CHIROPRACTIC NEUROLOGY CENTER

Dr. Shad J. Groves, DC, DACNB, FACFN, MS-ClinNeurSci • Dr. Karin Kim, DC, MS-ClinNeurSci • Dr. Cindy Downing, DC, DACNB

CANCELLATION POLICY FOR FIRST APPOINTMENTS 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 the appointment slot to other patients who may have an immediate need for care. Of course, we understand emergencies happen and will gladly accommodate any patient to the best of our abilities. Your health and well-being are always our priority.

There is a **$50 cancellation fee** if you're 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.

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New Patient Information

Date | For office personnel - Pt. Acct. # | I prefer to be called | SSN

Name (First, M.I., Last) | Address (City, State, Zip)

DOB | Age | Gender | Spouse's Name

Marital Status

○ Single ○ Married ○ Separated ○ Divorced ○ Widowed ○ Student ○ Minor

Children / Ages | Mobile | Work

Home | Email

Employer Address

Whom may we thank for referring you? (i.e. Friend, Google, Yelp, Insurance Directory, etc.)

PATIENT CONDITION

Reason for your visit today

Related to (circle/check all that apply)

☐ Work ☐ Sport ☐ Auto Accident ☐ Trauma ☐ Chronic

Is this due to an accident? ○ Yes ○ No

If yes, when did it occur?

When did your symptoms begin to appear?

Is this condition getting worse? ○ Yes ○ No

Have you had this, or similar conditions before? ○ Yes ○ No

Is this condition interfering with (circle/check all that apply)

☐ Work ☐ Sleep ☐ Daily Activity

If so, please explain

How often do you have pain?

○ Occasional ○ Intermittent ○ Frequent ○ Constant

Vitals (For Doctor/Office Staff to fill out)

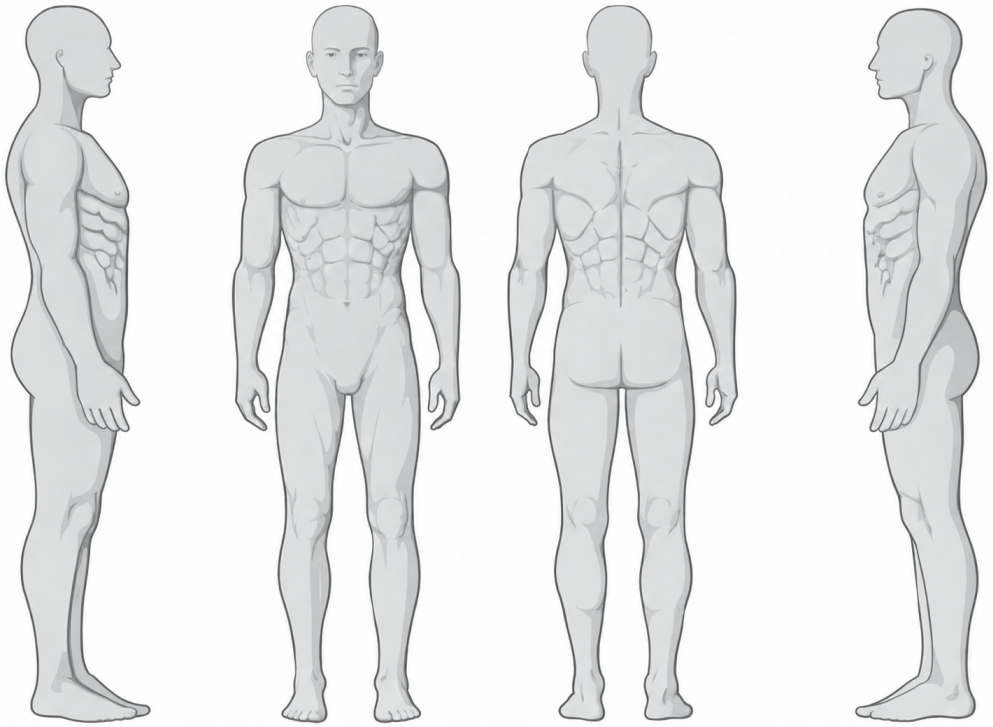
BP Left | P | BP Right | P | H | W

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Body Pain Map / Health History

Please indicate on the picture where your pain / symptom appears using the following markings. Please circle any areas of pain not represented by a symbol.

