinks/Day_____

Do you consume coffee or Caffeine Cups/Day _____

Medications:
Please list any medications you are currently taking, including dosage:

Medication	Dosage	Medication	Dosage
Medication	Dosage	Medication	Dosage

Place a an X on Yes or No to make us aware if you have had or have any of the following conditions:

AIDS / HIV	☐Yes ☐No	Gonorrhea	☐Yes ☐No	Pneumonia	☐Yes ☐No
Alcoholism	☐Yes ☐No	Gout	☐Yes ☐No	Polio	☐Yes ☐No
Allergy Shots	☐Yes ☐No	Heart Disease	☐Yes ☐No	Prosthesis	☐Yes ☐No
Anemia	☐Yes ☐No	Hepatitis	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Anorexia	☐Yes ☐No	Hernia	☐Yes ☐No	Problems	☐Yes ☐No
Appendicitis	☐Yes ☐No	Herniated Disk	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Arthritis	☐Yes ☐No	Herpes	☐Yes ☐No	Rheumatoid Fever	☐Yes ☐No
Asthma	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Slurred speech / Speech problems	☐Yes ☐No
Blurred Vision	☐Yes ☐No	Liver Disease	☐Yes ☐No	Stroke	☐Yes ☐No
Breast Lump	☐Yes ☐No	Loss of Consciousness	☐Yes ☐No	Suicide Attempt	☐Yes ☐No
Bronchitis	☐Yes ☐No	Measles	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Bulimia	☐Yes ☐No	Migraine Headaches	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Cancer	☐Yes ☐No	Miscarriage	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Cataracts	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Tumors, Growths	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Momentary Blackouts	☐Yes ☐No	Typhoid Fever	☐Yes ☐No
Chicken Pox	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Ulcers	☐Yes ☐No
Diabetes	☐Yes ☐No	Mumps	☐Yes ☐No	Vaginal Infections	☐Yes ☐No
Difficulty Swallowing	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Dizziness	☐Yes ☐No	Pacemaker	☐Yes ☐No	Whooping Cough	☐Yes ☐No
Emphysema	☐Yes ☐No	Parkinson's Disease	☐Yes ☐No	Other _____	
Epilepsy	☐Yes ☐No	Pinched Nerve	☐Yes ☐No	_____	
Fractures	☐Yes ☐No				
Glaucoma	☐Yes ☐No				
Goiter	☐Yes ☐No				

FAMILY HEALTH HISTORY

Has anyone in your family have or has ever had any of the following: (List the family member)

☐ Cancer (Type) _____
☐ Diabetes _____
☐ High Blood Pressure _____
☐ Glaucoma _____
☐ Migraines: _____
☐ Congenital Heart Defects _____
☐ Arthritis (Type) _____
☐ Low Blood Pressure _____
☐ Stroke/ Heart Attack _____
☐ Other: _____

Activities of Daily Living

Please indicate on a scale from 1 to 10, with 10 being the worst pain, each activity which you have difficulty performing and/or can perform only with pain.

HOUSEWORK
_____ Doing Laundry
_____ Making beds
_____ Vacuuming
_____ Washing dishes
_____ Ironing
_____ Carrying groceries
_____ Caring for pets
_____ Cooking
_____ Other _____

YARDWORK
_____ Mowing lawn
_____ Shoveling dirt
_____ Raking leaves
_____ Gardening

GENERAL
_____ Walking
_____ Standing
_____ Running
_____ Sitting
_____ Lifting children
_____ Bending
_____ Climbing stairs
_____ Reading
_____ Lying in bed
_____ Chewing
_____ Swimming
_____ Sports; List: _____

PERSONAL GROOMING
_____ Combing hair
_____ Shaving
_____ In/out bathroom
___Brushing teeth
_____ Other _____

TRAVEL
_____ Driving
_____ Riding (Passenger)

Minutes per day
Type of vehicle
_____ Auto
_____ Train
_____ Bus
_____ Truck
_____ Airplane

_____ Getting in and out of auto
_____ Playing piano
_____ Using computer keyboard
_____ Kneeling
_____ Sexual intercourse
_____ Exercising
_____ Sleeping
_____ Using Telephone

Please list any other difficulties you are experiencing with activity:

_____

INSURANCE

Our office will gladly assist you in filing your insurance claims. Your insurance will be billed based on services rendered. In most cases, we may accept assignment, which means that a portion of your account can be paid directly from your insurance company. Please understand that you are responsible for all charges incurred regardless of the filing arrangements, settlements or claim disputes.

I, the undersigned, certify that I (or my dependent) have insurance coverage through _____, and assign directly to Groves Chiropractic, Inc DBA Dr. Shad Groves, DC, DACNB, QME, Dr. Karin Kim, DC or Chiropractic Neurology Center 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 hereby authorize Chiropractic Neurology Center to release all information necessary to secure payment of benefits which may include the staff of Chiropractic Neurology Center speaking with my insurance to authorize treatment and expedite claims processing. I authorize the use of my signature below on all insurance submissions.

Our office is required to have your signed and dated permission. This authorization may be revoked by you at any time, by advising our office (privacy officer) of this revocation in writing. If you choose to not sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, or enrollment, however, you will be required to do your own billing.

Primary Insurance

Name of Insured: _____ Relationship: _____

Name of Insurance: _____ Group # _____

Member ID No.: _____

Secondary Insurance

Name of Insured: _____ Relationship: _____

Name of Insurance: _____ Group # _____

Member ID No.: _____

Signature of Patient (Parent or Guardian, if minor) _____

Date: _____

Please notify our office staff if you are being seen today due to a personal injury, Work. Comp. or Medicare case. Thank you.

