ACTIVE SPINAL AND SPORTS CARE, INC. *ARMEN AGACANYAN, DC, CCSP, DACRB*

NEW PATIENT INFORMATION

Name:____ Date of Birth:______/______/______
LAST FIRST MI

S.S. #________-________-________ Gender: ☐ Male ☐ Female Age:______ Primary Language:________________

Address________________________________ City____________________ State_______ Zip_______

Primary Phone: ☐ Cell ☐ Home ☐ Work Cell (_____)________________Home (_____)________________

Work (_____)________________ Email:____

Preference for Appointment Reminders: ☐ Email ☐Text Name of Cell Carrier:____________________________

Occupation:______________________________ Employer:______________________________

Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Children: ☐ Yes ☐ No How many?______________

Spouse (or Parent) Name:______________________________ Cell Phone:(____)____________________

Emergency Contact:______________________ Relation:______________ Phone:(____)____________________

Primary Care Physician Name:______________________________ Phone: (____)____________________

How did you hear about our office? ☐ www.activespinal .com ☐ Insurance Referral ☐ Internet: ______________

☐ Referred by one of our patients: Name ________________________ ☐ Other: ________________________

INSURANCE / PAYMENT INFORMATION

<u>DO YOU HAVE HEALTH INSURANCE</u>? ☐ YES ☐ NO <u>If yes, continue</u>:

Insurance Company Name:______________________________ Phone:(____)______________________________

Policy ID #:______________________________ Group #:______________________________

Insured's Name:______________________________ Insured's Date of Birth:______________________

<u>DO YOU HAVE MEDICARE "PART B" HEALTH INSURANCE?</u>: ☐ YES ☐ NO Medicare # ____________________________

<u>IS YOUR INJURY WORK RELATED</u>? ☐ YES ☐ NO <u>If yes, continue</u>: Date of injury: _______/_______/_______

Have you reported the injury to your employer? ☐ YES ☐ NO ☐ UNDECIDED

<u>IS YOUR INJURY RELATED TO AN AUTOMOBILE ACCIDENT</u>? ☐ YES ☐ NO <u>If yes, continue</u>:

Have you reported an injury claim to your Auto Insurance? ☐ YES ☐ NO Date of accident: ______/______/______

Your Auto Insurance Company:______________________________ Claim #:______________________________

Auto Insurance Address:____

Adjuster's Name:________________________ Adjuster's Phone:(____)____________________Ext.:_______

Is there a Medical Payment provision on your auto policy? ☐ YES ☐ NO ☐NOT SURE Amount: $________________

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Active Spinal & Sports Care, Inc., Armen Agacanyan, DC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am financially responsible for all charges for services rendered to me, whether or not paid by insurance and that payment is due at time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will immediately be due and payable.

I clearly understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the clinic does not promise that an insurance company will pay. Nor does the clinic promise than an insurance company should pay the fees as charged. I further understand that the clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is my obligation.

I hereby authorize Active Spinal & Sports Care Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and/or requests pertaining to my physical condition, including, but not limited to, all records, reports, progress notes, reports of diagnostic tests, x-rays and/or medical opinions.

______________________________ ______________________________ _____/_____/_____

PRINT RESPONSIBLE PARTY NAME RESPONSIBLE PARTY SIGNATURE DATE

PATIENT CONDITION

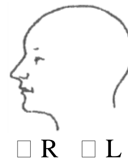
Chief Complaint: 1. ________________________________ How Long?__________________ Previous episode? ☐ YES ☐ NO

2. ________________________________ How Long?__________________ Previous episode? ☐ YES ☐ NO

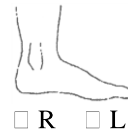
3. ________________________________ How Long?__________________ Previous episode? ☐ YES ☐ NO

Please mark on the drawings area and type of pain, using the codes indicated.

