Patient Registration Form

Last Name:______________________ First Name:____________________M.I.:_____

SS:________-__________-__________ DOB:__________________ Male/Female

Cell#:______________Home#:_____________Email: ______________________

Address:__________________________________City:_________Zip:__________

Circle one: Single Married Divorced Widow

Who referred you to our office: ______________________________________

Were you referred to a certain doctor? _________________________________

Is this visit due to an Auto Accident? Yes/No Work Related Injury? Yes/No

Major Complaints

Briefly describe your symptoms:_______________________________________

____

Employer

Employer Name:______________________________ Employer Phone #:__________

Address:___________________________ City:________________ Zip:__________

Occupation:____

If Student Name of School: _______________________________________

Spouse Information

Last Name:______________________ First Name:____________________M.I:_____

SS:________-__________-__________ DOB: ______________________ Male / Female

Please complete if patient is a Minor

Name of Father:________________________ DOB:______________ SS#:__________

Name of Mother:________________________ DOB:______________ SS#:__________

In case of an Emergency Contact:

Name:________________________Relationship:_________________Phone#:________

Signature:_________________________________ Date: ______________________

Formulario de Registro de Pacientes

Apellido:__________ Nombre:__________ M.I.:_____

SS:_____-_____-_____ Fecha de Nacimiento:__________ Hombre/Mujer

Tel#:__________ Cell#:__________ Correo Electrónico:__________

Dirección:__________ Ciudad:__________ Código Postal:_____

Marque uno: Soltero/a Casado/a Divorciado/a Viudo/a

Quien lo/la refirió a nuestra oficina:__________

¿Fue referido a un cierto doctor?__________

¿Es esta visita debido a un accidente de auto? Si/ No ¿Lesión del trabajo? Si/No

Quejas Principales

Brevemente describa sus síntomas:__________

____

Empleado

Nombre de empleador:__________ Teléfono#:__________

Dirección:__________ Ciudad:__________ Código Postal:_____

Ocupación:__________

Si es estudiante, Nombre de escuela:__________

Información del cónyuge

Apellido:__________ Nombre:__________ M.I.:_____

SS:_____-_____-_____ Fecha de Nacimiento:__________ Hombre/Mujer

Por favor complete esta parte si el paciente es menor de edad

Nombre del Padre:__________ FDN:__________ SS#:__________

Nombre de la Madre:__________ FDN:__________ SS#:__________

Contacto en caso de una emergencia

Nombre Completo:__________ Rel.:__________ teléfono#__________

Firma:__________ Fecha:__________

Financial Policy

Auto Accident or Personal Injury

- Please present our staff with your auto insurance or billing information and your group health insurance identification card and the original claim form as well as the police report. It is a legal procedure to bill both insurances at the same time. We will check your auto policy for Med. Pay. Be sure you have reported the auto accident to your insurance agent. If there are any credits we will refund at the close of the case. If you have an attorney, please provide us with the name and address of your legal counsel. We ask that you cooperate in the billing process of your case by signing the necessary forms provided by our staff.
- Nutrition and supports are to be paid for in full at the time they are received.
- If the only insurance coverage you have is for the driver of the auto that hit you, because this is considered third party and will not pay the doctor directly, you will need to pay cash for each visit, or get an attorney and have him/her sign a lien.
- Professional care is provided to you, our patient, and not an insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor.

Patient signature ______________________________________Date________________

Política financiera

Accidente de Auto o lesiones personales

- Por favor, presente a nuestro personal con su seguro de auto o información de facturación y de su tarjeta de identificación del seguro de salud de grupo y el formulario de solicitud original, así como el informe de la policía. Es un procedimiento legal para facturar a los dos seguros al mismo tiempo. Vamos a revisar su política de auto para cobertura médica. Asegúrese de que ha reportado el accidente a su agente de seguros. Si hay créditos se te reembolsará al cierre del caso. Si usted tiene un abogado, por favor proporcione el nombre y la dirección de su abogado. Le pedimos que coopere en el proceso de facturación de su caso mediante la firma de las formas necearías proporcionados por nuestro personal.

- Nutrición y soportes deben ser pagados en su totalidad en el momento en que se reciben.

- Si la única cobertura de seguro que tenga, es que el conductor del automóvil que lo chocó, puesto que se considera tercero y no pagará directamente al médico, Usted tendrá que pagar en efectivo por cada visita, o conseguir un abogado y que él / que firme un derecho de retención.

- El cuidado profesional se proporcionan a usted, nuestro paciente, y no una compañía de seguros. De este modo, la compañía de seguros es responsable ante el paciente y el paciente es responsable ante el médico.

