Welcome

Date: _____

The doctors and staff wish to welcome you and want to provide you with the best possible care.

Patient Information

Name: _____ E-mail: _____

Address: _____ City _____ State _____ Zip _____

Phone Home: _____ Cell: _____ Work: _____ Can we call? ___ Y ___ N

SS Number: _____ Sex: M ___ F ___ Age _____ Birthdate: _____

Single ___ Married ___ Widowed ___ Divorced ___ Spouse/Partner: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City _____ State _____ Zip _____

In case of emergency, who should we contact: Name: _____

Relationship _____ Phone Home _____ Work _____

Who can we thank for referring you? _____

Have you seen a chiropractor before? Y ___ N ___ Was it a good experience? Y ___ N ___ Are you pregnant? Y ___ N ___

Insurance Information

Insurance Co. _____ Group or ID# _____

Subscriber's Name _____ Birthdate _____ SS# _____

Relationship to Patient _____ Is this condition due to an accident? Y ___ N ___

Do you have an active insurance case? Y ___ N ___ Automobile? ____ Slip or Fall? ____ Work? ____

Are you starting an insurance case? Y ___ N ___

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Martinet Chiropractic Inc. all insurance 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 insurance submissions.

Signature: _____ Date: _____

Health History

Please mark anything that applies to you either presently, in the past, or not at all.

	Present, Past, No		Present, Past, No		Present, Past, No		Present, Past, No
AIDS/HIV	___ ___ ___	Difficult Urinating	___ ___ ___	Kidney Disease	___ ___ ___	Polio	___ ___ ___
Alcoholism	___ ___ ___	Dizziness	___ ___ ___	Liver Disease	___ ___ ___	Prostrate Problem	___ ___ ___
Allergies	___ ___ ___	Emphysema	___ ___ ___	Loss of Balance	___ ___ ___	Psychiatric Care	___ ___ ___
Anemia	___ ___ ___	Epilepsy	___ ___ ___	Measles	___ ___ ___	Rheumatoid Arthritis	___ ___ ___
Anorexia	___ ___ ___	Fainting	___ ___ ___	Menstrual Difficulties	___ ___ ___	Rheumatic Fever	___ ___ ___
Appendicitis	___ ___ ___	Fractures	___ ___ ___	Migraine Headaches	___ ___ ___	Scarlet Fever	___ ___ ___
Arthritis	___ ___ ___	Glaucoma	___ ___ ___	Miscarriage	___ ___ ___	Stroke	___ ___ ___
Asthma	___ ___ ___	Goiter	___ ___ ___	Mononucleosis	___ ___ ___	Thyroid Problem	___ ___ ___
Bleeding Disorders	___ ___ ___	Gonorrhoea	___ ___ ___	Multiple Sclerosis	___ ___ ___	Tonsillitis	___ ___ ___
Breast Lumps	___ ___ ___	Gout	___ ___ ___	Mumps	___ ___ ___	Tuberculosis	___ ___ ___
Bronchitis	___ ___ ___	Heart Disease	___ ___ ___	Nervousness	___ ___ ___	Tumours/Growths	___ ___ ___
Bulimia	___ ___ ___	Hepatitis	___ ___ ___	Osteoporosis	___ ___ ___	Typhoid Fever	___ ___ ___
Cancer	___ ___ ___	Hernia	___ ___ ___	Pacemaker	___ ___ ___	Ulcers	___ ___ ___
Cataracts	___ ___ ___	Herniated Disc	___ ___ ___	Parkinson's Disease	___ ___ ___	Vaginal Infections	___ ___ ___
Chemical Dependency	___ ___ ___	Herpes	___ ___ ___	Pinched Nerve	___ ___ ___	Venereal Disease	___ ___ ___
Chicken Pox	___ ___ ___	High Blood Pressure	___ ___ ___	Pneumonia	___ ___ ___	Whooping Cough	___ ___ ___
Diabetes	___ ___ ___	High Cholesterol	___ ___ ___			Other _____	
		Irritability	___ ___ ___			_____	

