Spine & Extremity Rehab Center

1221 Lafayette Street, Santa Clara, CA 95050

Patient Information

First Name: _____ Middle name: _____ Last Name: _____

Date of birth:_____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Employer/Occupation: _____

Name of Primary Doctor **if any**: _____ City: _____ Date of Last Visit: _____

Please Complete " If " Billing Party is Different from Patient

Billing Party's Full Name:_____

Billing Party's Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Fax:_____

Occupation/Employer:_____

Relationship to Patient:_____

Thank you!

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in the improvement of symptoms, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with the hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name: _____ **Date**: _____

Signature (If Under 18, Guardian/Parent signature): _____

Doctor's signature: _____ **Date**: _____

Doctor(s) of Chiropractic: Mehdi Panahi, DC, QME, IIE. / Rabeah Emampour, DC, QME, IIE.

PATIENT HIPPA AWARENESS

With my permission, this office (Dr. Mehdi Panahi, Dr. Rabeah Emampour, or any of their associates) may use and disclose protected health information (PHI) about me to carry out treatment, payment, communication with other healthcare facilities/physicians, and healthcare operations (PHO).

This office reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to the Office.

With my permission, the office may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out PHO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With my permission, the office may mail to my home or other designated location any items that assist the practice in carrying out PHO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

I have the right to request that this office restrict how it uses or discloses my PHI to carry out PHO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing this office to use and disclose my PHI for PHO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Print Name (Patient or Legal Guardian)

_____ _____

Signature (Patient or Legal Guardian) **Date**

Patient Name _____ **Date** _____

Date of Birth:_____ **Height:**_____ **Weight:**_____

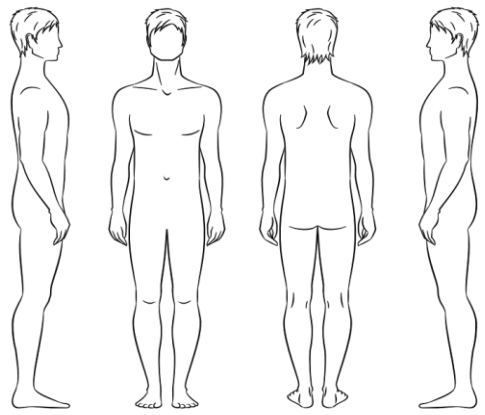
Primary Area of Concern/Pain
Indicate (x) on drawing to the right where you have pain/symptoms

Describe the pain/condition (tingling, numbness, sharp, stiffness, etc.)

_____
_____
_____

Rate your pain/condition (10 being worst)
1 2 3 4 5 6 7 8 9 10

Mark with (X)



How did your problem begin?_____
_____
_____
_____
_____

Please indicate if you have (had) ANY of the following conditions and explain more if needed:

□ DVT □ Recent sudden dizziness □ Fever lasting more than a day
□ Cardiovascular □ Recent Severe abdominal pain □ Any Allergies
□ Stroke □ **Pacemaker** □ Severe Headaches □ **Cancer**
□ Arthritis □ Surgery □ None of the above

Explain:_____

Doctor's Note:_____

_____

_____

_____

AUTHORIZATION FOR ASSIGNMENT AND RELEASE

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to this office "Spine & Extremity Rehab Center/ Dr. Mehdi Panahi / Dr. Rabeah Emampour" for services rendered.

REIMBURSEMENT POLICY:

We will bill your insurance company for services rendered, however, as an **out-of-network** facility, your insurance company may assign the payments to you, **assuming you have paid the facility in advance.** It is your responsibility to provide the payments to us.

At any point, your insurance company may deny claims or request a payment back after processing. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

Primary Insurance

Insured's Name: _____

Insured's Date of Birth: _____

Subscriber's Name (If different than Insured): _____DOB: _____

Insurance ID Number.: _____

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Secondary Insurance

Insured's Name: _____

Insurance ID No.: _____

Insured's Employer: _____

Insurance Co. Name: _____

Insurance Co. Phone No.: _____

Insurance Co. Address: _____

Insured's Date of Birth: _____