Firma de paciente ________________________________ Fecha________

Privacy Notice Form

This notice describes how chiropractic medical information about you may be used, how it may be disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at Cater Chiropractic we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another party, such as an insurance carrier, an HMO, PPO, or your employer, if they are responsible for the payment for your services.

*Your name, address, phone number, and your health case records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest of you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communication with you, but in our professional judgement we believe that you intend for us to provide care.

*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of our protected health information, other than as outlined above, will be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information in a different form, please advise us in writing as to your preference.

Privacy notice continued and signature line on back →

Privacy notice form continued

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Request to inspect, copy or amend our health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of our patient file and protected health information therein. We are also required to provide you with this notice of our private practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice if changes are made to our privacy notice we will notify in writing as soon as possible following the chances, any changes I our privacy notice will apply for all of your health information in our files.

Information that we disclose based on this privacy notice may be subject to re disclosure by the person to whom we proved the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: **Dr. Gregory H, Cater D.C**

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of the patients and staff. this environment is used for ongoing care and this is NOT the environment for taking patient histories, providing examinations or presenting report of findings. These procedures are completed in a private confidential setting. The use if this format is intended to make you experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you.

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Print Name: ______________________________

Signature: ______________________________ Date: ______________________

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures/examinations including various models of physical therapy and diagnostic x-ray. On me (or by the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who are now, or may be employed in the future, treat me at this clinic. I understand that results are not guaranteed.

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 no limited to fractures, disc injuries, strokes, dislocations, sprains and burns. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon all factors then known, is in my best interest.

The probability of these risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between on in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the -counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers.
- Hospitalization/Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the information of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Patient's Signature: ______________________________ Date: ______________

Consentimiento informado

Yo solicito y doy consentimiento para la realización de los ajustes quiroprácticos y otros procedimientos quiroprácticos / exámenes, incluyendo varios modelos de terapia física y de diagnóstico por rayos x en mí (o por el paciente mencionado, por el cual yo soy legalmente responsable) por el médico quiropráctico mencionado a continuación y/u otros médicos con licencia de la quiropráctica que están, o que estarán empleados en el futuro, me tratan en esta clínica. Yo entiendo que los resultados no están garantizados.

Yo entiendo y estoy informado de que, como en la práctica de la medicina, en la práctica quiropráctica, hay algunos riesgos de tratamiento, incluyendo, pero no limitado a fracturas, lesiones de disco, accidente cerebrovascular, luxaciones, esguinces y quemaduras. No espero que el médico anticipe y/o explique todos los riesgos y complicaciones. Deseo confiar en el médico para ejercer juicio en el curso del procedimiento que el médico sienta en ese momento, sobre la base de todos los factores conocidos hasta entonces, es en mi mejor interés.

La probabilidad que estos riesgos se produzcan: Las fracturas son ocurrencias raras y generalmente son el resultado de alguna debilidad subyacente del hueso, que revisamos durante la toma de su historia y durante el examen y rayos x. Accidente cerebrovascular ha sido objeto de gran desacuerdo. La incidencias de accidente cerebrovascular son muy poco frecuentes y se estima que ocurren entre el encendido en un millón y uno de cada cinco millones de ajustes cervicales. Las otras complicaciones también se describen generalmente como raras.

La disponibilidad y la naturaleza de otras opciones de tratamiento

Otras opciones de tratamiento para su condición pueden incluir:

- autoadministrado, analgésicos de venta libre y reposo
- Atención médica y los medicamentos recetados tales como antiinflamatorios, relajantes musculares y analgésicos.
- Hospitalización / Cirugía

Si opta por utilizar una de las opciones anteriores señaladas "otros tratamientos", debe tener en cuenta que existen riesgos y beneficios de tales opciones y es posible que desee hablar sobre esto con su médico primario.

El asistente de riesgos y peligros de permanecer sin tratar: Lo que queda sin tratar puede permitir la formación de las adherencias y reduce la movilidad, que podrá constituir una reacción de dolor reduciendo aún más la movilidad. Con el tiempo, este proceso puede complicar el tratamiento por lo que es más difícil y menos eficaz cuanto más tiempo se pospone.

Firma del paciente: ______________________________ Date: ________________

Assignment and instruction for direct payment to doctor

Subscriber:______________________________

Patient:______________________________

Claim #:__________________________ D.O.L:____________________

I hereby instruct and direct ____________________________________ insurance company to pay by check made out and mailed directly to:

Cater Chiropractic

1211 N. Main St.

Salinas, CA 93906

OR

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make the check out to me and mail it as follows.