N Numbness **P** Pins & Needles **B** Burning **A** Aching **S** Stabbing



Right lateral Front Back Left lateral

HEALTH HISTORY

Have you been seen for this condition by another health care provider?
○ Yes ○ No

Name, Address & Phone number of other providers whom you have seen for this condition

Are you currently pregnant?
○ Yes ○ No

I am
○ Left Handed ○ Right Handed

Do you exercise?
○ None ○ 1-2 times/week
○ 3-4 times/week ○ 5+ times/week

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?
○ Yes ○ No

Packs/Day

Do you drink Alcohol?
○ Yes ○ No

Drinks/Day

Do you consume coffee/caffeine?
○ Yes ○ No

Cups/Day

Medications (Please list Name AND Dosage)

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Health History Continued

Please check any of the following to make us aware of any Past or Current Conditions you may have.

- [ ] Headaches
- [ ] Joint Pain/Swelling
- [ ] Neck Pain
- [ ] Menstrual Difficulties
- [ ] Brain Fog
- [ ] Breathing Problems
- [ ] Sleeping Problems
- [ ] Fatigue
- [ ] Back Pain
- [ ] Lights Bother Eyes
- [ ] Nervousness
- [ ] Ears Ring
- [ ] Tension
- [ ] Broken Bones/Fractures
- [ ] Irritability
- [ ] Rheumatoid Arthritis
- [ ] Chest Pains/Tightness
- [ ] Excessive Bleeding
- [ ] Dizziness
- [ ] Osteoarthritis
- [ ] Shoulder/Neck/Arm Pain
- [ ] Pacemaker
- [ ] Numbness in Fingers
- [ ] Numbness in Toes
- [ ] Stroke/Heart Attack
- [ ] Ruptures
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Cancer
- [ ] Other: _____

- [ ] Coughing Blood
- [ ] Weakness in Extremities
- [ ] Gall Bladder Problems
- [ ] Loss of Balance
- [ ] Ulcers
- [ ] Fainting
- [ ] Weight Loss/Gain
- [ ] Loss of Smell
- [ ] Depression
- [ ] Loss of Taste
- [ ] Loss of Memory
- [ ] Unusual Bowel Patterns
- [ ] Buzzing in ears
- [ ] Feet Cold
- [ ] Hand Cold
- [ ] Circulation Problems
- [ ] Seizures/Epilepsy
- [ ] Arthritis
- [ ] Alcoholism
- [ ] Muscles Spasms
- [ ] Drug Addiction
- [ ] Frequent Colds
- [ ] HIV / AIDS
- [ ] Fever
- [ ] Sinus Problems
- [ ] Diabetes
- [ ] Indigestion Problems
- [ ] Eating Disorder
- [ ] Difficulty Urinating

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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
- [ ] Type of Vehicle: Train
- [ ] Type of Vehicle: Bus
- [ ] Type of Vehicle: Truck
- [ ] Type of Vehicle: Airplane

ADDITIONAL ACTIVITIES

- [ ] Getting in/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

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Emergency Contacts / Verbal PHI Authorization

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

Contact No. 1

Name

Phone

Address

Relationship

Contact No. 2

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 wanted "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 effects on your treatment, eligibility for benefits, enrollment, or payment.

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

Contact No. 1

Relationship

Telephone No.

PHI Restrictions

Contact No. 2

Relationship

Telephone No.

PHI Restrictions

Patient Signature

Date

Expiration Date/Event for authorization

No expiration date

☐ NO expiration date

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

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, 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 represented 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.

(Please indicate whether you are the parent or legal guardian of the patient or minor.)

Patient's Name

Date

Patient's Signature

Legal Parent/Guardian Name

Legal Parent/Guardian Signature

Expiration Date

Informed Consent to 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). This consent is made to be performed by one of the Doctor(s) of Chiropractic named above, and/or other licensed doctors of chiropractic and support staff who now, or in the future, provide treatment to me while employed by Chiropractic Neurology Center.

I understand and I 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 doctors to be able to anticipate and explain all the risks and complications. I wish to rely on the doctors to exercise judgment during the entire course of treatment, based upon the facts known at the time of treatment, that is in my best interest.

I further request and consent for various modes of physical therapy and chiropractic neurology procedures/techniques performed by the chiropractor named above, and/or other licensed doctors of chiropractic, who now or in the future may provide treatment while employed by Chiropractic Neurology Center, working or associated with, or serving as a backup 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. Chiropractic Neurology Center is required by federal HIPAA laws to have your signed and dated permission to access your PHI (Protected Health Information). This authorization to allow other healthcare providers access to your PHI for diagnosis and treatment may be revoked by you at any time, by advising our office of this revocation in writing.

I have read and understand the above consent. I have also had an opportunity to ask any and all questions about this consent, and by signing below I agree to the treatment and/or procedures recommended by any and all providers at Chiropractic Neurology Center. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name

Guardian Name

Relation to Patient

Patient/Guardian Signature

Date

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Patient Financial Responsibility Agreement

Chiropractic Neurology Center • Groves Chiropractic, INC
Dr. Shad Groves, DC, DACNB, FACFN • Dr. Karin Kim, DC
1225 E Wardlow Rd., Long Beach, CA 90807 • P: 562-997-0966 • F: 562-981-6637 • office@neurochiro.com

Patient Name | DOB | Acct #

Chiropractic Neurology Center is committed to providing quality care and service to all our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document and fully understand your responsibility as a patient, initial each policy, then sign and date below.

- ☐ **Self-Pay/CASH Patient Services**: I understand that if I am a CASH Patient or the office is not a Network Provider of my current insurance policy; I am responsible for the full Cash Patient Service amounts. I understand Chiropractic Neurology Center will expect payment in full for services rendered at time of service.
- ☐ **Insurance Information**: I understand that as a patient, it is my responsibility to supply the current and correct insurance card at time of service, or to update any incorrect information on file. Failure to provide this information may result in service charges being fully my responsibility.
- ☐ **Insurance Deductibles/Coinsurance/Co-payments/Non-Covered Services**: I understand that all required patient responsibility amounts applied by my insurance company after processing of claims are my financial responsibility. These amounts are not negotiable, and an estimate of balance due may differ from the final insurance processing. Furthermore, I understand that services not covered by my insurance policy will fully be my responsibility and will either be paid in full at time of service or after insurance has processed my claim. I understand Chiropractic Neurology Center will expect payment in ful full of the estimated patient responsibility at time of service, or after my claim has fully processed by insurance. Any overpayment will result in a credit to my account for future services.
- ☐ **Referrals & Authorizations**: I understand that it is ultimately the responsibility of myself as the patient, to verify if any referral or authorization is required by my insurance policy before any services are rendered by Chiropractic Neurology Center. I understand Chiropractic Neurology Center will do their best to inform me of such requirements prior to services rendered, but ultimately if services are denied for such requirements, I will be held financially responsible for said service(s).
- ☐ **Minors**: I understand services rendered to minor patients, I as the Parent/Guardian am responsible for all payments at time of service or applied as patient responsibility resulting from service rendered.
- ☐ **Late Cancellation/No Show Policy**: I understand that if I do not cancel any scheduled appointment at least 24 hours in advance, or no show a scheduled appointment I will be charged a Late Cancellation Fee/No Show Fee. These fees are based on the services scheduled and vary. A list of these fees will be readily available by the front desk staff at my request. Habitual Late Cancellation/No Show of appointments will result in dismissal from the practice.
- ☐ **Delinquent Account**: I understand it is my financial obligation as a patient that I must pay in full or settle any balances prior to any additional services being scheduled/rendered. Failure to bring my account current within 90 days of statement, can result in my balance being sent to a collection agency, and/or being dismissed from the practice.

I have read and agree to all financial policies of Chiropractic Neurology Center, and understand I am bound to these terms of my financial obligation as a patient. I also understand that Chiropractic Neurology Center has the right to amend these policies at any time.

Printed Name of Responsible Party | Relation to patient

Responsible Party Signature | DATE