HerringChiropractic

CASE HISTORY

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Cell Phone:** _____ **Email:** _____

Social Security # _____ **Age:**_____ **DOB:** _____ **Sex:** _____

Marital Status: _____ **Occupation**: _____ **Employer:** _____

Employer's Address: _____ **Phone:** _____

Spouse's Name: _____ **Referred By:** _____

What is your major complaint?_____

How long have you had this condition?_____

Other complaints: _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ **Yes** ☐ **No** ☐ **Constant** ☐ **Comes and goes**

Is this condition interfering with your: Work ☐ **Sleep** ☐ **Daily Routine** ☐ **Other:** _____

List surgical operations: _____

Are you taking any medications? _____**What kind?** _____

Other doctors seen for this condition: _____

Doctor's Name: _____ **Diagnosis:** _____

X-Rays/MRI: _____ **Other:** _____

Treatment: _____

Were you off work? _____ **If so, how long?** _____

Have you returned to your same job? **If not, why?** _____

*****DID YOU HAVE A SPECIFIC ACCIDENT? (i.e. car accident, work injury, slip and fall)*****

Did your accident occur at work? _____ **Were you involved in an automobile accident?** _____

*** If you answered yes to either please let the staff know if you have not already done so***

By signing this form, you agree to allow us to bill your insurance if applicable.

Our office has a $25 now show/cancellation fee. If you need to cancel, we ask that you give us 24-hour notice to avoid the fee. By signing this form, you agree to this policy.

Patient's Signature _____ **Date:** _____

IMPORTANT: Please check (✔) all present symptoms. **NAME:**_____ **DATE:** _____

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears
- ☐ TMJ – Jaw pain

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasms in shoulders

ARMS AND HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Arthritis in fingers
- ☐ Sensation of pins and needles in arms

ARMS AND HANDS (continued):
- ☐ Sensation of pins and needles in fingers
- ☐ Numbness in arms (R-L)
- ☐ Numbness in fingers (R-L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Loss of strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Irregular heartbeat
- ☐ Breast pain
- ☐ Dimpled or orange peel breast

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat _____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
  - ☐ Upper lumbar
  - ☐ Lower lumbar
  - ☐ Sacroiliac
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
  - ☐ lying down (sleeping)
  - ☐ walking
- ☐ Pain relieves when _____
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS, AND FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)

HIPS, LEGS, AND FEET (continued):
- ☐ Knee pain
  - ☐ Inside
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R-L)
- ☐ Pins and needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)
- ☐ Pain in feet (R-L)
- ☐ Weakness in the leg (R-L)

WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer
- ☐ Menopause

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/ swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep _____
- ☐ Loss of sleep _____ hrs./ night
- ☐ Loss of weight _____ lbs.
- ☐ Weight gain _____ lbs.
- ☐ Coffee _____ cups/ day
- ☐ Tea _____ cups/ day
- ☐ Cigarettes ____pack/ day
- ☐ Other _____
- ☐ Diabetes
- ☐ Hypoglycemia

REMARKS:

_____

_____

_____

_____

HerringChiropractic

PERSONAL INJURY QUESTIONAIRE

Name: _____

Attorney Name (if applicable): _____

Attorney Address: _____ **Attorney Phone:** _____

NATURE OF ACCIDENT:

1. Date of Accident: _____ Time of Day: _____ Weather Condition: _____

2. Were you: ☐ Driver ☐ Front Passenger ☐ Back left ☐ Back right

3. Number of people in your vehicle? _____ Other vehicle? _____

4. What direction were you headed? ☐ N ☐ E ☐ S ☐ W Street or Freeway? _____

5. Direction of other vehicle? ☐ N ☐ E ☐ S ☐ W Street or Freeway? _____

6. Where were you struck? ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

7. Did your airbags deploy? ☐ Yes ☐ No

8. Was a police report done? ☐ Yes ☐ No

9. What was the total damage to your car? (If known): _____

10. Were you rendered unconscious? ☐ Yes ☐ No If yes, for how long? _____

11. Any: ☐ Fractures ☐ Cuts ☐ Abrasions ☐ Bruises ☐ Burns

12. Please describe how you felt: _____

IMMEDIATELY AFTER THE ACCIDENT: _____

LATER THAT DAY: _____ **THE NEXT DAY**: _____

13. Were you taken to the ER? ☐ Yes ☐ No If yes, how were you transported there? _____

14. Were you admitted to the hospital? ☐ Yes ☐ No Hospital Name: _____

15. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

16. Have you lost time from work from this accident? ☐ Yes ☐ No If yes, last date worked _____

17. Do you notice any activity restrictions due to this injury? ☐ Yes ☐ No If yes, please describe in detail: _____

18. Did you have any physical complaints **BEFORE THE ACCIDENT?** ☐ Yes ☐ No

If yes, please describe: _____

19. Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No

If yes, please describe: _____

20. Have you ever been involved in an auto accident or slip and fall prior to this accident? ☐ Yes ☐ No

If yes, please describe, including date(s), and type(s) of accidents, as well as injuries received: _____