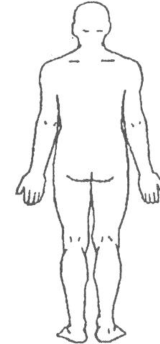
N-Numbness **P-Pain**
T-Tingling **A- Ache**
S-Soreness **ST-Stiffness**



☐ R ☐ L



☐ R ☐ L



Date you first noticed symptoms: ______________________ Describe how they began: ________________________________

____

How often are your symptoms present? ☐ 0%-25% (Occasional) ☐ 26%-50% ☐ 51%-75% ☐ 76%-100% (Constant)

How would you describe the symptoms? ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Weakness ☐ Dull ☐ Burning ☐ Stiffness

☐Throbbing ☐ Numb ☐ Tingling ☐ Cramps ☐ Achy ☐ At Night ☐ Unrelieved by position or rest

How are your symptoms changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing ________________________________

How would you rate your symptoms? (Use a scale of 0 – 10 where: 0 = none; 10 = most extreme) Best: ______ Worst:______

Rate interference with your daily activities in the past week (0 = none; 10 = unable to carry on activities) _________________

What makes your symptoms Worse?_______________________________ Better?_____________________________________

Have you seen any other health care professionals for this condition? ☐ YES ☐ NO <u>If yes, please list:</u>

Name/Specialty/Date:____ Name/Specialty/Date:____

Have you had any tests done for your symptoms? ☐ YES ☐ NO <u>If yes, please check test and give approximate date and area:</u>

☐ X-Rays________ ☐ CT Scan________ ☐ MRI________ ☐ Lab________ ☐ Other________________________________

Please indicate findings if known:____

Have you seen any other health care professionals for any other condition? ☐ YES ☐ NO <u>If yes, please list:</u>

Name:/City/Date: ____

Have you ever received chiropractic care before? ☐ YES ☐ NO <u>If yes, describe:</u> ______________________________________

EXERCISE, WORK, ACTIVITY HABITS

Exercise: ☐ None ☐ Light ☐ Moderate ☐ Heavy # Days/Week:____________ ☐ Running (distance): _____________

☐ Marathon/Triathlon ☐ Cycling ☐ Other Sports:____

Does Your Work Involve: ☐ Extensive Sitting ☐ Extensive Standing ☐ Light Labor ☐ Heavy Labor

☐ Alcohol: Drinks / Week________ ☐ Caffeine: Cups / Day________ ☐ Smoking: Packs / Day________

☐ High Stress: Reason____

FAMILY HISTORY:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure

☐ Heart Problems ☐ Rheumatoid Arthritis ☐ Stroke

PATIENT NAME____ DATE: _____________________________________

HEALTH HISTORY Check a box to indicate if you have now, or have a history of any of the following:

☐ AIDS/HIV	☐ Excessive Thirst	☐ Loss of Balance	☐ Stroke Date: __________
☐ Alcohol/Drug Dependence	☐ Fatigue	☐ Menstrual problems	☐ Thyroid Disorder
☐ Anemia	☐ Fever, recent	☐ Mononucleosis	☐ Tuberculosis
☐ Ankle Swelling	☐ Fractures	☐ Nausea	☐ Ulcers
☐ Arthritis	☐ Glaucoma	☐ Night Sweats	☐ Venereal Disease
☐ Asthma	☐ Goiter	☐ Numbness	☐ Visual Disturbances
☐ Bowel/Bladder Problem	☐ Gout	Area: __________________	☐ Vomiting
☐ Breathing Problem	☐ Headaches	☐ Osteoporosis	☐ Weight, Abnormal:
☐ Cancer: Explain_____________	☐ Heartburn	☐ Pacemaker	☐ Gain ☐ Loss
☐ Chest Pain	☐ Heart Problem	☐ Pinched Nerve	☐ Currently pregnant?
☐ Chronic Cough	☐ Hernia	☐ Pins / Needles	# of weeks___________
☐ Cold Limbs	☐ Herniated Disc	☐ Pneumonia	☐ Corticosteroid Use
☐ Depression	☐ Herpes	☐ Polio	(Cortisone, Prednisone, etc.)
☐ Diabetes	☐ High Blood Pressure	☐ Prostate Problem	☐ Taking Birth Control Pills
☐ Diarrhea	☐ High Cholesterol	☐ Prosthesis	☐ Other health problems
☐ Digestive Problem	☐ Infections	☐ Psychiatric Care	____________________
☐ Dizziness/Fainting	☐ Kidney Disease	☐ Rheumatic Fever	____________________
☐ Eating Disorder	☐ Liver Disease	☐ Ringing in Ears	____________________
☐ Epilepsy/Seizures	☐ Loss of Sleep	☐ Stiffness	____________________

