

11770 Bernardo Plaza Ct
Suite #351B
San Diego, CA 92128



Phone: (858)673-1733
Fax: (858)673-1068

BERNARDO WEST CHIROPRACTIC

Health History

Height: _____ Weight: _____

Have you seen a chiropractor before? Yes No When: _____

Please circle any conditions that you currently suffer from, and check any that you previously had:

Aids/ HIV	Chem Dependent	Headaches	Osteoporosis	Tumor
Alcoholism	Chicken Pox	Heart Disease	Pacemaker	Typhoid
Allergy Shots	Cold	Hepatitis	Parkinsons	Ulcers
Anemia	Diabetes	Hernia	Pinched Nerve	Whooping
Anorexia	Dizziness	Herniated Disc	Pneumonia	Viral Infection
Appendicitis	Emphysema	Herpes	Polio	Vision Problem
Arthritis	Epilepsy	High Cholesterol	Prostate Problems	Weakness
Asthma	Fever	Kidney Disease	Prosthesis	Other
Bleeding	Fibromyalgia	Liver Disease	Rheumatoid Arth	
Breast Lump	Flu	Measles / Mumps	Stroke	
Bronchitis	Fractures	Migraines	Suicide Attempt	
Bulimia	Glaucoma	Miscarriage	Thyroid Problem	
Cancer	Goiter	Mono	Tonsilitis	
Cataracts	Gout	MS	Tuberculosis	

Have you had Spinal X-RAYS, MRI, or CT Scan for your area of complaint? Yes No

Date(s) Taken: _____ Type of Imaging: _____

Falls: _____ Date: _____

Head Injury/ Whiplash: _____ Date: _____

Fractures/ Dislocations: _____ Date: _____

Surgeries: _____ Date: _____

Cancer: _____ Date: _____

Activities

<u>Exercise</u>	<u>Work Activity</u>	<u>Habits</u>
<input type="checkbox"/> None	<input type="checkbox"/> Sitting Hours a day ____	<input type="checkbox"/> Smoking How Often ____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing Hours a day ____	<input type="checkbox"/> Alcohol How Often ____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor Hours a day ____	<input type="checkbox"/> Caffeine How Often ____
<input type="checkbox"/> Extreme Sports	<input type="checkbox"/> Heavy Labor Hours a day ____	<input type="checkbox"/> Water How Often ____

List All Medications/ Vitamins/ Herbs that you are taking: _____

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Insurance Information:

Primary Insurance Information

Insurance Company: _____ Policy Holder's Name: _____

Relation to patient: _____ Policy ID Number: _____

Secondary Insurance Information

Insurance Company: _____ Policy Holder's Name: _____

Relation to patient: _____ Policy ID Number: _____

Financial Responsibilities:

All professional services rendered are charged to the patient and are due at the time of service unless arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payment. I understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is considered as valid as the original.

By initialing, I agree to the financial responsibilities section: INITIAL _____

Terms of Acceptance

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic has one main goal: to locate, analyze and correct interference to the nervous system. The purpose of the nervous system is to control and coordinate all bodily functions. Interference to this master system automatically produces improper function in the body. The subluxation (joint misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of subluxation through specific chiropractic adjustments allows the innate healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health. Our clinical objective for your care is to diagnose and correct nerve pressure which is being caused by vertebral subluxations and extremity subluxations. We offer no treatment of conditions or diseases other than vertebral and/or extremity subluxations.

By initialing, I agree to the terms of acceptance section: INITIAL _____

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Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by Dr. Forrest Granzotto and/or other licensed doctors of chiropractic who in the future treat me while working with or associated with Bernardo West Chiropractic. I have had an opportunity to discuss with Dr. Forrest Granzotto and/or clinic personnel the nature and purpose of chiropractic and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks of treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect Dr. Forrest Granzotto and/or clinic personnel to anticipate and explain all the risks and complications; and I wish to rely on Dr. Forrest Granzotto and/or clinic personnel to exercise judgment during the procedure for which he feels at the time, based on the facts then known, are in my best interest. I have read, or have had read to me, and understand the Terms of Acceptance and the Informed Consent sections above. I have also had the opportunity to ask questions about its content, and agree to the above-named procedures. I intend this consent form to cover the entire present course of care and for any future care with Bernardo West Chiropractic

