GALLAGHER CHIROPRACTIC WELLNESS CENTER

25283 Cabot Dr suite 109 Laguna Hills Ca 92653

Last Name: _____MI:_____ First Name:

Home Address: _____Apt_____City:

State: _____ Zip: _____Home Telephone: _____Cell Phone:

Notify in case of emergency: _____ Tel:

Date of Birth: _____/_____/_____Sex: ____F ____M Soc. Sec. #: /_____/

Marital Status: S M W D Age: _____ E-mail:

Height:_____Wt:_____Preferred Language:_____**Race:** Hispanic or Latino / Not Hispanic or Latino

(Circle one choice)

Ethnicity: American Indian or Alaska Native / Asian / Black or African American / Hispanic or Latino / Native Hawaiian or Pacific Islander / White (Circle one choice)

Employer: _____ Occupation:_____Work Phone:

Number of Hours worked:_____Whom may we thank for referring you?

METHOD OF PAYMENT (Circle Choice)

Self-Pay: Cash / Check / Credit Card / Private Insurance / Medicare

Date of Injury:____/_____/___Work Comp / Accident Attorney / Other:

INSURANCE INFORMATION

*Insured Name (if other than patient)*_____ *Insured Subscriber #:*

*Insured Date of Birth:*_____ *Soc. Sec # of insured*:

Medical Insurance _____ Subscriber Number:

Policy: _____ Group: _____ Tel of Insurance:_____

Address:

****
****

Worker's Comp/ Auto accident / Attorney:

Claim #:_____ Adjuster:

Address: _____City: _____ State:
Zip:

Tel: _____Fax:

ASSIGNMENT OF INSURANCE BENEFITS / PATIENT INFORMATION

Patient hereby assigns **GALLAGHER CHRIROPRACTIC WELLNESS CENTER** ("Provider") all rights to payment and benefits and all legal and other health plan, ERISA plan, or insurance contract rights that I (or my child, spouse or dependent) may have under my/our health plan(s) or health insurance policy(ies), and I hereby instruct and direct my health insurer or plan to pay by check made out and mailed to **GALLAGHER CHRIROPRACTIC WELLNESS CENTER ,** the medical expense or other professional healthcare provider benefits allowable under my current insurance policy for services rendered to me or my dependent(s). This assignment includes, but is not limited to, a designation that Provider can act on my/our behalf, as my/our representative or ERISA representative, as to any initial or subsequent claim determination or adverse notification/denial, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to Provider as a result of services rendered by Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer to accomplish, inter alia, payment of Provider. This assignment and designation remains in effect unless revoked in writing, and is a direct assignment of my rights and benefits under this policy. A photocopy of this Agreement shall be considered as effective and valid as the original. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all information of this sheet and have completed the above answers I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Patient or Beneficiary_____Date:

Area of Complaint/Condition_____
Mark Symptoms
When did your symptoms appear?_____
Is this condition getting progressively worse? __Yes __No __Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Weakness ☐ Other
How often do you have this pain?_____
Is it constant or does it come and go?_____

Does it interfere with your ____Work ____Sleep ____Daily Routine ____ Recreation
Activities or movements that are painful to perform ___Sitting ___Standing ___
Walking ___Bending ___Lying down

What treatments have you already received for this condition? _____Medications _____
Surgery _____Physical Therapy
_____Chiropractic Services _____ None _____Other/ Home Treatment

Name and Phone Number of other doctor(s) who have treated you for your condition

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test

Spinal Exam_____ Chest X-Ray_____ Urine Test

Dental X-Ray_____ MRI, CT, Bone
Scan_____

Place a mark on yes or no to indicate if you have or had any of the following:

