Tahoe Center of Natural Medicine
600 N. Lake Blvd
Tahoe City, California, US - 96145

Chiropractic Forms

Date *

First Name: *

Last Name: *

Date of Birth: *

Gender * ☐ Male ☐ Female

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married

If this is not your legal name, please list it here

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone

Work Phone

Fax

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 *

Address Line2

City *

Country *

State *

Zip code *

Postbox No

Emergency Contact Name ____________________

Emergency Contact Number ____________________

Extn ____________________

Who may we thank for referring you? ____________________

Other family members seen here ____________________

In case of emergency

Name of local friend or relative ____________________

Relationship with patient ____________________

Home Phone no. ____________________

Work Phone no. ____________________

Patient Condition

Reason for visit ____________________

When did your symptoms appear? ____________________

Is this condition getting progressively worse?
☐ Yes ☐ No ☐ Unknown

Rate of severity of your pain on a scale from 1 (least pain) to 10 (severe pain)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Type of pain
☐ Sharp ☐ Dull ☐ Throbbing
☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps
☐ Stiffness ☐ Swelling

How often do you have this pain? ____________________

Is it constant or does it come and go? ____________________

Does it interfere with
☐ Work ☐ Sleep ☐ Daily Routine
☐ Recreation

Activities or movements that are painful to perform
☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

Medications

Medication Name	Intake Details

Allergies

Allergies	Type	Severity	Reactions

Vitamins/Herbs/Minerals

Supplements

Supplement Name	Intake Details

Health History

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractor Services ☐ None

Name and address of other doctor(s) who have treated you for your condition

Date of Last

Physical Exam ____________________

Spinal X-Ray ____________________

Blood Test ____________________

Spinal Exam ____________________

Chest X-ray ____________________

Urine Test ____________________

Dental X-ray ____________________

MRI, CT-Scan, Bone Scan ____________________

Place "Yes" or "No" to indicate if you have had any of the following

AIDS/HIV ☐ Yes ☐ No

Alcoholism	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No
Breast Lumps	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No
Fractures	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No
Gout	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No
Date	____________________
Hernia	☐ Yes ☐ No
Herniated Disk	☐ Yes ☐ No

Herpes	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No
Liver Disease	☐ Yes ☐ No
Measles	☐ Yes ☐ No
Migraine Headaches	☐ Yes ☐ No
Miscarriages	☐ Yes ☐ No
Mononucleosis	☐ Yes ☐ No
Multiple Sclerosis	☐ Yes ☐ No
Mumps	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Parkinson's Disease	☐ Yes ☐ No
Pinched Nerve	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No
Polio	☐ Yes ☐ No
Prostate Problem	☐ Yes ☐ No
Prosthesis	☐ Yes ☐ No
Psychiatric care	☐ Yes ☐ No
Rheumatoid Arthritis	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No
Scarlet Fever	☐ Yes ☐ No
Stroke	☐ Yes ☐ No
Suicide Attempt	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No

Tuberculosis	☐ Yes ☐ No
Tumors, Growths	☐ Yes ☐ No
Typhoid Fever	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No
Vaginal Infections	☐ Yes ☐ No
Venereal Disease	☐ Yes ☐ No
Whooping Cough	☐ Yes ☐ No
Other	______________
Are you Pregnant?	☐ Yes ☐ No
Due date	______________

Below Injuries/Surgeries you have had (specify "Description" and "Date")

Falls	______________
Head Injuries	______________
Broken Bones	______________
Dislocations	______________
Surgeries	______________

Patient Care Financial Policy

We are a cash-based practice. Currently, we are unable to accept insurance for any of our in-house services. Full payment of all charges is required at time of service. We accept payment by cash, check, and credit/debit cards.

*2.5% will be added to the subtotal for credit card payments. Initial Checks denied for insufficient funds will incur a fee of $35.00. We are NOT recognized providers for Medicare, Medicaid or MediCal.

We are NOT contracted with any insurance providers; our services are not covered by insurance in CA. As a courtesy, we can provide you with a “Superbill” for services rendered. This can be submitted to your insurance company for review of possible benefits. The provided “Superbill” and any insurance submission for possible reimbursement are the sole responsibility of the patient.

The following are general guidelines to patient fees, final charges are determined based upon both time and complexity of the appointment. We reserve the right to adjust pricing without notification.

First Office Visit: $425.00 (This does not include required tests or supplements)

Chiropractic ONLY: $165

Return Office Visit:

15 min $125.00 - $150.00

30 min $195.00 - $250.00

45min $250.00 - $295.00

60 min $295.00 - $325.00

Chiropractic ONLY Return Visit: $85

Annual Prescription Renewal Appt: $275 (30 min)

Venipuncture: $25

Intramuscular Vitamin Injection: $35

Re-establishing Care: Patients not receiving care for a period greater than 3 years will require a more comprehensive return office visit to re-establish healthcare baseline.