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

INJURIES / SURGERIES / ACCIDENTS (Description / Date:) Auto Accidents:_______________________________

Falls:____ Head Injuries:____

Broken Bones:___________________________________ Dislocation:____

Surgeries (Including Cosmetic):____

MEDICATIONS: ____

VITAMINS / HERBS / SUPPLEMENTS: ____

ALLERGIES: ____

LATE CANCELLATION / NO SHOW POLICY: At Active Spinal & Sports Care, Inc. we emphasize quality Chiropractic and Healthcare services for our clients. Your well-being is important to us. Failure to provide our office with adequate notice of cancellation deprives another client from receiving care. If you wish to cancel or reschedule your appointment, we ask for at least 24 hours prior notification by phone in order to best assist those who may be in need of our services. Please note that our office charges at $35 fee for any missed appointments with less than 24 hours' notice.

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

________________________________	________________________________	______/______/______
PRINT PATIENT NAME	RESPONSIBLE PARTY SIGNATURE	DATE

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays, and physical therapy techniques, for me (or 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, 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, including but not limited to: muscle sprains and strains, disc injuries, dislocations, broken bones 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 on the facts then known, are in my best interest. I understand that chiropractic treatments are generally considered safe and effective.

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. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Armen B. Agacanyan, DC, CCSP, DACRB
Active Spinal & Sports Care, Inc.
88 West Second Street
Morgan Hill, CA. 95037
408-779-3565

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

______________________________ ______________________
Signature of Patient **Date**

______________________________ ______________________
Printed Name of Patient **Date**

______________________________ ______________________
Signature of Patient’s Guardian or Representative **Date**
(If patient is a minor or incapacitated)

______________________________ ______________________
Authorized Facility Signature **Date**

______________________________ ______________________
Translator (if translation required) **Date**

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY. Active Spinal & Sports Care, Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Active Spinal & Sports Care, Inc.."

"It is our policy to provide a substitute health care provider, authorized by Active Spinal &Sports Care, Inc. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

"*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Active Spinal & Sports Care, Inc. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons: We may disclose your health information to coroners or medical examiners.

Organ Donation: We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies: We may disclose your health information for military, national security, prisoner and government benefits purposes.

Courtesy Calls to Your Residence:

"As a courtesy to our patients, it is our policy to send a text, email, or call your home 1-3 days prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information

will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

Change of Ownership: In the event that Active Spinal & Sports Care, Inc. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Active Spinal & Sports Care, Inc. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Active Spinal & Sports Care, Inc. amend your protected health information. Please be advised, however, that Active Spinal & Sports Care, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Active Spinal & Sports Care, Inc.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Active Spinal & Sports Care, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Active Spinal & Sports Care, Inc. is required by law to comply with this Notice.

Active Spinal & Sports Care, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Armen Agacanyan by calling this office at 408-779-3565. If Armen Agacanyan is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints: Complaints about your Privacy rights, or how Active Spinal & Sports Care, Inc. has handled your health information should be directed to Armen Agacanyan by calling this office at 408-779-3565 If Armen Agacanyan is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 04/15/03.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Active Spinal & Sports Care, Inc. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____ _______________
Patient's Signature Date

____ _______________
Authorized Facility Signature Date