Aids/HIV	□Yes □No	Epilepsy	□Yes □No	Memory Loss	□Yes □No	Scarlet Fever	□Yes □No
Alcoholism	□Yes □No	Fatigue	□Yes □No	Miscarriage	□Yes □No	Shortness of Breath	□Yes □No
Allergy Shots	□Yes □No	G.I. problems	□Yes □No	Migraine	□Yes □No	Sleep Difficulty	□Yes □No
Anemia	□Yes □No	Glaucoma	□Yes □No	Headaches	□Yes □No	Stroke	□Yes □No
Anorexia	□Yes □No	Goiter	□Yes □No	Mononucleosis	□Yes □No	Suicide Attempt	□Yes □No
Appendicitis	□Yes □No	Gonorrhea	□Yes □No	Multiple Sclerosis	□Yes □No	Thyroid Problems	□Yes □No
Arthritis	□Yes □No	Hiatal Hernia	□Yes □No	Mumps	□Yes □No	Tingling	□Yes □No
Asthma	□Yes □No	Headaches	□Yes □No	Nausea	□Yes □No	Tonsillitis	□Yes □No
Bleeding Disorders	□Yes □No	Hearing Difficulty	□Yes □No	Nervousness	□Yes □No	Tuberculosis	□Yes □No
Bowel Problems	□Yes □No	Heart Burn	□Yes □No	Numbness	□Yes □No	Tumors, Growths	□Yes □No
Breast Lump	□Yes □No	Heart Disease	□Yes □No	Osteoporosis	□Yes □No	Typhoid Fever	□Yes □No
Bronchitis	□Yes □No	Hepatitis	□Yes □No	Pacemaker	□Yes □No	Ulcers	
Bulimia	□Yes □No	Hernia	□Yes □No	Parkinson's Disease	□Yes □No	Urinary Incontinence	
Cancer	□Yes □No	Herniated Disc	□Yes □No	Pinched Nerve	□Yes □No	Vaginal Infections	
Cataracts	□Yes □No	Herpes	□Yes □No	Pneumonia	□Yes □No	Venereal Disease	
Chemical Dependency	□Yes □No	High Blood Pressure	□Yes □No	Polio		Vomiting	
Chest Pain	□Yes □No	High Cholesterol	□Yes □No	Problems with Eyes		Weakness	
Chicken Pox		Itching		Ears, Nose, Throat		Whooping Cough	
Depression		Kidney Disease		Prostate Problems			
Diabetes		Liver Disease		Prosthesis			
Difficulty Voiding		Loss of Appetite		Psychiatric Care			
Emphysema		Loss of Concentration		Rheumatoid Arthritis		Other	
		Measles		Rheumatic Fever			

Exercise	**Work Activity**	**Habits** Right or Left Handed
□ None □ Moderate □ Daily □ Heavy	□ Sitting □ Standing □ Light Labor □ Heavy Labor	□ **Smoking-(Circle one choice) Current everyday, current some days, Former, Never, Smoker-current status unknown** □ Alcohol Drinks/Day □ Coffee/Caffeinated drinks Cups/Day □ High Stress Level Reason_____

Are you pregnant? □ Yes □ No Due date_____

Date	Description
Accidents/Workers Comp/ Car Accidents	_____
Falls/	_____
Injuries	_____
Broken Bones / Dislocations	_____
Surgeries	_____

Drug name and Phone #	Dosage	Purpose	Prescribing Dr. name
Medications			

Allergies:

_____

GALLAGHER CHRIROPRACTIC WELLNESS CENTER
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.

GALLAGHER CHRIROPRACTIC WELLNESS CENTER 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 Care Information

Treatment We may disclose your health care information to other healthcare professionals 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 GALLAGHER CHIROPRACTIC WELLNESS CENTER."; "It is our policy to provide a substitute health care provider, authorized by GALLAGHER CHIROPRACTIC WELLNESS CENTER 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 GALLAGHER CHIROPRACTIC WELLNESS CENTER 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."*

Workers' Compensation we may disclose your health information as necessary to comply with State Workers' 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.

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 on the evening prior to your scheduled appointment to remind you of your appointment time. 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 GALLAGHER CHIROPRACTIC WELLNESS CENTER sponsored fund-raising events."

Change of Ownership. In the event that *GALLAGHER CHIROPRACTIC WELLNESS CENTER* 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 *GALLAGHER CHIROPRACTIC WELLNESS CENTER* 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 *GALLAGHER CHIROPRACTIC WELLNESS CENTER* amend your protected health information. Please be advised, however, that *GALLAGHER CHIROPRACTIC WELLNESS CENTER* 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 *GALLAGHER CHIROPRACTIC WELLNESS CENTER* You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

GALLAGHER CHIROPRACTIC WELLNESS CENTER reserves 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, *GALLAGHER CHIROPRACTIC WELLNESS CENTER* is required by law to comply with this Notice.

