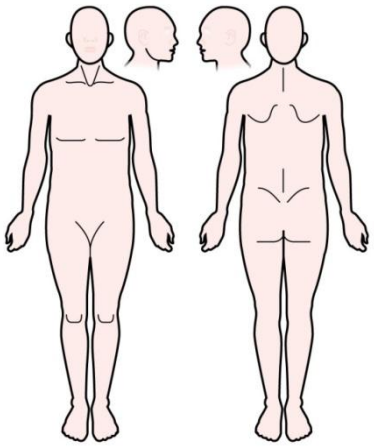
Bonita Chiropractic Center
Dr. Ed O'Neill D.C.
Date: _____

*IT'S YOUR FUTURE...*
*BE THERE HEALTHY*

**PLEASE PRINT**

Name: _____ Nick Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Northern Address: _____
E-mail Address: _____ Social Security #:_____
Date of Birth: _____ Gender M /F Material Status: S M W D
Spouses Name: _____ Emergency Contact _____ Phone: _____
Home Phone#:_____ Work #:_____ Cell #:_____
Referral Source: * Friend: _____ Doctor: _____ Other: _____

**Preferred Language?** English Spanish Other_____
**Race?** White Black or African American Asian Other_____
I do not wish to provide this information
**Ethnicity?** Non-Hispanic or Non-Latin Hispanic or Latino Other_____
I do not wish to provide this information



**What are your major complaints?**

| | Pain | | Numbness | | Tingling | |
|---|---|---|---|---|---|---|
| **Head** | | | | | | |
| **Neck** | | | | | | |
| **Upper Back** | | | | | | |
| **Mid Back** | | | | | | |
| **Lower Back** | | | | | | |
| | **Left** | **Right** | **Left** | **Right** | **Left** | **Right** |
| **Shoulder** | | | | | | |
| **Arm** | | | | | | |
| **Forearm** | | | | | | |
| **Hand** | | | | | | |
| **Buttock** | | | | | | |
| **Hip** | | | | | | |
| **Leg** | | | | | | |
| **Foot** | | | | | | |

**Symptoms**

Stiffness
Dull
Aching
Cramps
Nagging
Sharp
Burning
Shooting
Throbbing
Stabbing
Other

**Please mark areas of pain**

**Your pain is aggravated by:** Neck Movement Coughing Sneezing Standing Sitting
Lifting Reaching Walking Bending Straining At Stool

| | Yes | No |
|---|---|---|
| Do you experience pain every day? | ☐ | ☐ |
| Do your symptoms interfere with daily life? | ☐ | ☐ |
| Does pain wake you up at night? | ☐ | ☐ |
| Are your symptoms worse during certain times of the day? | ☐ | ☐ |
| Do changes in weather affect your symptoms? | ☐ | ☐ |
| Do you wear orthotics? | ☐ | ☐ |
| Have you had X-rays, CT Scan or An MRI Taken | ☐ | ☐ |
| If yes, what films and where? _____ | | |
| Have you been treated for any conditions in the last year? | ☐ | ☐ |
| If yes, please describe _____ | ☐ | ☐ |

| | |
|---|---|
| Is there any chance that you are pregnant?<br>Have you ever been treated by a Chiropractor before? | ☐ ☐ |

Date of last physical exam: _____

**Continue on Reverse**

| **MEDICAL HISTORY** | | |
|---|---|---|
| **Have you Ever:** | No Yes | Briefly Explain |
| Broken bones?<br>Been hospitalized?<br>Been in an auto accident?<br>Had Sprains/ Strains?<br>Been struck unconscious?<br>Had Surgery?<br>Have you had any spinal or joint surgery/ replacements | | |

| **Have you ever suffered from:** | | | |
|---|---|---|---|
| ☐Alcoholism | ☐Depression | ☐Irregular Cycle | ☐Prostate Trouble |
| ☐Allergies_____ | ☐Diabetes | ☐Kidney Infection | ☐Sciatica |
| ☐Anemia | ☐Digestion Problems | ☐Kidney Stones | ☐Shortness of Breath |
| ☐Arteriosclerosis | ☐Dizziness | ☐Loss of Memory | ☐Sinus Infection |
| ☐Arthritis | ☐Ears Ringing | ☐Loss of Balance | ☐Sleep Problems |
| ☐Asthma | ☐Excessive | ☐Loss of Smell | ☐Insomnia |
| ☐Back Pain | ☐Menstruation | ☐Loss of Taste | ☐Spinal Curvatures |
| ☐Breast Lump | ☐Eye Pain / Difficulties | ☐Lump in Breast | ☐Stroke |
| ☐Bronchitis | ☐Fatigue | ☐Neck Pain or Stiffness | ☐Swelling of Ankles |
| ☐Bruise Easily | ☐Frequent Urination | ☐Nervousness | ☐Swollen Joints |
| ☐Cancer | ☐Headaches | ☐Nosebleeds | ☐Thyroid Condition |
| ☐Chest Pain/Conditions | ☐Hemorrhoids | ☐Over Weight | ☐Tuberculosis |
| ☐Cold Extremities | ☐High Blood Pressure | ☐Pacemaker | ☐Ulcers |
| ☐Constipation | ☐Hot Flashes | ☐Polio | ☐Varicose Veins |
| ☐Cramps | ☐Irregular Heart Beat | ☐Poor Posture | ☐Venereal Disease |

Is there anything else Dr. O'Neill should know about your current condition, your progress or ways your current conditions is affecting your life? _____

_____

Are you currently taking any prescribed medications? No Yes If yes please list or provide a copy your list.