Social History

Height _____ Weight _____

Has your weight changed much in the last year? __Y__ N

How much Alcohol do you drink per week? _____

How much coffee do you drink a day? _____

How much soda do you drink a day? _____

Do you love sweets? __Y __N Do you crave salt __ Y__ N

Do you smoke? __Y __N Do you stretch daily? __ Y __ N

How many times a week do you exercise? _____

What type of exercise do you do? _____

How would your rate your daily stress level? L 1 2 3 4 5 H

Physical History

Please describe and date:

Any Falls: _____

Any Accidents: _____

Any broken bones: _____

Any surgeries: _____

Any hospitalizations: _____

What brings you in today? _____

What date did the problem start? _____

When was the most recent flare up? _____

Severity of pain 1 2 3 4 5 6 7 8 9 10

What do you think caused this complaint? _____

What makes it better? _____

What makes it worse? _____

2) _____

Severity of pain 1 2 3 4 5 6 7 8 9 10

What do you think caused this complaint? _____

What makes it better? _____

What makes it worse? _____

3) _____

Severity of pain 1 2 3 4 5 6 7 8 9 10

What do you think caused this complaint? _____

What makes it better? _____

What makes it worse? _____

Describe the pain: ____Sharp (knife like) ____Dull (like a toothache)

____Burning (hot) Other: _____

What time of day is the pain the worst?

____Morning____Afternoon____Evening____ Night____ All the time

The pain is _____ Occasional _____ Frequent _____ Constant.

