SPRINGER CHIROPRACTIC INC.

NEW PATIENT INFORMATION PACKET

CONFIDENTIAL

FINANCIAL AGREEMENT FOR SERVICES

Springer Chiropractic services are based upon each treatment being paid on the same day of the treatment. Patients with insurance are still expected to pay for their services and have their insurance company reimburse them since the insurance policy is an agreement between the patient and the insurance company, not the doctor and the insurance company.

Many of our patients have insurance and we help them submit their receipts so they can get reimbursed. If you have insurance and would like help please see the receptionist for assistance.

We understand that unusual circumstances sometimes do occur. It is your responsibility to bring to the attention of the Cashier any difficulties you may encounter regarding payment for your office visits.

Personal Injury Worker's Compensation and/or Disability cases must be approved at the front desk and verified regarding source of payments. All patients are ultimately responsible financially for any unpaid portion of their account.

Any account over 60 days past due will be charged 1.5% per month interest. Any legal or collection company fees which accumulate because of that patient's past due account will be paid by that patient. We expect patients to be ethical and stay in good communication with us if there are any unusual circumstances, upsets or suggestions. We will do the same for you. It is our hope that we will not need to apply the monthly interest charge. Additionally, there will be a service charge of $25.00 on any returned checks.

Once you have schedule an appointment, that time is reserved for you. If you cancel your appointment with less than 24-hour notice that time is often wasted. If you have an appointment on a Monday, and need to cancel that appointment we need to be notified prior to our office closing the preceding Saturday. We are not open on Sundays so calling on a Sunday does not give us adequate notice**. We regret that a $20.00 charge will be made for those appointments cancelled without 24 hours' notice.** Time and skill is the service provided here. Please assist us in not wasting them.

I, _____, understand and agree to the above.

Date: _____

IMPORTANT NOTICE

Due to the doctor's time being needed to treat patients we would prefer to discuss the following with you in writing. Please take a minute of your time to read the following and then if you have any questions or things to discuss please bring them up with the Doctor.

We wish to help as many of our patients along with their friends and family, as possible while at the same time keeping high standards of health care. To help maximize your results in achieving relief corrective care and long term wellness the doctor has recommended a treatment program of frequency of care. We would like to emphasize the importance of staying on your prescribed program and keeping all of your appointment once made.

1. To attend to the health needs of all of our patients it is important that we have your agreement to do your very best to comply with our policies regarding scheduling and missed appointments. Please give us the courtesy of 24 hour advance notice if something unexpectedly arises and you cannot keep you scheduled appointment. This helps us minimize wasting the appointment time and we can make it available to someone else that needs the care.

2. It is important to make up the missed appointment as soon as possible so you can continue your progress at its current rate. An example would be, if you were seeing the doctor Mondays and Thursday but could not come in this Thursday you come in Wednesday or Friday and not wait until your next scheduled appointment.

3. If you cannot give us 24 hour advance notice we regret that we must charge you the customary $20.00 missed appointment fee. If this situation occurs we still need you to call so if the need for emergency care arises for someone we can assist them. We do provide a courtesy appointment reminder call but it is your responsibility to keep track of your appointment should you not get a reminder call.

4. Please give yourself adequate time to travel to our office so that you will be on time for your appointment. We do our very best to be prompt but patients being late is one of the main reasons we get behind on our schedule. We understand that unexpected things arise with L.A. traffic but please give yourself some extra time.

5. We try our best to attend to your health needs and we need you to be considerate and help us attend to the needs of others. Please give us and others the same respect we give you.

I have read this and understand it.

_____

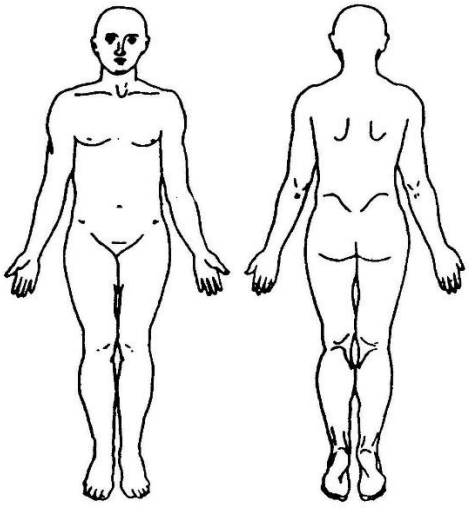
Patient Name

Thank you,

Springer Chiropractic, Inc.