By initialing, I agree to the Informed Consent to Chiropractic Adjustments and Care section:

INITIAL _____

Privacy Rights Notice and Acknowledgement

By signing this you are granting consent to this office to use and disclose your protected health information for the sole purpose of treatment, payment, and health care operations. Our notice of privacy practices will provide you with more specific information. You have a legal right to read the notice in its entirety before signing this consent and we encourage you to do so. Our notice of privacy practices is subject to change at any time without notice. If we change our privacy policy you may obtain a copy by contacting our office at 858-673-1733. I hereby acknowledge receipt of the Notice of Privacy Practices.

By initialing, I agree to the Privacy Rights Notice and Acknowledgement: INITIAL _____

I certify to the best of my knowledge, 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 provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be comanaged. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Print Name: _____ Signature: _____ Date: _____

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Notice of Privacy Practices

This page is for your records and may be taken home.

Our practice Bernardo West Chiropractic is committed to maintaining the privacy of your protected health information known as (PHI), which is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and the care and treatment you receive from our practice. In addition, this Notice describes your rights to access and control your PHI. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice carefully and if you have any questions or concerns about this Privacy Notice please do not hesitate to contact our privacy officer Forret Granzotto, D.C. at 11770 Bernardo Plaza Court Suite 351B, San Diego CA 92128, (858)673-1733.

This office is required by law to abide by the terms of this Notice of Privacy Practices as well as abiding by any other applicable state law that may govern privacy practices and/ or the scope of the practice of chiropractic. Our office may obtain at that time. Our office and/ or doctor will provide you with a copy of our Notice of Privacy Practices and make a good faith effort to obtain your written acknowledgment of our Notice, no later than the date of your first service delivery. We will also keep you notified of any changes to our Notice of Privacy Practices and if requested by you, our office will provide you with an updated copy of same.

Uses and Disclosures of PHI:

Our office may use and disclose your PHI for health care delivery purposes, which is known as treatment, payment, and health care operations (TPO). Your PHI may be used and disclosed by your doctor, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the doctor's practice. It should be noted that even though our list of uses and disclosures of your PHI is fairly comprehensive, it is difficult to take into account each and every single possibility of how your PHI may be used or disclosed. We can assure you that your doctor and his office staff will do everything possible to maintain the confidentiality of your PHI. Listed below are some of the more common types of uses and disclosures of your PHI that our office is allowed to make without your consent and/ or authorization. Any other uses and/or disclosures other than those listed below will only be made with your written authorization.

Treatment- Your PHI may be used and disclosed for the coordination or management of your health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding you or the referral of you from one health care provider to another.

Payment- Your PHI may be used and disclosed for payment which encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums to fulfill their coverage responsibilities and provide benefits under the plan and to obtain reimbursement for the provision of health care.

Health Care Operations- Your PHI may be used and disclosed for health care operations for certain administrative financial, legal, and quality improvement activities that are necessary to run its business and to support the core functions of treatment and payment.

Emergency Situations- Our office and/or doctor may use or disclose your PHI in an emergency treatment situation. If an emergency situation happens to arise, we are not required to obtain a written acknowledgment from you of our Notice of Privacy Practices until after the emergency situation has ended.

Minimum Necessary Standard- Our office and/or staff will make reasonable efforts to limit the use and disclosure of your PHI to the minimum necessary to accomplish the intended purpose.

Employee Limitations- Your doctor will also limit the use and disclosure of your PHI to member of his or her workforce to those who may need access to your PHI for treatment, payment, and health care operations.

Public Health Purposes and Activities- Your PHI may be disclosed to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability which would include reporting of disease or injury, reporting vital events like births or deaths and conducting public health surveillance, investigations, or interventions. In addition, your PHI may be disclosed for public health activities like child abuse or neglect, quality, safety or effectiveness of a product or activity regulated by the FDA and persons at risk of contracting or spreading disease as well as workplace medical surveillance. Again, this information will be limited to the minimum amount necessary to accomplish the public health purpose.