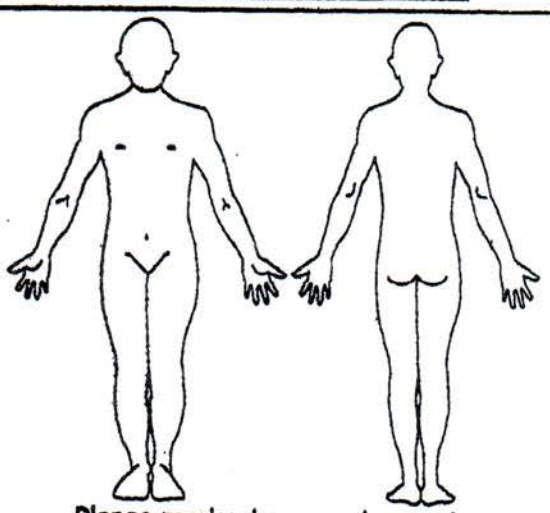
Is the pain local ____ Y ____ N

Does the pain travel or radiate down the arm or leg? ____Y____N

How far? _____

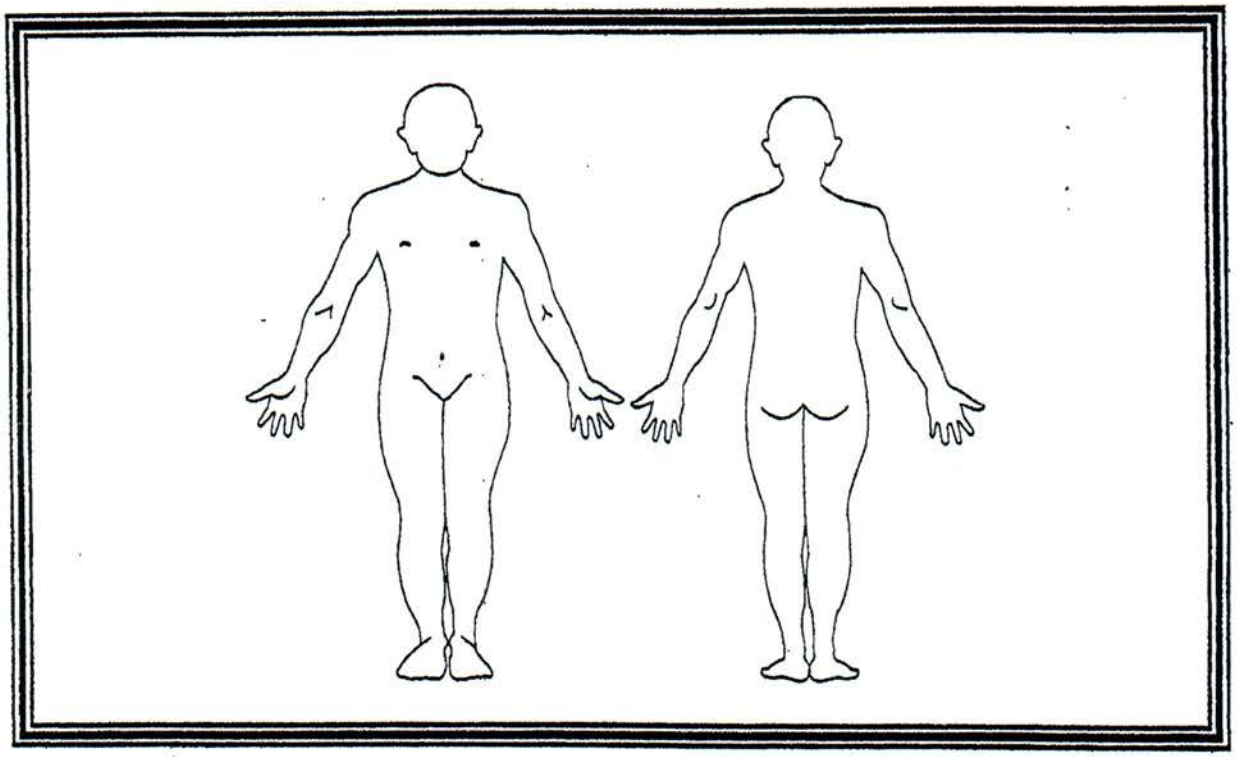
Do you have any ___ pain, ___ numbness, ___ tingling, ___ pins and needles in the ___ hands or ___ feet. ___ Y ___ N

Does this pain affect your sleep? ___ Y ___ N



Please mark where you have pain.