CURRENT HEALTH CONDITION

PLEASE OUTLINE ON THE DIAGRAM THE AREAS OF YOUR DISCOMFORT



PLEASE MARK ONE OF THE CIRCLES BELOW

O Job Related O Auto Related O Other

PLEASE FILL OUT SECTION A, B OR C (WHICHEVER APPLIES)

SECTION A

1. **Did you recently have an accident or injury? Yes/No**
2. **When did it occur? _____**
3. **Where did it happen (location)? _____**
4. **Describe the injury: _____**
5. **Mark on the diagram what part of your body was hurt.**
6. **What symptoms are you experiencing? _____**
7. **How have you already tried to help this? _____**
8. **Other comments: _____**

SECTION B

9. **Is your body ill? Yes/No**
10. **When did it start? _____**
11. **Describe the symptoms you are having: _____**
12. **Mark on the diagram the areas where you are feeling the symptoms.**
13. **How have you already tried to help this? _____**
14. **Other comments: _____**

SECTION C

15. **Do you have some other situation or pain you wish handled? Yes/No**
16. **What is it? _____**
17. **When did it start? _____**
18. **Describe any symptoms you are having:_____**
19. **Mark on the diagram the areas involved.**
20. **Other comments: _____**
21. **ANYTHING ELSE YOU WANT THE DOCTORS TO KNOW ABOUT YOUR CURRENT CONDITION?**

    _____

Please mark the symptoms that are present:

SYMPTOMS

HEAD
0 HEADACHE
- 0 entire head
- 0 back of head
- 0 forehead
- 0 temples
- 0 migraine

0 Head feels heavy
0 Loss of memory
0 Light-headedness
0 Fainting
0 Lights bother eyes
0 Loss of smell
0 Loss of taste
0 Loss of balance
0 Dizziness
0 Loss of hearing
0 Pain in ears
0 Ringing in ears
0 Buzzing in ears

NECK
0 Pain in neck
0 Neck pain with movement
0 Pinched nerve in neck
0 Neck feels out of place
0 Stiff neck
0 Muscle spasms in neck
0 Grinding sounds in neck
0 Grating sounds in neck
0 Popping sounds in neck
0 Arthritis in neck

SHOULDERS
0 Pain in shoulder joint (R-L)
0 Pain across shoulders
0 Bursitis (R-L)
0 Arthritis (R-L)
0 Can't raise arm
- 0 above shoulder level
- 0 over head

0 Tension in shoulders
0 Pinched nerve in shoulder
(R-L)
0 Muscle spasm in shoulders

LOW BACK
0 Low back pain
0 Low back pain is worse when:
- 0 working
- 0 lifting
- 0 stooping
- 0 standing
- 0 sitting
- 0 bending
- 0 coughing

0 Pinched nerve in low back
0 Slipped disc
0 Low back feels out of place
0 Muscle spasms
0 Arthritis

MID-BACK
0 Mid-back pain
0 Pain between shoulder blades
0 Sharp pain in mid-back
0 Muscle spasms

ABDOMEN
0 Nervous Stomach
0 Nausea
0 Gas
0 Constipation
0 Diarrhea

ARMS & HANDS
0 Pain in upper arm
0 Pain in forearm
0 Pain in hands
0 Pain in fingers
0 Pinched nerve in arm
0 Pinched nerve in fingers
0 Sensation of pins and needles in arms
0 Sensation of pins and needles in fingers
0 Fingers go to sleep
0 Hands cold
0 Swollen joints in fingers
0 Sore joints in fingers
0 Arthritis in fingers
0 Loss of grip strength

HIPS, LEGS & FEET
0 Pain in buttocks (R-L)
0 Pain in hip joints (R-L)
0 Pain down leg (R-L)
0 Pain down both legs
0 Leg cramps
0 Pins & needles in legs (R-L)
0 Numbness of leg (R-L)
0 Numbness of feet (R-L)
0 Numbness of toes
0 Feet feel cold
0 Cramps in feet (R-L)
0 Swollen ankles (R-L)
0 Swollen feet (R-L)
0 Painful joints in toes
0 Pain in foot (R-L)
0 Pain in knee (R-L)

GENERAL
0 Nervousness
0 Irritable
0 Depressed
0 Fatigue
0 Generally feel run-down
0 Loss of sleep
0 Loss of weight

CHEST
0 Chest pain
0 Shortness of breath
0 Pain around ribs

WOMEN ONLY

0 Menstrual pain

0 Cramping

0 Irregularity

Date of last period? _____

Are you now pregnant?