Business Associates Contract- A business associate is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a covered entity i.e. health care providers, health care plan or clearinghouse. Your PHI may be used or disclosed to a business associate provided we obtain satisfactory assurance from the business associate that the business associate will safeguard your PHI it receives or created from any misuse and will use the information only for the purposes for which it was engaged to do and not for the business associates independent use or purposes, except as needed for proper management and administration of the business associates.

Research Purposes- your PHI may be used or disclosed for research purposes which has been de-identified and/or you have authorized the use and disclosure of your PHI.

Worker's Compensation Purposes- Due to the variability among state laws, the Privacy Rule permits disclosure of your PHI for purposes as authorized by and to the extent necessary to comply with workers' compensation laws without your authorization and no minimum necessary determination is required.

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Marketing Purposes-Your PHI may be used and disclosed for marketing purposes if it is in the form of a face-to face communication or a communication involving a promotional gift of nominal value by the covered entity ie health care provider, health care plan or clearinghouse. Marketing is defined as making a communication about a product or service that encourages recipients of the communication to purchase or use the product or service that encourages recipients of the communication to purchase or use the product or service. This type of marking has certain exceptions, which do not require authorization for the use and disclosure of your PHI and are listed as follows.

1. A communication is not marketing if it is made for treatment of the individual.
2. A communication is not marketing if it is made for case management or care coordination for an individual or to direct or recommend alternative treatments, therapies, health care providers, or setting of care to the individual.
3. A communication is not marketing if it is made to describe a health related product or service that is provided by or included in a plan of benefits of the covered entity making the communication.

Note: Besides from the above exceptions any other form of marketing would require your authorization to use and disclose your PHI
Personal Representative- Your PHI may be used and disclosed, under State Law, to a person who is authorized to act on your behalf in making your health care related decisions.

Legal Proceedings – Your PHI may be disclosed if requested by any judicial or administrative proceedings, court order, a subpoena, law enforcement purposes etc.

Miscellaneous uses and disclosures of your PHI – We may use a sign-in sheet at our front desk so our staff can easily see who is seeking care. We are allowed to use and disclose your name in the waiting room when your doctor is ready to see you. We may use and disclose your PHI to contact you to remind you of your appointment. We are also allowed to use and disclose your name and address to send you a newsletter about our practice and services we offer. In addition, we may send you information about products or services that we feel may benefit you.

Patient's Right to Access and Control their PHI:

The Privacy Rule allows you certain rights with regards to your records, which are as follows:

You have the right to review and receive copies of your records as it relates to your own care.

Your request would have to be put in writing and the law requires that your doctor respond within 30 days of your request. In addition, your doctor is allowed to deny you access to your records, the denial has to be referred to a health care review professional, which would be the privacy officer who was designated. Your doctor is allowed to charge a copy fee, which should not exceed Sate law allowance.

You have the right to request the use and disclosure of your PHI be restricted. This means you have the right to request restrictions on how your doctor will use or disclose your PHI about treatment, payment, and health care operations. Your doctor is not required to agree to your request for restriction, but would be bound by any restrictions to which you and your doctor agree on.

You have the right to request to receive confidential communications from your doctor by alternative means or at an alternative location.

Your doctor must accommodate your request, provided it is reasonable, and you clearly state that not doing so could endanger you.

You have the right to request amendments (changes) to your records.

If changes are made to your record it does not mean that your doctor will destroy his or her records or your doctor will rewrite their records it means that your doctor will add an addendum to your current records to reflect your changes. Your doctor has the right to deny or reject your request to change your records, but have the right to submit a statement in the medical record that you disagree. Your doctor has the right to add to the record a rebuttal statement.

You have the right to receive your doctor's Notice of Privacy Practices.

The law requires that your doctor provide you in writing their policy on how they are protecting and using your PHI.

You have the right revoke an authorization.

The revocation can be done at any time provided it is in writing. There is an exception to revocation that is if your doctor has taken any action in reliance on the use or disclosure indicated in doctor's Authorization Notice.

Patients' Right to File a Complaint

If you believe, that any of your Privacy Rights have been violated by us you can file a written complaint with our Privacy Officer (please see our privacy officer to obtain a complaint form). Your complaint must be filed within 180 days of when you knew or should have known that the act had occurred. In addition, you can also file a written complaint either on paper or electronically with the Office of Civil Rights (OCR). Please note that the Privacy law prohibits our office from taking any retaliatory actions against you.