GALLAGHER CHIROPRACTIC WELLNESS CENTER is 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 or complaints about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Colleen P. Gallagher by calling our office at (949)215-2287. If Dr. Gallagher is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how *GALLAGHER CHIROPRACTIC WELLNESS CENTER* has handled your health information should be directed to Dr. Gallagher by calling this office at (949)215-2287. If Dr. Gallagher is not available, you may make an appointment for a personal conference in person or by telephone within 2 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

This notice is effective as of 12/19/2017

I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature, I provide *GALLAGHER CHIROPRACTIC WELLNESS CENTER* with

my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print)

Patient's Signature Date

Authorized Facility Signature Date

GALLAGHER CHIROPRACTIC WELLNESS CENTER

INFORMED CONSENT

PERSONAL

Patient's Name
INFORMED CONSENT

The determination of an appropriate plan of medical and/or chiropractic management for medical, orthopedic or chiropractic conditions may involve or include the utilization of physical examinations, muscle testing, physiotherapeutic exercise or rehabilitation procedures done in office or at home utilizing devices appropriate for same, spinal adjustments, diagnostic imaging including but not limited to x-rays, ultrasound or MRI, electrical stimulation or TENS unit application or ultrasound applied to muscles, nerve conductive velocity testing, acupuncture, venipuncture, injections into large or small joints or muscles, or prescriptions. Should these procedures be deemed appropriate in your case, you will be examined by a doctor or his or her mid-level provider ("Provider") to determine if you have any conditions that indicate you should not engage in any of the foregoing.

I the Patient ("Patient") acknowledge and understand that the above procedures carry with them a small inherent risk of injury, which include but are not limited to: minor strains of the specific muscles being used during testing or rehabilitation, muscle strains, dislocations, skin irritation, costovertebral sprains, fractures, disc trauma, minor burns, dizziness, bruising, local swelling, stroke or fatality, stomach upset, allergic reactions, electrical shock, injection site pain irritation or infection, bleeding or erythema, high levels of anesthetic in central nervous system in the event of inadvertent injections into blood vessels, temporary anesthesia or numbness or weakness in area injected, vasovagal reaction (fainting), soft tissue swelling, hematoma formation, nerve trauma or compartment syndrome requiring possible surgical decompression, joint stiffness, vessel nerve or joint injury, pneumothorax requiring possible intubation, gastrointestinal upset, nausea, headaches, hoarseness, difficulty swallowing or strange tastes, dimpling of skin, and rare side effects of medications utilized may include retention of salt and water, transient disturbances of blood sugar, blood, hemorrhage or pus in affected area, and allergic reactions which in rare cases can be severe, disability or fatality, seizure, arrhythmia, anaphylaxis, paralysis, or cardiac arrest. If you are receiving an injection involving Hyaluronate, you need to inform your provider if you have an allergy to chicken, eggs, feathers, or vaccine products derived therefrom. The Patient is at all times free to engage in alternatives to procedures which include not receiving or refusing the procedure, or other appropriate medical or surgical management. Patient always has the right to refuse any procedure at any time. It is Patient's responsibility to inform Provider if Patient does not want the procedure or wishes to stop the procedure after it has started. It is Patient's responsibility to inform Provider of any

prior adverse outcome or reaction to a similar treatment previously, or if such a reaction occurs during or after a procedure in this office. Patient understands that the doctor may not be able to anticipate and explain all potential risks and complications, and wishes to rely on the doctor to exercise his or her clinical expertise and best judgment based on the facts then known to him or her to determine a reasonable course of action which the doctor feels at the time – based upon the facts then known to him or her – is in Patient's best interests. Patient has read, or has had read to him or her, this entire informed consent form, in a language that Patient understands. Patient has had an opportunity to ask questions about its content, and by signing below, Patient indicates Patient's understanding that results are not guaranteed and that Patient has had the opportunity to discuss the purposes, procedures, risks and other factors and ask all questions Patient has about his treatment in the office. Patient also agrees to hold this office and its staff harmless for injuries caused by the use of durable medical equipment due to improper use or manufacture defects. Patient intends this consent form to cover the entire course of treatment for Patient's present condition and for any future condition(s) for which Patient seeks treatment at this office. Patient has read and understands the preceding statements and hereby consents to voluntarily participate in one or more of the above-described treatments, and/or other medical management procedures as deemed appropriate by Provider. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

Should I decide to receive treatment, I understand that I will be ultimately responsible for any and all charges incurred at this office. After a charge is 30 days past due a finance charge of 1.5% per month and penalty fee may be added. If any of my checks bounce, I will be billed a service fee. I hereby authorize this office to disclose medical information pertaining to my case to medical/technical consultants deemed appropriate by my doctor and submit claims to my insurance carrier on my behalf. However, I understand that verification of my eligibility and benefits is not a guarantee of payment.

The clinic is not liable for any lost or stolen property, or property damaged on the premise or in the parking lot. All supplements, supplies and durable medical equipment purchases are final. There are no exchanges or returns.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Patient Signature: _____ Date

Guarantor Signature:
_____ Date_____