0 Yes 0 No

If yes, how long? _____

PATIENT NAME: _____

Check each of the activities which you have difficulty performing and/or can perform only with pain. (There is no particular priority in the order presented).

HOUSEWORK

_____ Doing laundry
_____ Making beds
_____ Vacuuming
_____ Washing dishes
_____ Ironing
_____ Carrying groceries
_____ Caring for pets
_____ Cooking
_____ Other_____

YARDWORK

_____ Mowing lawn
_____ Shovelling snow
_____ Raking leaves
_____ Gardening

PERSONAL GROOMING

_____ Combing hair
_____ Shaving
_____ In/Out bathtub
_____ Brushing teeth
_____ Other

TRAVEL

_____ Driving
_____ Riding (Passenger)
Minutes per day
Type Vehicle:
Auto _____
Train _____
Truck _____
Bus _____
Airplane _____

GENERAL

_____ Walking
_____ Standing
_____ Running
_____ Sitting
_____ Lifting children
_____ Bending
_____ Climbing stairs
_____ Reading
_____ Lying in bed
_____ Chewing
_____ Swimming
_____ Sports: List:
_____

_____ Getting in and out of auto
_____ Playing piano
_____ Using typewriter/computer
_____ Kneeling
_____ Sexual intercourse
_____ Exercising
_____ Sleeping
_____ Using telephone
_____ Sitting in recliner

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:

_____

_____

Signed: _____ Date: _____

PERSONAL HISTORY

Date: _____ Social Security No.:_____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Business Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Sex: M F E-mail: _____

Business/Employer: _____ Type of Work: _____

Check One: 0 Married 0 Single 0 Widowed 0 Divorced 0 Separated Number of Children: _____

Name of Emergency Contact: _____ Phone Number: _____

Referred to this office by: _____

Do you have Insurance that you will be billing? _____ Yes _____ No

Name of Insurance Company: _____

Drugs you now take: 0 Nerve Pills 0 Pain Killers/Muscle Relaxers 0 Blood Pressure Medicine

O Insulin O Other: _____

List all recreational drugs you are currently taking, any in the past and when you took them:

_____

_____

List all vitamins, minerals herbs etc. and exact amounts you are using:

_____

_____

List types of exercise you normally do:

_____

Hours of sleep you usually have _____ Are they interrupted? _____

What position is your body in during sleep? _____

Amount of alcohol you consume per day _____ week _____ month _____

Amount of cigarettes you smoke per day _____ week_____

Glasses of water you consume per day _____ Cups of coffee per day _____

Number of bowel movements per day _____ Do you use white sugar? _____

Are you encountering outside stresses from family work etc. which may be adversely affecting you?

_____

_____

Are you or have you been under psychiatric care? _____

Are you currently seeing a psychologist? _____

Have you ever received electric shock? _____

PAST HEALTH HISTORY

Please check or describe if you had any of the following major surgery/operations:

0 Appendectomy 0 Tonsillectomy 0 Gall Bladder 0 Hernia 0 Broken bones

Other:

_____

_____

_____

List all major illnesses such as measles, polio, mumps, etc., and age it occurred:

_____

_____

List all strong medicines you have had in the past:

_____

_____

Hospitalization (Other than above): _____

_____

Previous Chiropractic Care: 0 None

Doctor's name and approximate date of last visit: _____

_____

Have you been treated for any health condition in the last year? 0 Yes 0 No

If yes please explain:

_____

_____

List all foreign countries you have been to: _____

_____

List any health problems or abnormalities associated with being in these countries:

_____

_____

Any other information that you feel the Doctor may need to know: _____

_____

_____

_____

FAMILY HEALTH HISTORY

Patient: _____ Date: _____

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space use the reverse side of this form.

CONDITION	FATHER AGE ___	MOTHER AGE ___	SPOUSE AGE ___	BROTHER(S) AGE___ AGE___	SISTERS(S) AGE___ AGE___	CHILDREN AGE___ AGE ___ AGE___
Arthritis						
Asthma–Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emotional Problems						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

_____

_____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care so that we may be guided by your wishes whenever possible.

O Relief Care O Corrective Care O Comprehensive Care O Check here if you want the Doctor to select the type of care appropriate for you condition.

