TAHOE CENTER OF NATURAL MEDICINE

CHIROPRACTOR REGISTRATION AND HISTORY

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Sex M ❑ F ❑	Marital status (circle one) Single / Mar / Div / Sep / Wid
If this is not your legal name, pleaselist it here	Home phone:	Cell phone:	Birth date: / /	Age:
Street address:				
P.O. box:	City:		State:	ZIP Code:
Occupation:	Employer:			Employer phone no.: ( )

Whom may we thank for referring you?

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to 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

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

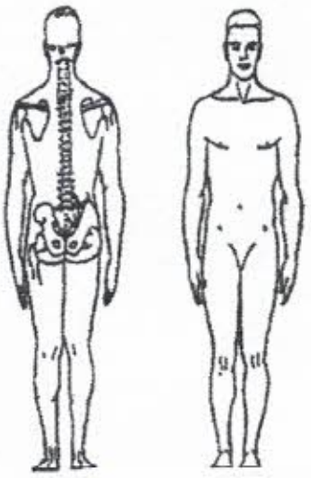
Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

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



Medications

_____

_____

Allergies

_____

_____

Vitamins/Herbs/Minerals

_____

_____

Revision 03/16

HEALTH HISTORY

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractor Services

❑ None ❑ Other _____

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 a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Polio	❑ Yes ❑ No
Alcoholism	❑ Yes ❑ No	Gout	❑ Yes ❑ No	Prostate Problem	❑ Yes ❑ No
Allergy Shots	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Prosthesis	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Hernia	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Anorexia	❑ Yes ❑ No	Herniated Disk	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Appendicitis	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Bleeding Disorders	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Suicide Attempt	❑ Yes ❑ No
Breast Lumps	❑ Yes ❑ No	Measles	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Bronchitis	❑ Yes ❑ No	Migraine Headaches	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Bulimia	❑ Yes ❑ No	Miscarriage	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Mononucleosis	❑ Yes ❑ No	Tumors, Growths	❑ Yes ❑ No
Cataracts	❑ Yes ❑ No	Multiple Sclerosis	❑ Yes ❑ No	Typhoid Fever	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Mumps	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Chicken Pox	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No	Vaginal Infections	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Parkinson's Disease	❑ Yes ❑ No	Whooping Cough	❑ Yes ❑ No
Epilepsy	❑ Yes ❑ No	Pinched Nerve	❑ Yes ❑ No	Other _____	
Fractures	❑ Yes ❑ No	Pneumonia	❑ Yes ❑ No	_____	

Are you pregnant? ❑ Yes ❑ No Due Date _____

Injuries/Surgeries you have had	Description	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 ALL 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:	**$365.00 (this does not include required tests or supplements)**
RETURN OFFICE VISIT:	
15 MINUTES	**$125.00 - $150.00**
30 MINUTES	**$195.00 - $250.00**
45 MINUTES	**$250.00 - $295.00**
60 MINUTES	**$295.00 - $325.00**

CHIROPRACTIC FIRST OFFICE VISIT	**$165.00**
CHIROPRACTIC RETURN VISIT	**$85.00**

ANNUAL PRESCIPTION RENEWAL APPT:	**$275.00 (30 MINUTES)**
INTRAMUSCULAR VITAMIN INJECTION:	**$35.00**

Zoom/Phone Appointments: Charged accordingly with in-office visits.

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.

Emails: Communication through email may 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 the 24- hour stated requirement.

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

Tahoe Center
Of Natural Medicine
PO Box 6869 ◦ 600 North Lake Blvd ◦ Tahoe City, CA 96145◦ Phone 530-583-0002 ◦ Fax 530-583-0044

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

Tahoe Center
Of Natural Medicine
PO Box 6869 ◦ 600 North Lake Blvd ◦ Tahoe City, CA 96145◦ Phone 530-583-0002 ◦ Fax 530-583-0044

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

Tahoe Center
Of Natural Medicine
PO Box 6869 ◦ 600 North Lake Blvd ◦ Tahoe City, CA 96145◦ Phone 530-583-0002 ◦ Fax 530-583-0044

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 Date

_____ _____

Patient/Guardian Signature Date

Tahoe Center
Of Natural Medicine
PO Box 6869 ◦ 600 North Lake Blvd ◦ Tahoe City, CA 96145◦ Phone 530-583-0002 ◦ Fax 530-583-0044

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, _____, 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

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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
[ ] Other

_____ _____

Name and title of employee

Date