_____

_____ _____

Date **Patient's Signature**

PERCEPTION OF PAIN FINDINGS

Name: _____ **Date of Accident:** _____ **Date of Exam:** _____

GRADE LEVEL OF PAINS FROM 1 TO 10

	No pain	**1-2** *Mild*	**3-4**	**5-7** *Moderate*	**7-8**	**9-10** *Severe*
Headaches						
Neck Pain						
Jaw Pain – Right						
Jaw Pain – Left						
Shoulder Joint - Right						
Shoulder Joint - Left						
Arm - Right						
Arm - Left						
Elbow Joint - Right						
Elbow Joint - Left						
Wrist – Right						
Wrist – Left						
Chest Pain						
Upper Back - Right						
Upper Back - Left						
Mid Back - Right						
Mid Back – Left						
Lower Back – Right						
Lower Back – Left						
Hip - Right						
Hip - Left						
Leg - Right						
Leg - Left						
Knee - Right						
Knee - Left						
Ankle – Right						
Ankle – Left						

SIGNATURE: _____

NAME: _____ ***DATE*:** _____

YOUR PAIN: Below are several areas in which we would like you to indicate where you have pain, and how it feels.

HEADACHES:

The FREQUENCY is:	→	☐	Constant (100%)	☐ Intermittent (50%)	☐ Occasional (25%)	☐	Other
The SEVERITY is:	→	☐	Mild	☐ Slight	☐ Moderate	☐	Severe
The QUALITY is:	→	☐	Dull/ Aching	☐ Sharp/ Stabbing	☐ Burning	☐	Throbbing
The Pain RADIATES:	→	☐	Down Left Arm	☐ Down Right Arm	☐ Down Both Arms	☐	How far down?

_____

NECK PAIN:

The FREQUENCY is:	→	☐	Constant (100%)	☐ Intermittent (50%)	☐ Occasional (25%)	☐	Other
The SEVERITY is:	→	☐	Mild	☐ Slight	☐ Moderate	☐	Severe
The QUALITY is:	→	☐	Dull/Aching	☐ Sharp/ Stabbing	☐ Burning	☐	Throbbing
The PAIN is:	→	☐	On the Left Side	☐ On the Right Side	☐ Both Sides	☐	More on one side
The Pain RADIATES:	→	☐	Down Left Arm	☐ Down Right Arm	☐ Down Both Arms	☐	How far down?

_____

MID BACK PAIN:

The FREQUENCY is:	→	☐	Constant (100%)	☐ Intermittent (50%)	☐ Occasional (25%)	☐	Other
The SEVERITY is:	→	☐	Mild	☐ Slight	☐ Moderate	☐	Severe
The QUALITY is:	→	☐	Dull/ Aching	☐ Sharp/ Stabbing	☐ Burning	☐	Throbbing
The PAIN is:	→	☐	On the Left Side	☐ On the Right Side	☐ Both Sides	☐	More on one side
The Pain RADIATES:	→	☐	Down Left Side	☐ Down Right Side	☐ Down Both Sides		

LOW BACK PAIN:

The FREQUENCY is:	→	☐	Constant (100%)	☐ Intermittent (50%)	☐ Occasional (25%)	☐	Other
The SEVERITY is:	→	☐	Mild	☐ Slight	☐ Moderate	☐	Severe
The QUALITY is:	→	☐	Dull/ Aching	☐ Sharp/ Stabbing	☐ Burning	☐	Throbbing
The PAIN is:	→	☐	On the Left Side	☐ On the Right Side	☐ Both Sides	☐	More on one side
The Pain RADIATES:	→	☐	Down Left Leg	☐ Down Right Leg	☐ Down Both Legs		

OTHER AREAS: Please describe and list any additional areas of pain you may be experiencing (Arms, Legs, Feet, Ribs, Knees, etc.) using the same descriptions from above.