Cater Chiropractic

1211 N. Main St.

Salinas, CA 93906

Direct payment to **Cater Chiropractic** are for the professional or medical expense allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **This is a direct assignment of my rights and benefits under this policy.** This payment will not exceed the amount I owe to Cater Chiropractic. I have agreed to pay, in a current manner, any balance of the professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney, or attorney involved in this case.

Signature of Policy Holder:__________________________ Date: ____________________

TO: ______________________________ **PATIENT:** ______________________________

Attorney At Law

______________________________ ______________________________

______________________________ ______________________________

NOTICE OF DOCTOR'S LIEN

I do hereby authorize Cater Chiropractic to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was injured on ______________________.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing for medical services rendered as a result of this accident, **and to withhold such sums from any settlement or judgement as may be necessary** to adequately protect said doctor. And I hereby further give a **LIEN** on my case to said doctor against **any and all proceeds** (including "medical payments") **of my settlement or judgement which may be paid to you,** my attorney, or myself, as the result of the injuries for which I have been treated.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney must honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by the subsequent attorney. **You will notify said doctor if a new attorney replaces you within 30 days of such substitution of counsel, and you will notify such subsequent attorney, IN WRITING, when the file is transferred, of the existence of this lien agreement.**

I expressly authorize and direct my attorney to release information concerning my case, **including settlement disbursement,** to said medical facility if for any reason the doctor's lien is not fully and timely satisfied. You are further instructed to return this lien to the doctor promptly, and to complete and return Status Request correspondence, as reasonably required by the doctor, within ten (10) days of your receipt of such Request.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement or judgement by which I may eventually recover.

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protection the doctor's interest, the doctor will not await payment but may declare entire balance as presently due and payable, and may pursue collection, accordingly.

Dated: ______________________ ______________________________

Patient's Signature

The undersigned attorney of record for the above-referenced patient does hereby agree to observe ALL of the foregoing terms, and agrees to withhold such sums from any settlement or judgement as may be necessary to adequately protect said doctor named above. Attorney further agrees that in the event this lien is litigated, the prevailing party will be awarded attorneys' fees and costs.

Dated: ______________________ ______________________________

Attorney's Signature

Please date, sign and return one copy to the doctor's office. Also keep one copy for your records.

CATER CHIROPRACTIC
1211 N. MAIN STREET
SALINAS, CA 93906
(831)449-2225

Exam:

Xray:

Consultation Form

Name:______________________________ Date:____________________
Referral:______________________________ Dr: ____________________
History of complaint:____
____
____
____
____

( )H.A/Neck/UB/MB/DL/LB other:______________O:__________ Cons/Freq/Inter/Occa
Sharp/Dull/Muscle Ache/ Burning sensation________________Scale: 0-10:__________
Detail:____
Radiation:____
What aggravates:__________________________What alleviates:______________
( )H.A/Neck/UB/MB/DL/LB other:______________O:__________ Cons/Freq/Inter/Occa
Sharp/Dull/Muscle Ache/ Burning sensation________________Scale: 0-10:__________
Detail:____
Radiation:____
What aggravates:_______________________ What alleviates:__________________
( )H.A/Neck/UB/MB/DL/LB other:______________O:__________ Cons/Freq/Inter/Occa
Sharp/Dull/Muscle Ache/ Burning sensation________________Scale: 0-10:__________
Detail:____
Radiation:____
What aggravates:_______________________What alleviates: __________________
( )H.A/Neck/UB/MB/DL/LB other:______________O:__________ Cons/Freq/Inter/Occa
Sharp/Dull/Muscle Ache/ Burning sensation________________Scale: 0-10:__________
Detail:____
Radiation:____
What aggravates:_______________________What alleviate:__________________

Other Symptoms:____
TX/X-Rays Received: ____
Chiro TX:____
Medication/Supports:____
Limitations on ADL's:____
Exercise:____________Cardio:______________Wt.Lifting:____________Other:__________
Diet: Good/Average/Not Good Vitamins/Nutrients:_________________________
Type of work____

<u>In the past 6 months, have you had any of the following?</u>

Headaches: Y/N______________________________

Dif. Sleeping:: Y/N______________________________

Dizziness: Y/N______________________________

Loss of Energy: Y/N______________________________

Blurred Vision: Y/N______________________________

Tired in the A.M:Y/N______________________________

Loss of Concen: Y/N______________________________

Buzz/Ring Ear: Y/N______________________________

Depression: Y/N______________________________

RunDown: Y/N______________________________

Nervousness: Y/N______________________________

Faint/Palpitation:Y/N______________________________

<u>In the past 6 months have you had any of these general problems?</u>

Sinus: Y/N______________________________

Kidney/Bladder: Y/N______________________________

C/S PN/Stiffness: Y/N______________________________

Colon/Constipation: Y/N______________________________

Shoulder (R or L): Y/N______________________________

Low Back: Y/N______________________________

Arm/Hand/(R or L): Y/N______________________________

Hip (R or L): Y/N______________________________

UB/MB/Ribs: Y/N______________________________

Leg Pain(R or L): Y/N______________________________

Chest Pains: Y/N______________________________

Poor Circ.: Y/N______________________________

Lung/Heart: Y/N______________________________

Stomach/Digestion:Y/N______________________________

Gall Bladder/Liver Y/N______________________________

Other:______________________________

Previous Pertinent Medical History:

Hospital/Surgery: Yes/No:______________________________

____

Accidents (MVA/Falls) Yes/No:______________________________

____

Job Accidents (Open/Closed) None:______________________________

____

Meds Taken for any Condition:______________________________

Allergies:______________________________

Family History of back problems:______________________________

Other: ______________________________

____

____

____

Personal Injury Questionnaire

Patient Name:________________________________ Date: ____________ File #:______________

1.What date and time was the accident?

____

Were you driving or passenger? (where were you seated)

Details of Accident: ____

____

____

____

____

____

2. What street/highway were you on? (location) What was the closest cross street or exit?

____

*Were you heading South, East, North or West? ____________________________________

*How were you hit? Rear ended, head on, broad sided or swiped on the side?____________________

*If stopped at a light or stop sign, were you the first car or second at the top light?________________

*was your foot knocked off from the brakes?____

*Did you hit the car in front of you?____

*How fast was your vehicle going?________ *How fast was the other vehicle going?________________

3. On impact, were you looking forward, looking to the side?______________________________

*Did your car move due to the impact?____

*Were you wearing a seatbelt?____

*Your headrest, does it come up to below your neck, mid head or top of head?____________________

*Did you hit anything in your vehicle or did anything flew on impact?__________________________

4. Road/Visibility condition-weather, was it foggy, dry, sunny, wet, raining or clear?__________________

5. Did the ambulance come?___ Police report taken?___ What hospital did you go to?__________________

*What did they do for you at the ER?____

X-rays MRI CT Findings Labs done

*Were you released or hospitalized?____

*What did they tell you?____

____

6. Did you see any other health care professionals/M.D?_____________________________

When?_________________________________ What did they do?____________________

____

Medication?_______________________________How many times/office visits?____________

7. After your accident, how did you feel? Dizzy or light headed? Did you lose consciousness?

____

List areas of where it hurt the most.

A.

B.

C.

8. Any bruises?____________________________________ Where and how big?_______________

9. Did you do anything on your own like ice, hot pack or massage or have you taken over the counter medications?

____

10. What do you do for work?______________________ Have you missed any days of work?___________

11. What other symptoms have you felt since?_Difficulty sleeping? Decreased appetite?Nausea?Etc.

____

12. How were you feeling prior to the accident-great, good, or bad?_________________________

*Have you had any of the symptoms you described above prior to the accident?___________________

13. Estimate of damage to the patient's vehicle?____________________________Mild/Moderate/Totaled

*Did you see the other vehicle's damage?_________________________________Mild/Moderate/Totaled

14. Any other pertinent information not taken?_______________________________________

____

____

____

CATER CHIROPRACTIC

Patient Information

Patient Number: ______________________ Date: ____________________

Last Name: ____________________ First Name: ____________________ DOB: __________ Age: _______ M/F

Email: ________________________________ Referred By: ________________________________

Thank you date: ____________ Report Dates 1. ______________ 2. ______________ 3. ______________

Presenting Complaints:

1. ____________________/10 2. ____________________/10 3. ____________________/10

4. ____________________/10 5. ____________________/10 6. ____________________/10

X-Ray Findings: Views Taken: ____

____

____

____

____

Onset: ______________ **Diagnosis:** ____

____

____

____

TX Recommendations: Chiro: ____

____

Disability Status: ____

____ Re Exam: ______________________________

Therapy: IF IST Myofascial Class IV Laser Ice Massage

Recommended Exercises: Back: ______________________________ Neck: ______________________

EXT EX: ______________________________ General /Exercise: ______________________________

Current Diet/Vitamins: ____

Recommended Nutrition: ____

Home Care Recommendations: ____

Denneroll: ____

Insurance Summary:

%	Exam	X-Rays	OV's	DED	MET	Amt to Ded	Copay	TX