Phone Appointments: Charged accordingly with in-office visits. If you have any questions or concerns regarding this charge, feel free to ask at the time of your call. Phone consults are not reimbursed by insurance.

Emails: Communication through email will be subject to charges based on complexity and time.

Cancellations: We require a minimum of 24 hours for any changes to your scheduled appointment. We reserve the right to charge for missed appointments, or appointments cancelled with less than 24 hours' notice.

Supplements: Nutritional supplements, herbs, and homeopathic remedies are often recommended as a part of your treatment plan. We do carry most of the products we recommend at competitive prices, although you are free to purchase from any source you choose. However, most products available to health care providers are often of a higher quality not found in many over-the-counter brands. Most supplements are NOT FDA approved for treatment of any condition.

Other Tests: We do not mark-up any outsourced testing services offered through our office.

Patient/Guardian Signature ______________________________

Date ______________________________

FINANCIAL DISCLAIMER

I claim full responsibility for services rendered at the Tahoe Center of Natural Medicine (TCNM). I understand that payment is required at the time of service, unless other arrangements have been made.

Naturopathic care is not recognized by Medicare or Medicaid. We are not contracted providers with either system. Any care provided through our offices can NOT be billed to either Medicare or Medicaid.

A Super Bill with diagnostic and procedural information is provided for you to submit to your insurance company for possible reimbursement. Again, this does not apply to either Medicare or Medicaid. At this time I understand there is no official insurance reimbursement for naturopathic care. TCNM does not submit to insurance on the behalf of the patient, it is the sole responsibility of the patient. The Super Bill is provided at the time of service, they can not be reproduced later and should be maintained for your own records.

It is our policy we receive 24-hour cancellation notice. If we do not, we reserve the right to charge the full fee for a missed appointment.

Patient Signature ______________________________

Date ______________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment.

I (specify name) hereby acknowledge that The Tahoe Center of Natural Medicine has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the office's Privacy Officer: ______________________________

Christina Campbell

(530) 583-0002

I also understand that I am entitled to receive updates upon request if the Tahoe Center of Natural Medicine amends or changes it Notice of Privacy Practices in a material way.

Signature ______________________________

Relationship to Patient- if signed by someone other than the patient ______________________

THIS SECTION IS TO BE COMPLETED BY THE TAHOE CENTER OF NATURAL MEDICINE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

☐ Patient declined to sign this Written Acknowledgement

Name and title of employee Date ______________________

PRIVACY RULE CONSENT

By signing this form, you are giving Tahoe Center of Natural Medicine permission to use and disclose your protected health information for the purposes of treatment and payment associated with your care.

We have a “Notice of Privacy Practices” that provides more detailed information regarding how we may use and disclose your health information. You have the right to review this document detail at any time. You have the right to request restrictions on how we may use and disclose your health information. We are not required by law to agree with your request, but we will do whatever we can to accommodate requests that are reasonable. You also have the right to revoke this consent in writing at any time, unless your health information has already been used or disclosed in reliance on this consent for the diagnosis, treatment or payment for the medical services for which you sought treatment.

A copy of our “Notice of Privacy Practices” may be obtained by contacting our offices at 530-583-0002, or in writing at POB 6869, Tahoe City, CA 96145. Please note that our “Notice of Privacy Practices” may be changed as needed to comply with Federal Law.

Printed Name ______________________

Patient Signature ______________________

Date ______________________

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Doctor Campbell uses a spinal manipulative therapy involving her hands or a mechanical instrument in such a way as to move your joints to release pressure. She will examine and discuss her diagnosis with you. In addition, she will refer you to other doctors and suggest alternative therapies as needed.

Chiropractic care is safe. Uncommon side affects of treatment include straining of muscles or connective tissues and rarely, fractures of ribs. Extremely rare occurrences (in the order of one in several million treatments) are reports of cerebral vascular accidents (strokes) and even the reports of deaths that have been attributed to chiropractic care.

Some patients may feel stiffness and soreness following the first few days of treatment.

Dr. Campbell will make ever reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to her attention, it is your responsibility to inform her. Compared to other forms of treatment — especially drug therapy — chiropractic care is very safe!

By signing below, you acknowledge that you have read the above explanation of the chiropractic adjustment and related treatment. By signing below, you understand the risks that may be involved in treatment and have decided that it is in your best interest to undergo the treatment recommended.

Having been informed of the risks, you hereby give your consent to that treatment.

Patient's Name

Patient/Guardian Signature ______________________

Date ______________________