	Frequency	**Severity**	**Quality**	**Pain**
Other:				
Other:				
Other:				
Other:				

Back Index

Form BI100

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

Form N1-100

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

HerringChiropractic

Insurance Information

Patients Name: _____ **Date of Accident:** _____

Your personal auto insurance information (or provide us with a copy of your card):

Insured: _____ **Relationship to insured:** _____

Insurance Company: _____ **Phone #:** _____

Address: _____

Policy #: _____ **Claim #:** _____

Adjuster: _____

****

Third party insurance information (person's insurance who was at fault):

Insured: _____ **Relationship to insured:** _____

Insurance Company: _____ **Phone #:** _____

Address: _____

Policy #: _____ **Claim #:** _____

Adjuster: _____

****

Patient's health insurance information (or provide us with a copy of your card):

Insurance company: _____ **Phone#:** _____

Insured: _____ **Relationship to insured:** _____

Address: _____

ID #: _____ **Group #:** _____

HerringChiropractic

Informed Consent to Chiropractic Treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first days of treatment.

2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature **Print Name**

_____ _____

Date **Witness Signature (to be signed by office)**

HerringChiropractic

Patient Name: _____ Date: _____

List the names, addresses, and phone numbers of any DOCTORS and/or HOSPITALS you have been to for these symptoms.

Doctors/Hospital Seen for Current Symptoms:

(Example - ER, primary doctor, etc.)

Name_____

Address: _____

Phone Number: _____

Date of Treatment: _____

****

Name_____

Address: _____

Phone Number: _____

Date of Treatment: _____

****

Name_____

Address: _____

Phone Number: _____

Date of Treatment: _____

HerringChiropractic

ATTORNEY – PATIENT LIEN AGREEMENT TO PAY DOCTOR

To: _____

_____

_____

RE: Medical Reports and Doctor's Lien

Patient: _____

Date of Accident: _____

Herring Chiropractic
15817 Bernardo Center Dr #105
San Diego, CA 92127
858-674-7200 (office)
858-674-7277 (fax)

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself with regard to the accident in which I was involved.

I hereby authorize and direct my attorney to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of this accident and by reason of any other bills that are due to the doctor and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to the attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith. I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

I agree that this lien will be null and void if I change attorneys, and the new attorney fails to endorse this lien within ten days of his engagement. All monies due the doctor will then be immediately due and payable.

DATED: _____ **PATIENT SIGNATURE:** _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor named above. Attorney further agrees that in the event this lien or the underlying debt is litigated, the prevailing party will be awarded reasonable attorney fees as well as costs.

DATED: _____ **ATTORNEY SIGNATURE:** _____

Attorney: Please sign and send back.

HerringChiropractic

DR. LARRY M. HERRING
15817 Bernardo Center Drive, Suite 105
San Diego, CA 92127
(858)-674-7200

ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving health care services at the Herring Chiropractic Center. I have been advised that Herring Chiropractic is willing to wait for payment for these services, if there continues to be reasonable chance that payment will be made either by insurance proceeds, or out of the settlement of a liability claim.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment of benefits to Herring Chiropractic; or

2. If a liability claim exists, and my attorney refuses to agree to protect the interest of Herring Chiropractic, or if I have not engaged the services of an attorney;

then I agree to pay for services rendered on a current basis. My bill will be paid in full as soon as my liability claim is settled, or within three months of the date of my last treatment, whichever occurs first.

Date: _____

Patient's Signature:_____

Witness: _____

HerringChiropractic

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ **Date of Request:** _____

As required by the Privacy Regulations, The Doctors Office may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

HERRING CHIROPRACTIC

15817 Bernardo Center Dr. #105

San Diego, CA 92127

(858) 674-7200

Patient Health Information authorized to be disclosed: (please circle below)

Doctors Reports ☐ **MRI Reports** ☐ **X-Rays** ☐ **Chart Notes** ☐ **All Medical Records** ☐

Other _____

Effective dates for this authorization: _____ through _____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:
1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment. enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Patient **Date**

_____ _____

Authorized Signature of Facility **Date**

Privacy Notice

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

By way of my signature, I provide the Doctors Office with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient name (Print)

_____ _____

Patient Signature **Date**

_____ _____

Authorized Facility Signature **Date**

If you would like a copy of the privacy notice for your records, please let the front desk staff know.

Our privacy notice is also available on our website.