Please mark any scars you have



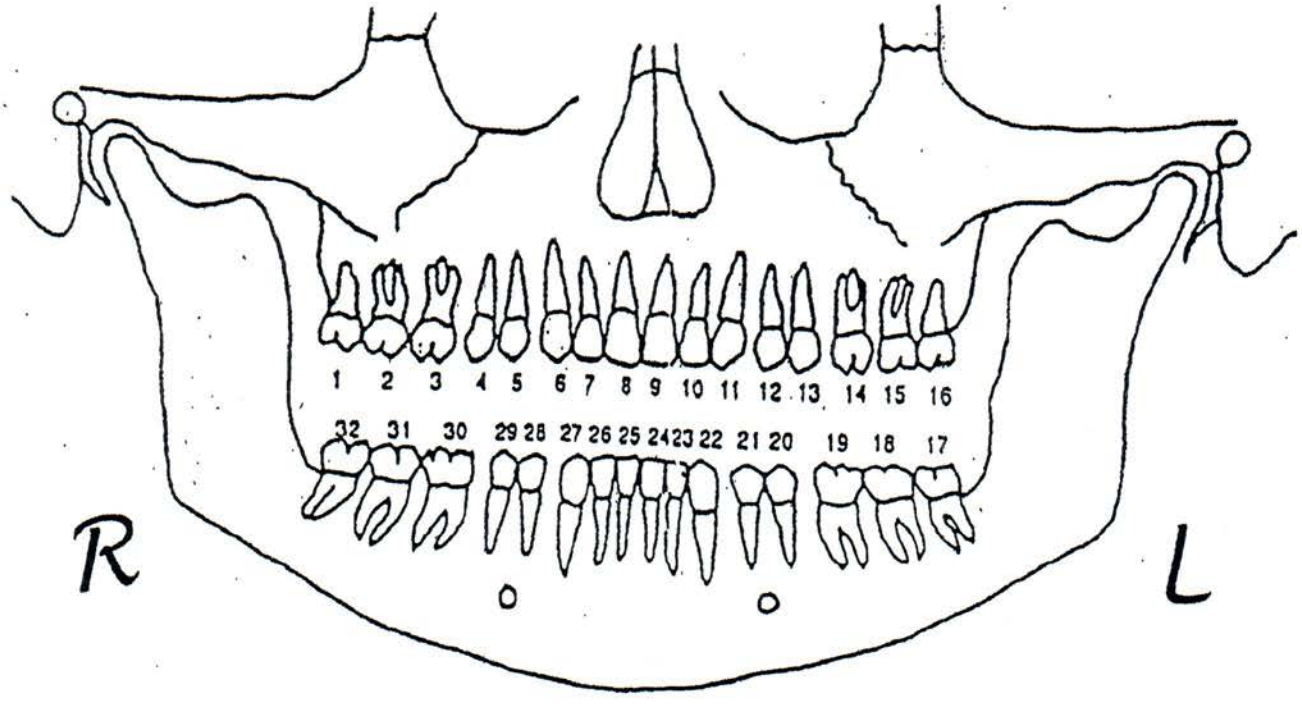
Dental Chart

Please mark any dental work you have had using the following key

(X) Pulled/Missing tooth (A) Amalgam filling (C) Composite Filling (--) Crown (R) Root canal

Dentures: ___Upper ___Lower Braces: ___Upper ___Lower Retainer/Night guard ___Upper ___ Lower

Do you have any clicking or popping in either jaw? ___ L ___R



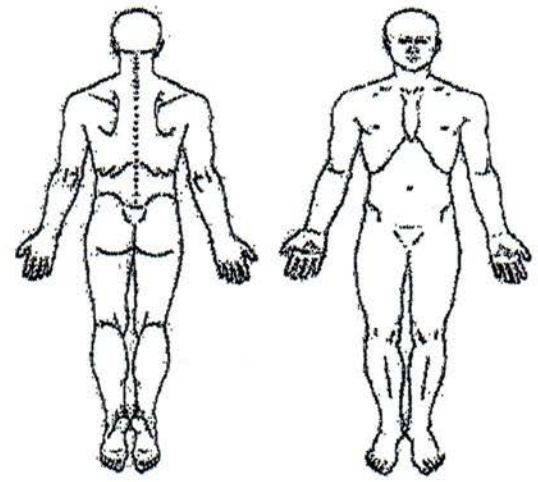
Please list what Supplements, Vitamins, Minerals, Herbs, or Drugs you are taking.

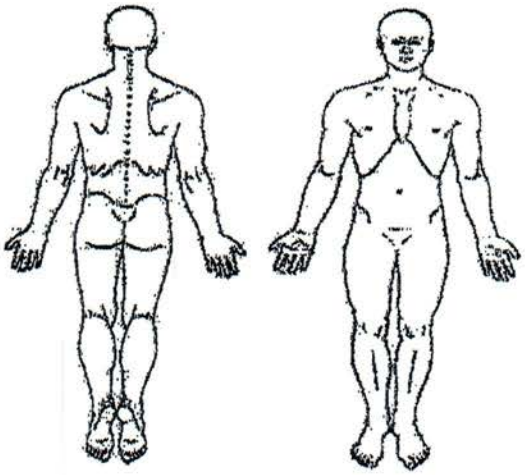
Supplements	How many a day? Morning	Lunch	Dinner	How long have you been taking this?	Who prescribed / suggested taking?
Prescription or over the counter medications					

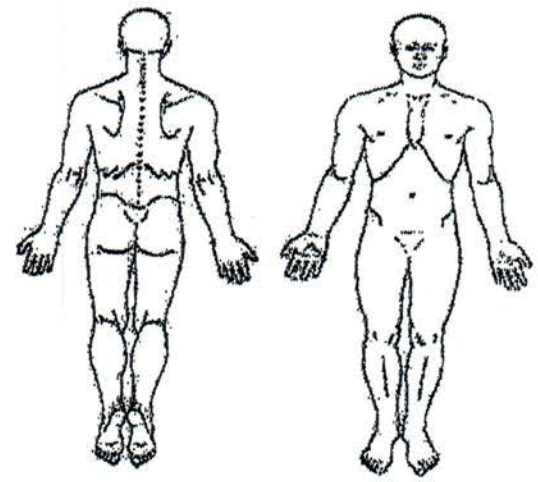
HISTORY OF INJURIES

NAME_____ **DATE**_____

PLEASE MARK ALL PLACES THAT HAVE EVER BEEN INJURED
(Sprains, Strains, Broken Bones, Severe Bruises, Surgery, Scars, Head Bumps, Cuts, Burns, Etc)







What happened?	When did it happen?
What happened?	When did it happen?
What happened?	When did it happen?

