Welcome to

MARTIN CHIROPRACTIC

225 E. Buena Vista Street, Barstow, CA 92311 (760)-256-2171 www.DrScottMartin.com

Name:_____ Date of Birth_____ Age_____
Last First Middle Initial

Address:_____ Social Security # _____
City State Zip Code

Home Phone #_____Mobile Phone # _____cell phone carrier_____Work Phone#_____

Please CIRCLE your Contact Preference #

Email_____ □Male □Female Driver's License #_____ □Single □Married □Widowed □ Divorced

Your Employer:_____Address_____ Occupation:_____

Spouse Name:_____Spouse Employer:_____ Spouse Work #:_____

Emergency Contact Person and Phone #:_____Whom may we thank for referring you to our office?_____

HEALTH HISTORY Please mark and X only on those conditions which are applicable

□ AIDS/HIV	□ Diabetes	□ Migraine Headaches	□ Rheumatic Fever
□ Anemia	□ Emphysema	□ Multiple Sclerosis	□ Stroke
□ Appendicitis	□ Epilepsy	□ Osteoporosis	□ Thyroid Problems
□ Arthritis	□ Fractures	□ Parkinson's Disease	□ Tumor/Growth
□ Asthma	□ Gout	□ Pinched Nerve	□ Ulcers
□ Bleeding Disorder	□ Heart Disease	□ Polio	□ Other_____
□ Breast Lump	□ Hernia	□ Prostate Problems	_____
□ Bronchitis	□ Herniated Disc	□ Prosthesis	_____
□ Cancer	□ Kidney Disease	□ Psychiatric Care	_____
□ Chemical Dependency	□ Liver Disease	□ Rheumatoid Arthritis	_____

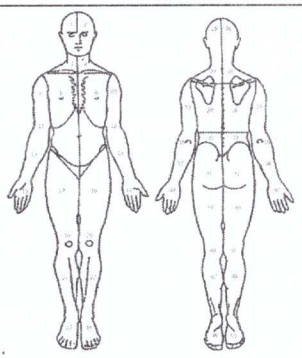
Height _____ Weight_____ Do you have a PACEMAKER? □Yes □No

Please list any previous surgeries _____

Are you PREGNANT ? □No □Yes Due Date_____ Do you smoke ? □No □Yes How many per day?_____

Exercise Habits: □None □Moderate □ Daily □Heavy Work Activities: □Sitting □Standing □Light Labor □ Heavy Labor

PATIENT CONDITION: Reason for this visit today _____



Please mark an X on the picture to the right where you have pain or other symptoms……..
Have you had any X-Rays / MRI / CT Scan of the problem area within the last 12 months? □Yes □No

Name and phone # of other doctor(s) who have treated you for this condition:_____
What treatment have you already received for this condition? □ Medications □ Surgery □Physical Therapy □Chiropractic Care

Please list your current Medications _____

Please list any Allergies_____

How often do you have this pain? □Constantly □Frequently □Occasionally □ Intermittently
When did your symptoms appear?_____ Is this condition getting worse? □ Yes □ No

Is this condition due to an accident? □No □Yes - please give date and location_____
Type of accident □ Auto □ Work □Other_____
If you have an attorney regarding this case please list name and phone #:_____

INSURANCE INFORMATION

Name of Insured:_____Relationship to Patient_____

Insurance Company:_____Phone #_____

Identification # _____ Group #_____ Effective Date:_____

IS PATIENT COVERED BY ADDITIONAL INSURANCE ? □No □ Yes If yes, please complete information below

Insurance Company:_____Phone #_____

Identification #_____ Group#_____ Effective Date:_____

INSURANCE ASSIGNMENT

I, the undersigned, have insurance coverage with_____ and assign directly to Dr. Scott Martin, all
Name of Insurance Company
medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I certify that 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 office immediately whenever I have changes in my health condition or health plan coverage in the future.*

X_____ X_____

Signature Date

CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Scott Martin and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back up for Dr. Scott Martin, including those working at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with Dr. Scott Martin and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at this time, based upon the facts then known, is in my best interests. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. ***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.***

X_____ X_____ X_____

Print Name Signature Date

Notice of Privacy Practices

I have read the Notice of Privacy Practices that was provided to me. I understand that I have the right to a paper copy of this policy at any time upon request. If I have any questions, I may contact 760-256-2171.

X_____ X_____

Signature Date

STATEMENT OF NO ACCIDENT OR INJURY

I certify that my condition is not pre-existing to my insurance effective date nor the result of an auto accident or work related injury.

