

Brinegar Chiropractic & Massage Center

Dr. Kenneth Brinegar DC, Dr. Niccole O'Dell DC

INITIAL HEALTH STATUS

Chiropractic

Patient Name _____ Birthdate _____ Gender: M / F
Address _____ City _____
State _____ Zip _____ Phone _____ Email _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

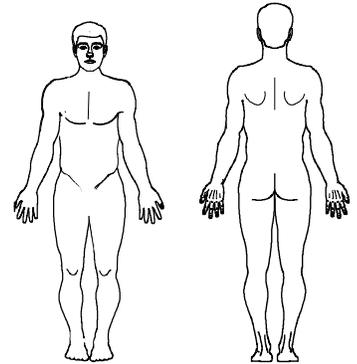
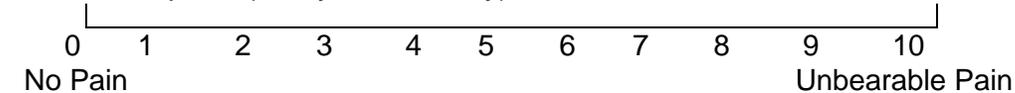
- Headache Neck Pain Mid-Back Pain Low Back Pain
 Other _____

Is this? Work Related Auto Related N/A

Date Problem Began _____

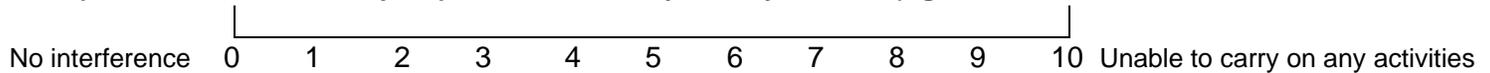
How Problem Began

Current complaint (how you feel today):



How often are your symptoms present? 0 – 25% 26 – 50% 51 – 75% 76 – 100%

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?)



In general would you say your overall health right now is: Excellent Very Good Good Fair Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently Pregnant, # Weeks _____ |
| <input type="checkbox"/> Stroke (Date) _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tobacco Use - Type _____ |
| <input type="checkbox"/> Epilepsy/Seizures | Frequency _____/Day |
| <input type="checkbox"/> Other Health Problems (Explain) _____ | <input type="checkbox"/> Medications _____ |

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner 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.

Patient Signature _____ Date _____

Referred by: _____

PATIENT CONSENT

For use and/or disclosure of protected health information to carry out treatment, payment, and healthcare options.

_____, hereby states that by signing this consent, I acknowledge and agree as follows:
(Print Name)

1. You have the right to a paper copy of the Notice of Privacy Practices for your review before signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the practice to provide treatment to me, and also necessary for BCC (Brinegar Chiropractic Center) to obtain payment for that treatment and to carry out its health care operations. BCC has explained to me that the Privacy Notice will be available to me in the future at my request. BCC has further explained my right to obtain a copy of the Privacy Notice prior to signing the Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. BCC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by BCC:
 - a. a postcard mailed to me at the address I have provided
 - b. telephoning me at home or on my cell phone, and leaving a message on my answering machine or with an individual answering the phone
 - c. email reminders, offers, updates, and promotions
 - d. appointment reminders via text message at the number I have provided
4. BCC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided at home) in order for BCC to treat me and obtain payment for that treatment, and as necessary for BCC to conduct its specific health care options.
5. I understand that I have a right to request that BCC restrict how many PHI is used and/or disclosed to carry out treatment, payment, and/or healthcare operations. However, BCC is not required to agree to any restrictions that I have requested. If BCC agrees to a requested restriction, the restriction is binding on BCC.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *future* transactions, with the understanding that any such revocation shall not apply to the extent that BCC has already taken action in reliance on this Consent.
7. I understand that if I revoke this consent at any time, BCC has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, BCC is unable to treat me.
9. It is the practice of this office to provide chiropractic care in an "open adjusting" and "open door" environment. This environment is used for ongoing care and is NOT used for taking patient histories, performing examinations, or presenting reports and/or findings.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g, Attorney-In-Fact, Guardian, Parent if a minor)

Relationship to Patient

Date signed ____/____/____

Witness: _____

FINANCIAL POLICY
BRINEGAR CHIROPRACTIC & MASSAGE CENTER
DR. KENNETH BRINEGAR D.C., DR. NICCOLE O'DELL D.C.