Informed Consent for Chiropractic Treatment of Your Pain

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.

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

Martinet Chiropractic Inc.

1454 Leimert Boulevard, Oakland, California 94602 (510) 530-3328)

NON-INSURED

We request 100%of the services be paid at the time services are rendered.

PRIVATE HEALTH INSURANCE

If you have insurance coverage we ask that you pay 100% of your services at the time of each visit. To assist you in determining what benefits may be available to you through your health insurance carrier we will provide you with an Insurance Verification Form. Once you have called your insurance carrier, verified your benefits, and returned a copy of the verification form to our office, we will bill your carrier directly for you at the end of each month. Since we will not be accepting assignment (direct payment from the insurance carrier) they should send available benefits directly to you.

MEDICARE

Dr. Martinet is not a Participating Provider with Medicare, and therefore you will be responsible for paying for all services you receive at the time the services are rendered. We are required to submit your claims directly to Medicare. Medicare will send reimbursement directly to you. If you have a supplemental insurance policy that covers chiropractic please ask Medicare to forward claims directly to your supplemental carrier for processing.

IT MUST BE UNDERSTOOD:

1. This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.
2. This clinic provides services that we feel are of the most benefit to you in your healing. Many of these services are beyond what most insurance policies will cover. As you are responsible for any charges occurred, if you DO NOT wish to receive these services please let us know.
3. This clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.
4. Any charges older than 30 days that remain on your account will be charged a 1.5% monthly interest rate, Past due accounts may also be referred to an agency for collection.
5. **We require notice of cancellation 24 hours prior to your schedule appointment. By signing below you understand that a charge of $45.00-$95.00 will be made to your account for any appointment which is cancelled without a 24 hour notice. A payment will be charged to the card listed below.** This card will also be charged for any phone-in supplement orders. (Visa MasterCard Discover American Express ATM)

Card#_____ Expiration Date:_____ Billing Zip:_____

Patient's Signature_____ Patient's Name Printed_____

Dr. Jean Paul Martinet, D.C. ~ Martinet Chiropractic, Inc

1454 Leimert Boulevard ~ Oakland, California ~ 94602 (510) 530 ~3328

Dr. Martinet uses only the most advanced treatments and protocols to return you to optimum health. He spends a lot of time and money to bring the most advanced techniques possible to his practice and then ultimately to his patients.

I understand that during the course of my treatment at Martinet Chiropractic, I may receive alternative medical services such as: Bemer 3000 Treatments, Heart Rate Variability, Ionic Foot Baths, Low Level Cold Laser Therapy, Neuro Emotional Technique Therapy, Thought Field Therapy, and varied supplements. I understand that these services are not covered under my current health insurance policy.

I understand, as well, that I am responsible for these services and that these services will not be billed to my health insurance carrier.

Your signature below acknowledges that you agree to bear full financial responsibility for all and any services listed above.

Print Patient Name: _____

Patient Signature: _____

Date: _____

Acknowledgment of Receipt of Privacy Practices Notice

Health Insurance Portability and Accountability Act

HIPAA

This document acknowledges that you have been given, read,
and understand the Notice of Privacy Practices.
This document is not a contract, authorization, release,
or consent form. This document will remain with your records.

Print Patient Name: _____ Date: _____

Patient Signature: _____

❖ ❖❖ ❖ ❖❖ ❖

If the patient is a minor, (under 18), a parent, or legal guardian **must** sign below.

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Martinet Chiropractic, Inc.

1454 Leimert Blvd, Oakland, Ca. 94602
Office: (510) 530-3328
Office Fax: (510) 530-2566

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Please note:

Upon request, we will give you a copy of your records within 15 days of the request. State board and HIPAA Rules allow us to charge a reasonable fee for copying these records. Please check with our Chiropractic Office Staff for information on these fees. Thank you.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Martinet Chiropractic, Inc.