X_____ X_____

Signature Date

Thank You

MARTIN CHIROPRACTIC (760) 256-2171 www.DrScottMartin.com

Martin Chiropractic

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225 East Buena Vista Street
Barstow, CA 92311
760-256-2171 • Fax 760-259-3937
www.DrScottMartin.com

Insurance Benefits/Coverage Statement

Your insurance company will only pay for services that it determines to be "reasonable and necessary". If your insurance company determines that a particular service is an elective, non-essential procedure under their policy guidelines, they will deny payments for that service. Your insurance company may make a decision regarding your coverage at anytime. A procedure that may have been previously approved may not be approved in the future due to a change in coverage.

Examples of commonly denied treatments, based on our experience that your insurance company may deny payment for are: consultations, office visits, office procedures, and physiotherapy.

The aforementioned treatments may be considered non-medically necessary. Your insurance company may deny payment for other procedures/treatments not mentioned, but for the same reasons stated. Please note, it is your responsibility to verify coverage with your insurance carrier. **Our staff can only give general information about what is *usually* covered by most carriers and/or what is provided by your insurance company website information.**

Keep in mind that the care Dr. Martin believes is medically necessary may not be considered a medical necessity or a covered medical benefit under your insurance plan. In some cases, Dr. Martin might decide that you need medical care which is not covered by your insurance policy.

By signing below you acknowledge that you have been notified by Dr. Martin/staff that your insurance company may deny payment for the services identified above, for the reason stated. You also acknowledge that if your insurance company denies payment that you agree to be personally and fully responsible for all charges.

_____ _____

Patient Signature Date

"Good health through chiropractic care"

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please as questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment ☐ **Please Initial**

As a part of the analysis, examination, ant treatment, you are consenting to the following procedures: ☐ **Patient Initials**

Spinal manipulative therapy, range of motion testing, muscle strength testing, ultrasound, radiographic studies, palpation, orthopedic testing, postural analysis, hot/cold therapy, vital signs, basic neurological testing, EMS.

The material risks inherent in chiropractic adjustments.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I 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 one 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-flammatory, 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 formation of adhesions and reduce mobility which may set up a pain reactions further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Martin and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____ **Patient Name:** _____ **Patient Signature/Guardian:** _____

Dr. Scott L. Martin, D.C., Martin Chiropractic, 225 E. Buena Vista, Barstow, CA 92311 760-256-2171

MARTIN CHIROPRACTIC

225 E. Buena Vista, Barstow, CA 92311 Phone 760-256-2171 Website WWW.DRSCOTTMARTIN.COM

HIPAA 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.

Uses and Disclosures

Some examples of how we may use or disclose your healthcare information:

- Your health care provider or a staff member may disclose your health information to another healthcare provider, hospital, or treatment facility in order to refer you for diagnosis, assessment, treatment, or testing.
- Your health care provider or a staff member may disclose your health information, including your billing records, to another party such as an insurance carrier, an HMO, a PPO, or your employer or their insurance carrier, if they are potentially responsible for the payment of the services your receive.
- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders, information about your treatment alternatives, or other health related information that may be of interest to you. If you refuse us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
- At any time, you may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. You are also entitled to an electronic copy of any records maintained in that format.

Permitted Uses and Disclosures Without Your Consent or Authorization

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

- We are permitted to use or disclose your health information when required to do so by applicable federal or state laws.
- We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information to under state or federal law.
- We are permitted to use or disclose your health information to an appropriate governmental authority if we reasonably believe you are the victim of abuse, neglect, or domestic violence.
- We are permitted to use or disclose your health information for state and federal health oversight activities of the healthcare system and government benefit programs.
- We are permitted to use or disclose your health information to a law enforcement authority as required by laws to report certain types wounds or physical injuries or to comply with a court order, subpoena, or administrative request authorized by law.
- We are permitted to use or disclose your health information to a law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- We are permitted to use or disclose your health information to a correctional institution if we provide healthcare services to you as in inmate.
- We are permitted to use or disclose your health information if we provide healthcare services to you in an emergency.
- We are permitted to use or disclose your health information if we provide care to you that is related to a workplace injury to the extent necessary to comply with Worker's Compensation rules and regulations.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. Your revocation request will not be honored if:

- We have already released your health information before we receive your request to revoke your authorization.
- You were required to give your authorization as a condition of obtaining insurance; the insurance company may have a right to your health information if they decide to contest any of your claims.
- Any circumstance in which we are permitted or required to use or disclose your health information without your consent or authorization.

Your Right to Limit Use or Disclosure

If there are healthcare providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want use to disclose your health information, please let us know in writing which providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your healthcare information. We are not required to agree to your restriction; however, if we agree with your restriction, the restriction is binding on us. If we do not agree to your restriction, you may seek care from another healthcare provider.

Other than the circumstances described above, any other use or disclosure of your health information will only be made with your written authorization.

Patient Signature:_____ **Date:** _____