WHOLE BODY
CHIROPRACTIC & MASSAGE

1399 S. WINCHESTER BLVD SUITE #140, SAN JOSE, CA 95128 | P: 408-261-0772 | F: 408-261-0766

PATIENT REGISTRATION

Name:_____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Number: _____ Ok to leave detailed message? Y | N Sex: M | F

Date of Birth: _____ Age: _____ Email Address: _____

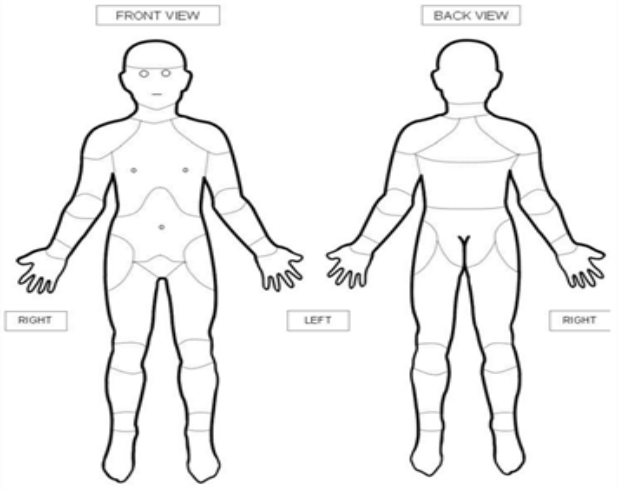
Marital Status: _____ Spouse 's Name: (if applicable) _____

Occupation: _____ Employer: _____

Heath Insurance Company: _____ Health Insurance ID # _____

Describe your current symptoms and how it began: ☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low-Back Pain ☐ Other: _____

Is it ☐ Work Related ☐ Auto Related ? ☐ N/A



Current Complaint: *How are you feeling today?*

0 1 2 3 4 5 6 7 8 9 10

No Pain *Unbearable Pain*

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 (IE; work, social activities, household chores?)

0 1 2 3 4 5 6 7 8 9 10

No Interference *Unable to carry on any activities*

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

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Date Symptoms Started: _____

Have you had any of the following

SPINAL X-RAYS, MRI's, CT Scans done? Y | N

Regarding the area of complaint? Y | N

Date(s) taken: _____ **Please check the all that applies:**

☐ Alcohol/Drug Dependence ☐ Prostate Problems ☐ Recent Fever ☐ Diabetes ☐ High Blood Pressure ☐ Menstrual Problems ☐ Stroke ☐ Urinary Problems ☐ Corticosteroid Use ☐ Currently Pregnant ☐ Taking Birth Control ☐ Pain Unrelieved by Position or Rest ☐ Dizziness/Fainting ☐ Numbness ☐ Pain at Night ☐ Cancer/Tumor ☐ Visual Disturbances ☐ Abnormal Weight Gain or Loss ☐ Osteoporosis ☐ Tobacco Use ☐ Epilepsy/Seizures ☐ Surgeries: _____ ☐ Other Health Problems: _____

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

Patient Signature: _____ Date:_____

CONTINUED ON THE BACKSIDE

Dr. Maramag/Dr. McClure will gladly prepare medical claim forms but we cannot render services on the assumption that our charges will be paid by an insurance company. **You are responsible for payment whether or not paid by insurance.**

Authorization for Release of Medical Records

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to Dr. Maramag/Dr. McClure. I understand that I am financially responsible for my balance not covered by my insurance carrier and if I am accepted as a patient I am expected to pay at the end of each visit unless other arrangements are made. A copy of this signature is valid as the original.

I hereby authorize the release of medical information requested by Dr. Maramag/Dr. McClure from other providers, such as medical notes and diagnostic imaging as found necessary by Dr. Maramag/Dr. McClure to aid in diagnosis, Chiropractic and physical therapy.

I certify to the best of my knowledge 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 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. 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.

I hereby request and consent to both Chiropractic and physical therapy care.

Patient Signature: _____ Date:_____

CONTINUED ON THE NEXT PAGE

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.

Dr. Maramag/Dr. McClure 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 Information

Treatment

We may disclose your health care information to other healthcare professional within our practice for the purpose of treatment, payment or healthcare operations. (Example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Dr. Maramag/Dr. McClure."

"It is our policy to provide a substitute health care provider, authorized by your doctor 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. (Example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to your treating doctor 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."

Worker's Compensation

We may disclose your health information as necessary to comply with State Worker's 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.

Patient Signature: _____ Date:_____

CONTINUED ON THE BACKSIDE

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

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below: (example)
"As a courtesy to our patients, it is our policy to call your home, work and/or mobile phone prior to a scheduled appointment to remind you of your appointment time and/or after a missed appointment to reschedule it. 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."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Dr. Maramag/Dr. McClure sponsored fund-raising events.

Change of Ownership

In the event that Dr. Maramag/Dr. McClure's clinic 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 Dr. Maramag/Dr. McClure 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 Dr. Maramag/Dr. McClure amend your protected health information. Please be advised, however, that Dr. Maramag/Dr. McClure 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 Dr. Maramag/Dr. McClure.

Changes to this Notice of Privacy Practices

Dr. Maramag/Dr. McClure reserve 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, all independent doctors are required by law to comply with this Notice.

Dr. Maramag/Dr. McClure, are 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 your independent doctor by calling this office.

Complaints

Complaints about your Privacy rights, or how Dr. Maramag/Dr. McClure has handled your health information should be directed to your independent doctor, since he/she is the Privacy Officer of his/her independent practice by calling this office. If your independent doctor is not available, you may make an appointment for a personal conference in person or by telephone within two 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

Patient Signature: _____ Date:_____

CONTINUED ON THE NEXT PAGE

Informed Consent for Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury.*

Other options for the treatment of pain include: *do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery*. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

My signature below confirms that I have read the paragraphs above and that I understand what my chiropractor has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

_____

Witness Name **Signature** **Date**

Patient Signature: _____ Date:_____

CONTINUED ON THE BACKSIDE

WHOLE BODY
CHIROPRACTIC & MASSAGE

1399 S WINCHESTER BLVD #140 SAN JOSE, CA 95128
(408) 261-0772 [P]. (408)261-0766 [F]
WholeBodySJ@gmail.com

Assignment of Insurance Benefits and Direction to Pay

I hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and directly pay Dr. Drew McClure/Dr. Russell Maramag for professional services rendered to me. This includes a direct assignment of my rights and benefits under any such policy of insurance. This assignment of insurance benefits is provided so that Dr. Drew McClure/Dr. Russell Maramag may attempt to collect any unpaid and overdue insurance benefits directly from the insurance carrier. I authorize any holder of insurance information about me to release such information to Dr. Drew McClure/Dr. Russell Maramag needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize Dr. Drew McClure/Dr. Russell Maramag to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf. A copy of this agreement will be as valid as the original. I have read and I do understand this agreement thoroughly.

Patient Signature: _____ Date:_____