Patient Registration

CONTACT INFORMATION

Full Name_____ Date of Birth_____

Street Address_____

City_____State_____ZIP_____

Phone Number_____Type: Mobile____Home____Work____

Email Address_____ Gender: M____F____

Employer's Name_____ Occupation_____

Employer's Phone_____ Employer'Address_____

Spouse's Name_____ Spouse's Occupation_____

Names of Children_____Ages of Children_____

Marital Status: Married____Single____Widowed____Divorced____

How did you find out about Dr. Val?_____

EMERGENCY CONTACT

Contact Name:_____Contact Phone Number:_____

Contact Address:_____Relationship:_____

CURRENT HEALTH PROFILE

Height_____Weight_____

Primary Reason for Visit_____

Other Doctors Seen for This Condition:_____

When did this condition begin?_____

How did it start?_____

Describe the symptoms (e.g. achy, diffuse, tight, etc.)_____

What types of medications do you currently take?_____

On a scale of 0-10 (10 being the worst), rate your discomfort_____

Do your symptoms occur more in any of the following?

Morning Afternoon Night W/activity Constant

What daily activities are affected by this condition?_____

Informed Consent To Care

You are the decision maker for your health care. Part of our role is to provide you with the 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 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 typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving,and playing tennis. Arterial dissections occur 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.

The reported association between chiropractic visits and stroke is exceedingly rare and estimated to be related in one in a one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons /year and risk of death has been estimated as 104 per one million users. 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 prescriptions 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 recommendations 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_____

Dr. Val Chiropractic - 740 Garden View Ct. Ste 206 Encinitas CA. 92024

OUR FINANCIAL POLICY

Thank you for choosing us as your Chiropractic health care provider. We are committed to your treatment being successful. The following is a statement of our *Financial Policy*, which we require you to read, and sign prior to any treatment.

Patients

All Patients are responsible for payment at the time of service. It is requested that 100% of your first visit be paid at the time of your visit.

New Patient Appointments:

Range in prices depends on the time required and the condition of the patient. The fees account for the scope of assessment, depth of case management, and services rendered. I customize my services for each patient, so I will determine the specific time and cost for these appointments. I reserve the right to provide an alternative fee schedule based upon whether we are providing services to an individual/pregnant mom/kids/family all at once.

Payment and Billing

I do accept insurance if they accept me, and I will work to get your services covered based on your plan. Patients are responsible for all charges. Payments for services are accepted and processed by check, cash, or debit/credit card on the patient's file. For your convenience, we accept all credit cards.

Missed Appointments and Fees

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of **24 hours in advance** if you are unable to do so.
At Dr. Val Chiropractic, your scheduled appointment time is reserved just for you. We do not overbook appointment times to provide you with personalized and quality care.

Failure to comply with this policy will necessitate the assessment of the following fees:

- **First missed appointment**: Our staff will call to reschedule your next appointment. We understand things happen and you will not be billed for your first missed appointment.
- **Second missed appointment**: You will receive a note via e-mail/mail/text **(select which you prefer)** stating this is your second missed appointment and that you have been charged a **cancellation fee. A fee of $40 will be charged** as well as a credit card kept on file for any missed future appointments that are canceled or rescheduled with less than 24-hour notice.

We offer several methods of payment for our Chiropractic care at our office. Please read carefully and choose the plan which applies to you. Our main concern is your health and well-being, and we will do our best to help accommodate and serve you.

_____ **PLAN #1** INSURANCE – If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please bring us your insurance information, on or before your second visit. Until we have verified your Chiropractic coverage, you will be required to pay for your care. Most patients will pay co-pay, in addition to meeting their yearly deductible. In the event the check should come to you, you are expected to bring the check to us. Remember, insurance companies balk at "maintenance" and "long-term rehabilitation." Most "health" policies are designed and intended to only take care of acute problems, they want you to eventually "get off" insurance. At this point, we will present affordable cash plans.

_____**PLAN # 2 CASH** – Fees are to be paid at the time services are rendered or prior. After payment for the initial visit, you will only be responsible for payments for all future services.

Professional Fees are as follows:

1.	Comprehensive Initial Exam/X-rays	$70-$350
2.	Established Patient Office Visit/Re-exam	$50-$150
3.	Full Spine/Extremity Spinal Manipulations:	
	• **Adults**	$75- $140
	• **Pediatric 0-18 years**	$45
5.	Deep Muscle Stimulation	$25
6.	Myofascial Release	$25
7.	Kinesiology Taping	$25
8.	Therapeutic Exercise/Stretching/Rehabilitation	$25
9.	Instrument Assisted Soft Tissue Mobilization	$25
10.	Radiology Report Second Opinion	$30
11.	Craniosacral Therapy	$68

_____**PLAN # 3** AUTO INJURY – You will supply us with the accident report, your car insurance, health insurance, and liable parties' insurance, and attorney if applicable. Until the insurance is verified, you will be required to pay for your care. We will bill your insurance directly after we verify coverage.

_____**PLAN #4** MEDICARE – Per established Medicare guidelines, please bring us your Medicare information on or before your second visit. We will bill your Medicare directly. In the event the check should come to you. You are expected to bring the check to us.

Patient Accountability

You are expected to be an active participant in your care. Your chiropractor's recommended treatment plan, exercises, stretches, ice/heat applications, life-style changes, or other active processes must be followed to ensure optimum progress.

I have read and understand this Policy Agreement.

By signing below, I will abide by its terms.

Patient Name:_____ Date: _____

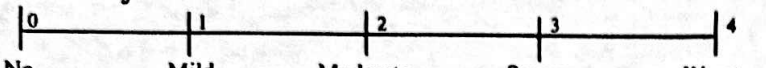
Patient Signature:_____

Functional Rating Index

For use with Neck and/or Back Problems only.

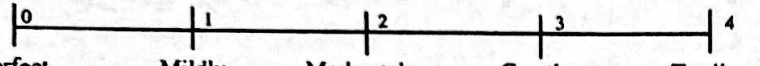
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity



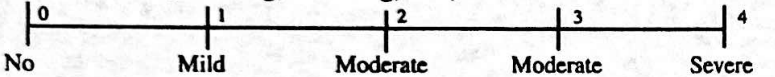
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



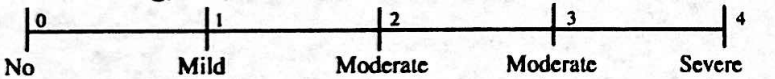
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



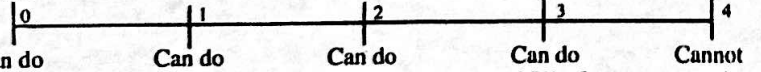
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



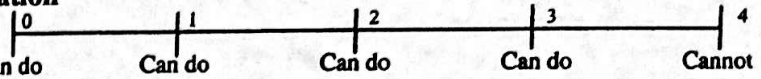
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



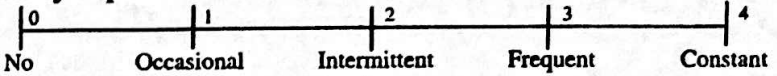
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



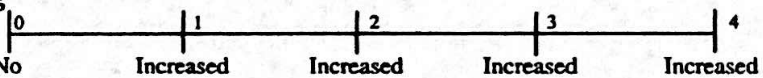
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



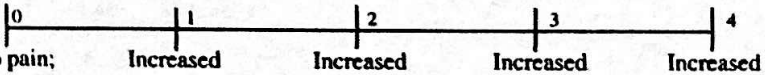
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



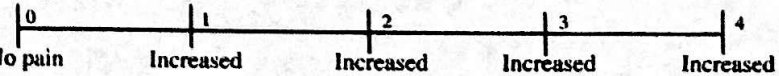
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date