Name: _____ Dose: _____ Often: _____
Name: _____ Dose: _____ Often: _____
Name: _____ Dose: _____ Often: _____
Name: _____ Dose: _____ Often: _____

Are you currently taking any vitamins, minerals or herbs? No Yes If yes please list or provide a copy your list.

Name: _____ Dose: _____ Often: _____
Name: _____ Dose: _____ Often: _____
Name: _____ Dose: _____ Often: _____
Name: _____ Dose: _____ Often: _____

| **Habits** | **None** | **Former** | **Light** | **Moderate** | **Heavy** |
|---|---|---|---|---|---|
| Alcohol<br>Coffee<br>Tobacco<br>Drugs<br>Exercise<br>Sleep | | | | | |

**Signatures**

Name of the insured_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree all services rendered to me are my personal responsibility for payment. I understand if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be due.

Patients Signature: _____ Date: _____

Spouse's or guardian's signature : _____ Date: _____

# BONITA CHIROPRACTIC CENTER

Welcome to our office. Thank you for choosing us as your health care provider. To avoid any misunderstanding regarding this policy, it is necessary to read and sign this financial policy before treatment.

1.) PAYMENT AT THE TIME OF SERVICE: Payment is due in full at the time of service including co-pays unless it is solely covered by Medicare or Insurance Company.

2.) MEDICARE PATIENTS: We are participating physicians with Medicare. You will be responsible for 20% of the approved Medicare fee, the $100 yearly deductible and full payment of any non-covered services. As a courtesy, we will file your claim with a secondary insurance, although you will be responsible for any remaining balance if payment is not received.

3.) PATIENT RESPONSIBILITY: We cannot guarantee that we are a participating provider with your insurance. It is the patient's responsibility to know if we are on your insurance provider list. All patients are responsible for office co-pays, yearly deductibles and any non-covered benefits at the time of service.

4.) ASSIGNMENT OF BENEFITS – AUTHORIZATION TO RELEASE INFORMATION: I hereby assign, transfer and convey all medical/surgical benefits, including but not limited to Major Medical, Medicare, private insurance, PIP and any other health plan benefits to which I am entitled, as well as any cause of actions arising from the non-payment of such benefits to Bonita Chiropractic Center.

This order will remain in effect until revoked by both parties in writing. A photocopy of this assignment is to be considered as valid as the original. In exchange for this assignment of benefits Bonita Chiropractic Center will bill my insurance carrier directly. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I am aware that finance charges of 1.5% will begin accruing monthly when my bill is 30 days past due and if payment is not received within 90 days, your account will subject to referral to a collection agency and you will be responsible for their additional fees. I hereby authorize Bonita Chiropractic Center to release all information necessary to secure payment and to complete disability forms. I also authorize release of medical information, including HIV information, to other doctors and/or healthcare providers involved in my care.

I give permission to Bonita Chiropractic Center to take my picture for the sole purpose of identification by the Doctor and staff.

5.) CANCELLATION/NO SHOW POLICY: It is the patient's responsibility to keep their reserved appointment time. Appointments you book are time we specifically set aside for you. Other patients and new patients sometimes cannot get in to be seen because there are no appointments available. If you do not arrive for your scheduled appointment without a 24-hour cancellation notice you will be responsible for a $25.00 non-fundable fee.

I have read and understand my financial responsibilities. I understand and agree to this policy as outlined above.

_____ _____

Patient/ Guardian Signature Date

_____

Patient's Name (Please print clearly)

**ACKNOWLEDGMENT OF RECEIPT**
**OF**
**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By **checking the lines below** I authorize being contacted for appointment reminders, birthday greetings and/or promotions about the practice by:

Mail _____;
Email_____; at email address _____;
Telephone numbers_____;
_____;
By voice mail _____;
By text message _____;
By FaceBook address _____.

By checking this checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.**

List below the names and relationship of people to whom you authorize the Practice to release PHI.

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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 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**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures *if necessary*:

- ☑ Spinal Manipulation
- ☑ Palpation
- ☑ Vital Signs
- ☑ Range of Motion Testing
- ☑ Orthopedic Testing
- ☑ Basic Neurological Test
- ☑ Muscle Strength Test
- ☑ Postural Analysis Test
- ☑ Ultrasound
- ☑ Hot/Cold Therapy
- ☑ EMS
- ☑ Radiographic Studies
- ☑ SEMG
- ☑ Myofascial Release

**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 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 if 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
- Hospitalization
- Surgery
- Medical care and prescription drugs, such as anti-inflammatory, muscle relaxants, and pain-killers

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 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 adjustment and related treatment. I have discussed it with [Dr. Ed O'Neill or Dr. Alex Szecsodi] 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 herby give my consent to that treatment.**

**Verification of non-pregnancy**

Date _____ File # _____

Date of L.M.P _____

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent of Guardian (if a minor)

Dated: _____

_____
Doctor's Name

_____
Signature

_____
Witness

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