_____ _____

Date Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

**THE PURPOSE OF
OUR CHIROPRACTIC CENTER
IS TO SUPPORT
EACH INDIVIDUAL
IN ACHEIVEING THEIR
OPTIMUM HEALTH
AND TO
EDUCATE THEM
SO THAT THEY MAY
UNDERSTAND HEALTH
AND CHIROPRACTIC
AND IN TURN EDUCATE
OTHERS.**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare and necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature X _____ SS# _____ Date: _____

Guardian or Spouse's Signature Authorizing Care_____ Date: _____

INFORMED CONSENT TO
CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name(s) and Address (es) of Office or Clinic

_____

_____

_____

Print Name(s) of Doctor(s) Treating This Patient

_____

_____

_____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Representative Date

(If minor or physically incapacitated)

_____ _____

Witness to Patient's Signature Date

_____ _____

Translated By Date

Privacy Disclosure

OUR PLEDGE REGARDING YOUR IDENTITY AND YOUR MEDICAL INFORMATION

We create a record of the care and services you receive at this office. We need this record to provide you with quality care. We understand that medical information about you and your health is personal and we are committed to protecting your identity as a patient and the medical information about you.

However, there may be instances where your identity and/or medical information may be disclosed without your prior authorization. This notice will tell you about the ways in which we may use and disclose medical information about you.

For Treatment: Your name and medical information is given to the doctors and appropriate staff who work at Springer Chiropractic for the purpose of providing you with treatment.

For Payment: We disclose your name and medical information about you to our insurance billing person and/or collection agency so that treatment and services you receive here may be billed and collected.

Appointment Reminders: We supply a service to you reminding you of your next appointment with us. The phone numbers you supply Springer Chiropractic with will be used for your reminder call. The reminder may be left on an answering machine or with whoever answers the phone.

Mailings: Postcards, emails, and other mailings may be sent to you from our office. These various mailings identify you as a patient at Springer Chiropractic.

Sign in Sheets: When you sign your name on our sign-in sheet, other patients may have the opportunity to see your name which would identify you a patient.

Folders: We take every precaution to ensure only authorized staff have access to your patient folder and its contents. Your name, however, is clearly written on the folder. These folders are at times on the receptionist desk and on the outside of the door of the doctors in view of other patients.

Referrals: When you have helped another person by bringing them into our office for care, we thank you by writing your name on a board in reception that can be read by other patients.

Patient of the week: When you are chosen as patient of the week entitling you to a free visit, your name is placed on this board indicating such.

Success Stories: When you write a Success Story we may put it on the bulletin board in reception that it can be seen by other patients.

Individuals Involved in Your Care: We may release medical information about you to a friend or family member who is involved in taking care of you while you are convalescing.

Individuals Involved in Payment for Your Care: We may give your information to someone who helps pay for your care.

In Emergencies: (such as being sent from here to the hospital). We may tell your relevant family or friends your condition and that you are in the hospital.

Springer Chiropractic Business Associates: There are independent contractors who may come to this office and may be exposed to patient identity and/or information. The associate, such as someone who does computer repairs, data entry etc., must sign a business associate agreement not to disclose patient identity or information to anyone.

Reports: We will disclose medical information about you when required to do so by federal, state or local law. Also, if applicable, an ethics report may be written and issued.

In Response to a Court Order: such as a subpoena, warrant, summons or similar process.

Authorization: Uses and/or disclosures, other than those described above will be made only with your written authorization.

I have read and understood the above _____ _____

Patient Signature Date

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information, you must submit your request in writing to Springer Chiropractic, Inc. There is a fee for the copying of records.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask to amend the information. To request an amendment, your request must be made in writing and submitted to Springer Chiropractic, Inc. Your request may be denied if the information in the medical record is accurate and complete or if the information was not created by us.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you. To request a list of disclosures, you must submit your request in writing to Springer Chiropractic, Inc.

Right to Request Restrictions: You have the right to request restrictions or limitations on the medical information we use and/or disclose about you for treatment, payment or health care operations. We will comply with your request unless the information is needed to provide you emergency treatment.

Involved in Your Care: You have the right to request a limit on the medical information we disclose about you to someone who is involved in taking care of you while you are convalescing.

Payment of Your Care: You have the right to request a limit on the medical information we disclose about you to someone involved in the payment of your care.

To Request Restrictions: You must make your request in writing to Springer Chiropractic, Inc. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. To request confidential communication, you must make your request in writing to Springer Chiropractic, Inc.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes to this Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the office manager of Springer Chiropractic, Inc., and we will work it out. You can file a complaint with the Secretary of the Department of Health and Human Services.

I have read and understood the above: _____ _____

Patient Signature Date