In the case of an emergency whom may we contact? Please list the name, address, phone number and relationship of the individual listed.

Emergency Contact:

Name: _____ Phone: _____

Address: _____

Relationship: _____

Alternate Emergency Contact:

Name: _____ Phone: _____

Address: _____

Relationship: _____

AUTHORIZATION TO VERBALLY COMMUNICATE WITH A FAMILY MEMBER/FRIEND

Our office is required by the Federal HIPAA Laws to have you sign whether you desire to have your PHI discussed with a family member or friend. If you authorize our office to speak with a family member or friend please indicate the name of the person, relationship to you and what may be discussed. If you have any aspects of your PHI that you do not want disclosed, please list the specific aspects of your PHI below that you want "restricted." This authorization may be revoked by you at any time, by advising our office (privacy officer) of this revocation in writing. If you choose to not sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

☐ YES, I authorize verbal communication with the following person(s):

☐ Verbal ☐ Telephone No:
Name of Family or Friend: _____
(relationship)

PHI Restrictions: _____

☐ Verbal ☐ Telephone No:
Name of Family or Friend: _____
(relationship)

PHI Restrictions: _____

Patient Signature: _____ Date: _____

Expiration Date/Event for Authorization:
☐ No expiration date.
☐ Date: _____

Chiropractic Neurology Center
Dr. Shad J Groves DC, DACNB, FACFN
1225. E. Wardlow Rd
Long Beach, CA 90807
562-997-0966
562-981-6637 Fax

Protected Health Information (PHI) Authorization

The Health Insurance Portability and Accountability Act (HIPAA) require that all health care providers comply with patient privacy laws. Patient confidentiality and privacy applies to any protected health information (PHI). Federal laws now require signed and dated authorization from patients in several aspects of patient care, transmission of medical information, confidentiality, and patient rights relating to their medical records. In order for this authorization to be valid you must sign and date and indicate an expiration date or event for your authorization. The privacy rules require that the doctor post the notice in a prominent place.

Privacy Notice

I acknowledge that Chiropractic Neurology Center (CNC) located at 1225 E. Wardlow Rd. Long Beach, CA 90807, has presented me with a copy of their privacy practices and I have been able to read the practice policies notice that has been provided. This notice explains how my protected health information (PHI) may be used and what Chiropractic Neurology Center's responsibilities are regarding my privacy rights. I have been allowed to request a printed sheet of Chiropractic Neurology Center's privacy notice. Indicate whether you are the parent or a legal guardian of the patient or minor.

Patient's Name_____ Date_____
Print

Patient's Signature_____

Legal Parent/Guardian Name _____
Print

Legal Parent/Guardian Signature_____

Expiration Date_____

Dr. Shad J. Groves, DC, DACNB
Dr. Karin Kim, DC
1225 E. Wardlow Road
Long Beach, CA 90807
562-997-0966 / Fax 562-981-6637

Authorization to Use or Disclose Protected Health Information

Patient Name:_____

Address:_____

Date of Birth:_____ Patient File #:_____

As required by the Privacy Regulations, this facility may not use or disclose your protected health information except as provided in our Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my PHI to the following person (s), entity (s), or business associates of this office:

_____

Patient Health Information authorized to be disclosed:

Chart notes: _____ History / Exam Evaluation: ____ X-Ray / MRI Films: ____

Narrative / Supplemental Reports: ____Other:_____

For the specific purpose of: (describe in detail & check all that apply):

__At the request of the individual (no purpose need be specified) __Additional / Coordination of Medical Care

__Insurance Eligibility/ Benefits __Change of Provider __Legal Investigation or Action

__Other (Specifiy):_____

Effective Dates for this authorization: __/__/__ through __/__/__.

This authorization will expire at the end of the above period. However, I further understand that the information disclosed above may be re-disclosed to additional parties and no longer protected due to reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that the revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this auth.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of PHI being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____

Signature of Patient or Pt's Authorized Representative Date

_____

Authorized Signature of Facility Date

Chiropractic Neurology Center (CNC)
Dr. Shad J Groves DC, DACNB, FACFN
Dr. Karin Kim DC
1225 E Wardlow Rd.
Long Beach, CA 90807

INFORMED CONSENT TO TREAT / CONSULTATION TREATMENT & CARE

I hereby request and consent to the performance of a chiropractic neurology examination, including but not limited to diagnostic x-rays on me, or the patient named below, for whom I am legally responsible to sign for. This consent is made to be performed by one of the doctors of chiropractic named above.

I further request and consent for various modes of physical therapy and chiropractic neurology procedures/techniques by the chiropractor named above / or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as a back up or in consultation with the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office, hospital, clinic or location. Our office is required by the Federal HIPAA (Health Insurance Portability and Accountability Act of 1996) laws to have your signed and dated permission to let other team member's access you're PHI (Protected Health Information). This authorization to allow other healthcare provider's access to your PHI for diagnosis and treatment may be revoked by you at any time, by advising our office (privacy officer) of this revocation in writing.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor(s) to be able to anticipate and explain all risks and complication, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at this time, based upon the facts known then, is in my best interest.

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-name 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 ant CNC.

Patients Name_____ Date _____
Print

Patients Signature_____

Witness Name_____ Date_____
Print

Witness Signature_____