Insurance billing is done as a courtesy to the patient. Payment is expected at the time of services rendered, unless other arrangements are made in advance. While we attempt to verify coverage, BRINEGAR CHIROPRACTIC & MASSAGE CENTER; Dr Kenneth Brinegar D.C. is not responsible for quoted services your plan covers, and to what extent.

CASH PATIENTS: If you have no current insurance coverage, or your plan does not cover our services, you are considered a cash patient. Payment is expected in full each visit.

INSURANCE: We will assist you with your insurance plan and bill your insurer, but ultimately your insurance is a contract between you and your insurance company. Understanding the nature and extent of your coverage is your responsibility. Payment for co-payments, deductibles, and non-covered services are payable at the time of your visit.

AUTO ACCIDENTS: Patients are responsible for their bills regardless of who is at fault. We will bill your auto-med carrier, if you have one, or expect your attorney to honor our lien. You are responsible for your account. If you receive payment from 3rd party insurance, you are required to forward payment to BRINEGAR CHIROPRACTIC CENTER; Dr. Kenneth Brinegar D.C.

WORKER'S COMPENSATION: By law, the cost of treatment for work injuries is covered by your employer.

BOUNCED CHECKS: There is a \$35 fee for any returned checks.

MISSED APPOINTMENTS: Maintaining your treatment schedule is very important. Please give 24 hours notice of cancellation to avoid a broken or missed appointment charge of \$25 or more. If you miss too many scheduled appointments, you may be released from care. Emergencies are taken into consideration.

I agree to be responsible for and pay all costs of collection, including but not limited to attorney's fees incurred in the event that I do not pay my bill. I understand that there is a 3% interest charge per month on unpaid balances over 30 days past due.

By executing this document and accepting treatment, I agree that any payments that are made by an insurance company will be made directly to the doctor. I will execute any documents necessary to accomplish this, or I will pay In full as services are rendered and await insurance payment myself. In the event that insurance payment should come to me for whatever reason, I agree to immediately deliver payment to BRINEGAR CHIROPRACTIC & MASSAGE CENTER; Dr. Kenneth Brinegar D.C.

I authorize BRINEGAR CHIROPRACTIC & MASSAGE CENTER; Dr. Kenneth Brinegar D.C. to release all relevant information regarding my case to my insurance company, attorney, other health care provider, and to allow BRINEGAR CHIROPRACTIC & MASSAGE CENTER; Dr. Kenneth Brinegar D.C. to file a complaint with the insurance commissioner against my insurer, if necessary to collect my benefits. By my signature below I indicate that I have read and understand the extent and intent of this agreement.

Agreed this _____ day of _____, _____ in California.
Day Month Year

Patient/Guardian signature _____

Print Name _____

INFORMED CONSENT

BRINEGAR CHIROPRACTIC & MASSAGE CENTER;
Dr. Kenneth Brinegar DC, Dr. Niccole O'Dell DC

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 ask questions before you sign if there is anything that is unclear.*

The nature of chiropractic adjustment/manipulation:

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.

Examination / Treatment

As a part of the examination and treatment we provide, you are consenting to the following procedures:

- Spinal Manipulative Therapy
- Range of Motion Testing
- Muscle Strength Testing
- Ultrasound
- Radiographic Studies
- Palpation
- Orthopedic Testing
- Postural Analysis
- Hot/Cold Therapy
- Low Level Laser
- Vital Signs
- Basic Neurological Testing
- EMS
- Other (please specify) _____

The material risks inherent in chiropractic adjustment:

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 estimated to occur between one in one million and one in five million in cervical adjustments. The other complications are also generally described as rare.

(Continued on next page)

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, injections, and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above and 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 reaction, 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 adjustments and related treatment. I have discussed it with *Dr. Kenneth Brinegar DC* and have had any 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 consent to that treatment.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative or Guardian
(e.g. Attorney-In-Fact, Guardian, Parent if a minor)

Relationship to Patient

Date signed ____/____/____

Witness: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE