EMAIL ADDRESS: _____

PATIENT INFORMATION FORM

First Name _____ M.I. _____ Last Name _____ Phone ( )_____

Address _____ City _____ State _____ Zip _____

Age _____ Sex _____ Birth Date ____/____/____ Marital Status (S M W D) Spouse's Name _____

Social Security # _____ Occupation _____ Employer _____

Work Phone ( )_____ Work Address _____ City _____ State ____ Zip _____

Referred By _____ Person Responsible For This Account _____

HEALTH INSURANCE INFORMATION

Name Of Insured _____ Relation To Patient _____ Insured's SSN # _____

Insurance Company _____ Group # _____ Policy # _____

Phone ( )_____ Address _____ City _____ State ____ Zip _____

SECONDARY INSURANCE INFORMATION

Name Of Insured _____ Relation To Patient _____ Insureds SSN # _____

Insurance Company _____ Group # _____ Policy # _____

Phone ( )_____ Address _____ City _____ State ____ Zip _____

AUTOMOBILE INSURANCE INFORMATION

Name Of Insured _____ Relation To Patient _____ Insureds SSN # _____

Insurance Company _____ Group # _____ Policy # _____

Phone ( )_____ Address _____ City _____ State ____ Zip _____

ATTORNEY INFORMATION

Attorney Name _____ Phone ( )_____

Address _____ City _____ State _____ Zip _____

What is your major complaint? _____

Is this condition due to an: A) Auto Accident B) Work Injury C) Other Accident D) Unknown Cause E) Illness

Are the symptoms: A) Improving B) Getting Worse C) About The Same D) Intermittent (come & go) **Date Symptoms Appeared** _____

Circle activities which aggravates your condition: A) Standing B) Walking C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Coughing

Have you had these symptoms before? (YES / NO) If so, when? _____

Have you seen another doctor for this condition? A) M.D. B) Chiropractor C) Osteopath D) Acupuncturist E) Dentist F) Podiatrist G)_____

Name Of the Doctor _____ Phone ( )_____ Date Consulted _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, and fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature _____ Date _____

SYMPTOM SURVEY

PATIENT NAME _____ DATE _____

Circle only what applies to this injury, illness or accident.

GENERAL SYMPTOMS
A) Nervousness B) Irritability C) Fatigue D) Depression
E) Loss Of Sleep F) Tension G) PMS H) Jaw Pain

HEAD
A) Headaches 1) Mild 2) Moderate 3) Severe
How Often (1 2 3 4 5 6) Per (Day / Week / Month)
Are They 1) Sharp 2) Dull
Are They 1) Constant 2) Intermittent
Located 1) Back Of Head 2) Forehead 3) Temple
4) Right Side 5) Left Side 6) Behind Eyes
B) Light headed C) Memory Loss D) Fainting E) Blurred Vision
F) Double Vision G) Sensitive To Light H) Loss Of Balance
I) Hearing Loss J) Ringing In Ears

NECK
A) Pain 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
Pain Increased by: 1) Forward Movement 2) Backward Movement
3) Rotate Head Left 4) Rotate Head Right
5) Bend Neck Left 6) Bend Neck Right
B) Stiffness C) Muscle Spasms D) Grinding / Grating

SHOULDERS
A) Pain In Joint 1) Left 2) Right 3) Both
B) Pain Across Shoulders 1) Left 2) Right 3) Both
C) Limitation Of Movement 1) Left 2) Right 3) Both
D) Tension 1) Left 2) Right 3) Both

ARMS
A) Pain In Upper Arm 1) Left 2) Right 3) Both
B) Pain In Elbow 1) Left 2) Right 3) Both
C) Pain In Forearm 1) Left 2) Right 3) Both
D) Pins & Needles (arm) 1) Left 2) Right 3) Both
E) Pins & Needles (forearm) 1) Left 2) Right 3) Both
F) Numbness In Arm 1) Left 2) Right 3) Both
G) Numbness In Forearm 1) Left 2) Right 3) Both

HANDS
A) Pain In Wrist 1) Left 2) Right 3) Both
B) Pain In Hand 1) Left 2) Right 3) Both
C) Pins & Needles (hand) 1) Left 2) Right 3) Both
D) Numbness 1) Left 2) Right 3) Both

MID BACK
A) Pain 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
Pain Type 1) Sharp/Stabbing 2) Dull Ache
B) Muscle Spasms in 1) Left 2) Right 3) Both

CHEST
A) Deep Chest Pain 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
B) Pain Around Ribs 1) Left 2) Right 3) Both
C) Shortness Of Breath
D) Irregular Heartbeat

ABDOMINAL SYMPTOMS
A) Pain 1) Left 2) Right 3) Both
B) Nervous Stomach C) Nausea D) Gas E) Constipatio
F) Diarrhea G) Heartburn H) Indigestion I) Loss Of Appetite

LOW BACK
A) Upper Lumbar Pain 1) Left 2) Right 3) Both
B) Lower Lumbar Pain 1) Left 2) Right 3) Both
C) Sacro-Iliac Pain 1) Left 2) Right 3) Both
D) Muscle Spasms 1) Left 2) Right 3) Both
Low Back Pain Level 1) Mild 2) Moderate 3) Severe

HIPS AND LEGS
A) Pain In Buttocks 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
B) Pain In Hip Joint 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
C) Pain Down Leg 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
Pain Radiates to 1) Knee 2) Calf 3) Foot
D) Numbness Down Leg 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
E) Pins & Needles (legs) 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
F) Knee Pain 1) Left 2) Right 3) Both
G) Leg Cramps 1) Left 2) Right 3) Both

FEET
A) Ankle Pain 1) Left 2) Right 3) Both
B) Swollen Ankle 1) Left 2) Right 3) Both
C) Foot Pain 1) Left 2) Right 3) Both
D) Numbness of Feet 1) Left 2) Right 3) Both
E) Swollen Feet 1) Left 2) Right 3) Both
F) Cramps 1) Left 2) Right 3) Both

The above is true and correct to the best of my knowledge.

Patient Signature _____

NECK PAIN:

1. My neck pain began:	( ) gradually	( ) suddenly
2. I have pain:	( ) sometimes	( ) all of the time
3. My pain goes into my:	( ) right arm	( ) left arm ( ) both
4. I have tingling and/or numbness in my:	( ) right arm	( ) left arm ( ) both
5. My pain is worse when I:		
cough or sneeze	( )Yes	( ) No
bend forward	( )Yes	( ) No
lift	( )Yes	( ) No
push	( )Yes	( ) No
pull	( )Yes	( ) No
turn my head	( )Yes	( ) No
6. My pain wakes me up during the night	( )Yes	( ) No
7. Changes in the weather affect my pain	( )Yes	( ) No
8. I have neck stiffness	( )Yes	( ) No
9. I have headaches	( )Yes	( ) No
10. If I do get headaches, they occur:	( ) sometimes	( ) all of the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____

_____

_____

_____

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )

14. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

Describe: _____

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

Describe: _____

_____

_____

16. Have you had any surgeries? ( ) Yes ( ) No

If yes, list type of surgery and date: _____

_____

_____

17. Have you had any nervous or mental illnesses? ( ) Yes ( ) No

Have you had psychiatric care? ( ) Yes ( ) No

18. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

19. Have you returned to work since this accident? ( ) Yes ( ) No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my:	( ) low back	( ) mid back	( ) upper back
2. My pain began:	( ) gradually	( ) suddenly	
3. I have pain:	( ) sometimes	( ) all of the time	
4. My pain goes into my:	( ) right leg	( ) left leg	( ) both
5. I have tingling and/or numbness in my:	( ) right leg	( ) left leg	( ) both
6. My pain is worse when I:			
cough or sneeze	( )Yes	( ) No	
sit	( ) Yes	( ) No	
bend	( )Yes	( ) No	
walk	( )Yes	( ) No	
lift	( )Yes	( ) No	
push	( )Yes	( ) No	
pull	( )Yes	( ) No	
7. My back is worse with sexual activity	( )Yes	( ) No	
8. My pain wakes me up during the night	( )Yes	( ) No	
9. Changes in the weather affect my pain	( ) Yes	( ) No	

WORK COMP HISTORY

Patient _____ Phone _____

Address _____ City _____ State ____ Zip _____

Age _____ Birth Date _____ Sex _____ S/S # _____

Name of Compensation Carrier: _____ Phone _____

Address of Carrier: _____ City _____ State ____ Zip _____

Employer's Name: _____ Phone _____

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

1. Type of Business _____ Your Occupation _____
2. Date Injured _____ Hour _____ AM/PM Last Date Worked _____ Are you off work? ( )Y ( )N
3. Previous Workers' Compensation Injury? ( ) Y ( ) N
4. Accident reported to employer? ( ) Y ( ) N Name of person reported to: _____
5. Injured at: _____ City _____ State ____ Zip _____
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____

_____

8. In your own words, please describe the accident: _____

_____

_____

9. Have you been treated by another doctor for this accident? ( ) Y ( ) N
   If yes, please list doctor's name and address: _____

   _____

   What type of treatment did you receive? _____

   How long were you treated by this doctor? _____

10. Are you: ( ) improved ( ) unchanged ( ) getting worse

11. What types of medicines are you taking? _____

_____

12. Have you had physical therapy? ( ) Y ( ) If yes, how often?
    ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week
    ( ) Monthly ( ) Other
    Does the physical therapy help? ( ) Y ( ) N ( ) Don't know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now? ( ) Y ( ) N ( ) Don't know
    If yes, describe: _____

    _____

    _____

    Were these similar complaints the results of a previous accident? ( ) Y ( ) N
    Please provide details of accidents: _____

    _____

    _____

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
3. On the job, I lift: Up	( )	( )	( )	( )
to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	( )Yes ( ) No	( )Yes ( ) No	( ) Yes ( ) No
Left hand	( )Yes ( ) No	( )Yes ( ) No	( )Yes ( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No

Describe: _____

_____

_____

8. Are you required to be around moving machinery? ( ) Yes ( ) No

Describe: _____

_____

_____

9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No

Describe: _____

_____

_____

10. Are you required to drive automotive equipment? ( ) Yes ( ) No

Describe: _____

_____

_____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No

Describe: _____

_____

_____

12. Please list any additional comments: _____

_____

_____

Signature: _____ Date: _____

Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

EMPLOYEE:

1. Name _____ Today's Date _____
2. Home Address _____
3. City _____ State _____ Zip _____
4. Date of Injury _____ Time of Injury _____ _____ a.m. _____ p.m.
5. Address/Place where injury happened _____
6. Describe injury and part of body affected _____

   _____
7. Signature of employee _____

EMPLOYER: *COMPLETE THIS SECTION AND GIVE THE EMPLOYEE A COPY IMMEDIATELY AS A RECEIPT.*

8. Name and address of employer _____

   _____
9. Date employer first knew of injury _____
10. Date claim form was provided to employee _____
11. Date employer received claim form _____
12. Name and address of insurance carrier or adjusting agency _____

    _____
13. Signature of Employer Representative _____
14. Title _____ 15. Telephone _____

EMPLOYER: You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within one working day of receipt of completed form from employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Original (Employer's Copy) 90 89555 DWC Form 1 (1/1/90)

DOCTOR'S FIRS[illegible]EPORT OF OCCUPATIONAL IN[illegible]RY OR ILLNESS

STATE OF CALIFORNIA

Within 5 days of your initial examination, for every occupational injury or illness, send this report to insurer or employer (only if self-insured). Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send one copy of this report directly to the Division of Labor Statistics and Research, P.O. Box 603, San Francisco, CA 94101; and notify your local health officer by telephone within 24 hours and by sending a copy of this report within seven days. For a supply of this form, please call (415) 557-1924.

1. **INSURER NAME AND ADDRESS**

PLEASE DO NOT USE THIS COLUMN

Case No.

2. **EMPLOYER NAME**

Industry

3. Address: No. and Street City Zip

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes)

County

5. **PATIENT NAME** (First name, middle initial, last name)

6. Sex ☐ Male ☐ Female

7. Date of Birth Mo. Day Yr.

Age

8. Address: No. and Street City Zip

9. Telephone Number ( )

Hazard

10. Occupation (Specific job title)

11. Social Security Number - -

Disease

12. Injured at: No. and Street City County

Hospitalization

13. Date and hour of injury or onset of illness Mo. Day Yr. Hour _____a.m. _____p.m.

14. Date last worked Mo. Day Yr.

Occupation

15. Date and hour of first examination or treatment Mo. Day Yr. Hour _____a.m. _____p.m.

16. Have you (or your office) previously treated patient? ☐ Yes ☐ No

Return Date/Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination

B. X-ray and laboratory results (State if none or pending.)

20. **DIAGNOSIS** (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved ? ☐ Yes ☐ No

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☐ Yes ☐ No
If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ No
If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

If further treatment required, specify treatment. Estimated duration

24. If hospitalized as inpatient, give hospital name and location. Date admitted Mo. Day Yr. Estimated stay

25. **WORK STATUS** Is patient able to perform usual work? ☐ Yes ☐ No
If "no", patient can return to: Mo. Day Yr.
Regular work_____
Modified work_____ Specify restrictions _____

Doctor's Signature_____ CA License Number_____

Doctor Name and Degree (Please Type)_____ IRS Number_____

Address_____ Telephone Number ( )

FORM 5021 (Rev. 3) 1989

Incomplete information or delay in submitting this report

THE EPWORTH SLEEPINESS SCALE

Name _____ Date _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances	_____

~~permit~~	
~~Sitting and talking to someone~~	
~~Sitting quietly after a lunch without alcohol~~	
In a car, while stopped for a few minutes in traffic	

To check your sleepiness score, total the points . Check your total score to see how sleepy you are.

Patient Signature

HIPAA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review it carefully.

Our Promise To You our Valued Patient....

This is not meant to alarm you. Quite the opposite. We want to assure you that we take the new Federal (HIPAA-Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now?
The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the Internet, phones fax machines and any device used to copy or transfer that data.

We want to advise you that we have developed policies and procedures for your practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we will assure adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of obtaining payment for services and conducting health care business. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used To Provide Treatment
Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health professionals providing you treatment.

To Obtain Payment
Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make all effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. Some of our best reaching opportunities use clinical situations experienced by patient receiving care in our office. As a result, your health information may be included in the training programs for students, interns, associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders
Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of you family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers telephone or electronic reminders such as e-mail (*unless you tell us that you prefer not to receive reminders.*)

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health and or national security.

For Law Enforcement
As permitted or required by state of Federal law, we may disclose your health information to a proper a proper authorities for the purpose of law enforcement including under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends, and Caregivers
We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing you information. In the event of an emergency, were you unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research
Advancing heath care knowledge often involves learning from the careful study of health histories or prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State of Local law required us, we will not disclose your health information other than with your written authorization. *You may revoke that authorization in writing at any time.*

Patient Rights
This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences for our patients.

Confidential Communications
You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communication. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information
You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information
You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for request.

Request a Paper Copy of this Notice
You have the right to request and obtain a copy of the Notice of Privacy Practices directly form our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.
You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy right have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgement

Patient Name(s):

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have questions, pleas let us know. If not, we would appreciate your acknowledgement by signature that you have received, thoroughly and reviewed and understand this policy.

_____ **Date** _____

Patient Signature

Thank You For Your Trust and Confidence

AUTHORIZATION FOR RELEASE OF RECORDS INCL PROTECTED HEALTH INFORMATION

IMPORTANT: Do not sign this form unless you have read it carefully and understand all its provisions. Eligibility for treatment will not be conditioned upon providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM**:	Please **SEND** Medical Information **TO**:
_____	MENDYK CHIROPRACTIC, INC.
Name of Health Provider	Name of Person or Entity to Receive Information
_____	DERICK J. LAJOM, D.C.
Name of Medical Office/Hospital	Title (Physician, Therapist, Attorney
_____	22635 ALESSANDRO BLVD STE 400 UNIT D
Street Address	Street Address
_____	MORENO VALLEY, CA 92553
City, State and Zip Code	City, State and Zip Code

I hereby authorize _____ **to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.**

Release and/or disclose records and information regarding:

_____ _____
Name of Patient (List Other Names Used) Date of Birth

_____ (____) _____
Address City State Zip Code Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Specify the records to be released and/or disclosed:

- ☐ **General Medical Information** (from_____ to _____)
- ☐ **Information Regarding Specific Injury or Treatment** (from _____ to _____)
- ☐ **X-ray's, MRI's CT scans, films and reports**
- ☐ **Laboratory Results**
- ☐ **Mental Health** (from _____ to _____)
- ☐ **Alcohol/Drug** (from _____ to _____)
- ☐ **HIV Test Results** (from _____ to _____)
- ☐ **Other (specify):** _____

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Signature of Patient or Patient's Representative Date

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purposes only: _____

_____

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.

_____ _____ _____
Date Signature of Patient or Patient's Representative Indicate Relationship (if Signed by Other than Patient

MENDYK
CHIROPRACTIC, INC.

Informed Consent for Chiropractic Care

Kristian D. Mendyk, D.C.
Graduate: Los Angeles College of Chiropractic
Member: CCA
Industrial Disability Evaluator
QME, State Appointed
M.U.A. Certification Program

Derick J. Lajom, D.C.
Graduate: Los Angeles College of Chiropractic
Member: ACA
Industrial Disability Evaluator
QME, State Appointed

When a patient seeks chiropractic health and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I_____ being the parent or legal guardian of _____have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle_____

Signature_____ Date_____

1688 North Perris Blvd. Suite G-2
Perris, CA 92571
Tel. (951) 943-1722
Fax (951) 943-3133

22635 Alessandro Blvd. Suite 400 Unit D
Moreno Valley, CA 92553
Tel. (951) 697-0246
Fax (951) 697-0176

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

ID OR CASE NO.

(Print or type names and addresses; include ZIP Codes)

Injured Worker _____ Address _____

Date of Claimed Injury _____ Social Security Number _____ Date of Birth _____

Attorney for Injured Worker _____ Address _____

Employer _____ Address _____

Insurance Carrier or, if Self-Insured, Certificate Name _____

Address Where Claim Administered _____

Adjusting Agency, if Agency Administered _____

Attorney for Employer/Carrier _____ Address _____

Lien Claimant _____ Address and Telephone No. _____

Attorney for Lien Claimant _____ Address and Telephone No. _____

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of _____ Dollars ($_____) against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (Mark appropriate box):

- ☐ The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or
- ☐ The reasonable medical expense incurred to prove a contested claim; or
- ☐ The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury, or
- ☐ The reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or
- ☐ The reasonable fee for interpreter's services performed on _____, 19____.
- ☐

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990, FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER, the lien claimant declares under penalty of perjury that:

- ☐ a copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or
- ☐ the lien claimant does not have a copy of the claim form, but made the following efforts to secure one:

☐ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

Signature of Attorney for Lien Claimant _____ Signature of Lien Claimant _____ Date _____

EMPLOYEE'S CONSENT TO ALLOWANCE OF LIEN

I consent to the requested allowance of a lien against my compensation.

Signature of Attorney for Injured Worker _____ Signature of Injured Worker _____

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

ID OR CASE NO.

(Print or type names and addresses; include ZIP Codes)

Injured Worker _____ Address _____

Date of Claimed Injury _____ Social Security Number _____ Date of Birth _____

Attorney for Injured Worker _____ Address _____

Employer _____ Address _____

Insurance Carrier or, if Self-Insured, Certificate Name _____

Address Where Claim Administered _____

Adjusting Agency, if Agency Administered _____

Attorney for Employer/Carrier _____ Address _____

Lien Claimant _____ Address and Telephone No. _____

Attorney for Lien Claimant _____ Address and Telephone No. _____

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of _____ Dollars ($_____) against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (Mark appropriate box):

- ☐ The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or
- ☐ The reasonable medical expense incurred to prove a contested claim; or
- ☐ The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury, or
- ☐ The reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or
- ☐ The reasonable fee for interpreter's services performed on _____, 19____.
- ☐

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990, FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER , the lien claimant declares under penalty of perjury that:

- ☐ a copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or
- ☐ the lien claimant does not have a copy of the claim form, but made the following efforts to secure one:

☐ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

Signature of Attorney for Lien Claimant _____ Signature of Lien Claimant _____ Date _____

EMPLOYEE'S CONSENT TO ALLOWANCE OF LIEN

I consent to the requested allowance of a lien against my compensation.

Signature of Attorney for Injured Worker _____ Signature of Injured Worker _____

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

NOTICE AND REQUEST FOR ALLOWANCE OF LIEN

ID OR CASE NO.

(Print or type names and addresses; include ZIP Codes)

Injured Worker _____ Address _____

Date of Claimed Injury _____ Social Security Number _____ Date of Birth _____

Attorney for Injured Worker _____ Address _____

Employer _____ Address _____

Insurance Carrier or, if Self-Insured, Certificate Name _____

Address Where Claim Administered _____

Adjusting Agency, if Agency Administered _____

Attorney for Employer/Carrier _____ Address _____

Lien Claimant _____ Address and Telephone No. _____

Attorney for Lien Claimant _____ Address and Telephone No. _____

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of _____ Dollars ($_____) against any amount now due or which may hereafter become payable as compensation to the above named worker on account of the above claimed injury.

This request and claim for lien is for (Mark appropriate box):

- ☐ The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or
- ☐ The reasonable medical expense incurred to prove a contested claim; or
- ☐ The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury, or
- ☐ The reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or
- ☐ The reasonable fee for interpreter's services performed on _____, 19____.
- ☐

NOTE: ITEMIZED STATEMENT JUSTIFYING THE LIEN MUST BE ATTACHED

FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990, FOR WHICH THE LIEN CLAIMANT DOES NOT HAVE A WCAB IDENTIFICATION NUMBER, the lien claimant declares under penalty of perjury that:

- ☐ a copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or
- ☐ the lien claimant does not have a copy of the claim form, but made the following efforts to secure one:

☐ A copy of the lien claim and supporting documents was served by mail or delivered to each of the above-named parties.

Signature of Attorney for Lien Claimant _____ Signature of Lien Claimant _____ Date _____

EMPLOYEE'S CONSENT TO ALLOWANCE OF LIEN

I consent to the requested allowance of a lien against my compensation.

Signature of Attorney for Injured Worker _____ Signature of Injured Worker _____

EMPLOYEE'S L_SIGNATION OF PERSONAL CHIROPRACTOR

(California Labor Code Section 4601)

Attention: Personnel

To: _____

From: _____ **Employee #:**_____

This letter serves as notification that if, during the course of my employment I experience an industrial injury of a musculo-skeletal nature, I hereby request to be treated by my personal Chiropractor.

I hereby designate Dr. _____ , D.C. as my "Personal Chiropractor" pursuant to Section 4601 of the Labor Code.

Dr. _____, D.C. is my regular Chiropractor who has previously directed my treatment and who retains my Chiropractic treatment records, including my Chiropractic history.

Signed by: _____ Date: _____

Received by: _____ Date: _____

DYNAMIC NEUROLOGY ASSOCIATES, INC.

HOJA PARA DETERMINAR EL MPN (RED DE PROVEEDORES MÉDICOS)

POR FAVOR MARQUE LOS CUADROS QUE CORRESPONDAN

PARTE A
SU LESIÓN OCURRIÓ ANTES DEL 1ERO DE ENERO DEL 2005

Si su lesión en el trabajo ocurrió después del 1ero de Enero del 2005 no complete la parte A y siga con la Parte B

Si su lesión en el trabajo ocurrió antes del 1ero de Enero del 2005, marque el cuadro que corresponda, ya sea A1 o A2 (no los dos)

A1 ☐ La lesión ocurrida en el trabajo ocurrió antes del 1ero de Enero del 2005, y la compañía de seguros no le ha pedido que vaya a ver a un doctor que pertenezca a la misma para tratamiento.

(Si la lesión ocurrió antes del 1ero de Enero del 2005, y la compañía de seguros no le ha pedido que usted sea visto por uno de sus doctores USTED NO NECESITA LLENAR EL RESTO DE ESTE FORMULARIO).

or

A2 ☐ La lesión relacionada con el trabajo ocurrió antes del 1ero de Enero del 2005, y la compañía de seguros ha pedido que usted vaya a ver a un doctor de la compañía de seguros para tratamiento, pero su actual doctor le ha dicho a la compañía de seguros que su condición medica requiere que usted siga bajo tratamiento por su actual doctor {CCR § 9767.9}.

PARTE B
SU LESIÓN OCURRIÓ DESPUÉS DEL 1ERO DE ENERO DEL 2005

Si su lesión en el trabajo ocurrió después del 1ero de Enero del 2005 conteste las siguientes preguntas

B1 ☐ Su patrón/ compañía de seguros no tienen una **Red de Proveedores Médicos.**

(Si usted sabe que su patrón o la compañía de seguros no tienen una Red de Proveedores Médicos, usted no necesita llenar el resto de esta forma, pero si usted si sabia de esa red continúe con la pregunta B2).

B2 ☐ Su empleador o compañía de seguros no tenia un doctor a una distancia de menos 15 millas de su casa o trabajo, o el doctor que su patron/ compañía de seguros le dijo que viera no tenia una cita disponible en menos de 3 dias, o el especialista al que usted fue referido no tenia una cita disponible en menos de 20 dias del dia en que usted la ordeno {CCR § 9767.5}.

B3 ☐ Usted le notifico a su patron que se lesiono en el trabajo o lleno de Reclamo de Compensación al trabajador, pero su patrón no le dio permiso de ver a un doctor en las 24 hrs. después de darle la forma de reclamo. {CCR § 9767.6}.

ver 002

B4 ☐ Si su empleador no le dio una forma de reclamo, donde le explican cuales son sus derechos y su elegibilidad para obtener beneficios de compensación al trabajador incluyendo el procedimiento para recibir dichos beneficios, así como una descripción de los diferentes tipos de beneficios; que es lo que sucede a su hoja de reclamo después de ser llenada; el acceso a una lista de doctores con los que usted puede ser tratado; el papel de su medico de cabecera; sus derechos para pedir a otro doctor; como obtener tratamiento medico mientras su reclamo aun no es aceptado; como protegerse de discriminación, y que usted tiene el derecho de estar o no de acuerdo con las decisiones que afecten y estén relacionadas con su reclamo, así como también puede obtener información gratuita en División de Workers' Compensation (Departamento de Compensación al Trabajador), y que usted puede consultar a un abogado. {LC § 5401(a)}.

B5 ☐ Su patron o la compania de seguros no le han informado que rechazaron ser responsables de su reclamo {CCR § 9767.6(c)}.

B6 ☐ Su empleador no puso avisos actualizados en el trabajo donde se indicara el nombre y numero de teléfono de la persona a la que necesitaría contactar en caso de una lesión en el trabajo, sus derechos bajo las leyes de compensación al trabajador en California, y dicho aviso indicaba el nombre de la compañía de seguros que tiene su patrón, o que no tiene ninguna compañía de seguro {LC § 3550}.

B7 ☐ Cuando lo contrataron, su patron no le dio un aviso por escrito en Ingles y Español donde se indicara el nombre y numero de teléfono de la persona a la que necesitaría contactar en caso de una lesión en el trabajo, sus derechos bajo las leyes de compensación al trabajador en California, y otro aviso por escrito donde se indicara el nombre de la compañía de seguros que tiene su patrón, o que no tiene ninguna compañía de seguro {LC § 3551}.

B8 ☐ Cuando su patrón se cambio a la Red de Proveedores médicos (MPN), o cuando lo contrataron, o cuando se lesiono nunca se le dio nada por escrito explicándole en Ingles y en Español lo que es la Red de Proveedores Médicos (MPN), un numero de teléfono gratuito para contactar a la Red de Proveedores Médicos (MPN), información sobre como obtener una lista de doctores que pertenezcan a la Red de Proveedores Médicos (MPN), como escoger un medico dentro de la Red de Proveedores Médicos (MPN), que hacer si tiene problemas para hacer una cita con un doctor dentro de la Red de Proveedores Médicos (MPN), como cambiar su doctor de la Red de Proveedores Médicos (MPN), como obtener una recomendación para ver a un especialista, como pedir una segunda o tercera opinión de un doctor dentro de la Red de Proveedores Médicos (MPN), y como pedir la opinión medica de un doctor independiente {CCR § 9767.12}.

I hereby declare under the penalty of perjury that the above information provided is true and accurate to the best of my knowledge.

_____ Date: _____

Patient's Name *(please print)*

_____

Patient's Signature

DYNAMIC NEUROLOGY ASSOCIATES, INC.

MPN DETERMINATION CHECK-OFF SHEET

PLEASE CHECK OFF THE APPROPRIATE BOXES

PART A
YOUR INJURY HAPPENED BEFORE JANUARY 1, 2005

If your work related injury happened after January 1, 2005 skip Part A, and go directly to Part B

If your injury happened before January 1, 2005 check off either A1 or A2, not both

A1 ☐ The work related injury happened before January 1, 2005, and the insurance company has not requested that you see an insurance company doctor for treatment.

(If the injury occurred before January 1, 2005 and the insurance company has not told you to treat with their doctor, YOU DO NOT NEED TO FILL OUT THE REST OF THIS FORM).

or

A2 ☐ The work related injury happened before January 1, 2005 and the insurance company has requested that you see an insurance company doctor for treatment, but your doctor has told the insurance company that your condition requires that your doctor continue to treat you {CCR § 9767.9}.

PART B
YOUR INJURY HAPPENED AFTER JANUARY 1, 2005

If your work related injury happened after January 1, 2005 answer the following questions

B1 ☐ Your employer / insurance company does not have a Medical Provider Network.

(If you know your employer or its insurance company does not have a medical provider network, you do not need to fill out the rest of this form, otherwise continue with B2).

B2 ☐ Your employer / insurance company did not have a doctor within 15 miles of your home or workplace, or the doctor your employer / insurance company told you to see did not have an appointment available within 3 business days, or the specialist doctor which you were referred to by this doctor did not have an appointment available within 20 business days of your request for an appointment {CCR § 9767.5}.

B3 ☐ You notified your employer you were injured on the job or filed a claim for workers' compensation, but your employer did not arrange for you to see a doctor within 1 working day {CCR § 9767.6}.

B4 ☐ Your employer did not give you a claim form within one day of the time that you told your employer you were injured on the job, that told you your rights and eligibility for workers' compensation benefits, including the procedure to be used for you to collect workers' compensation benefits, a description of the different types of benefits, what happens to the claim form after its filed, access to a list of doctors you can treat with, the role of your primary treating physician, your right to select a different doctor, how to get medical care while your claim is pending, your protection against discrimination, and that you have the right to disagree with decisions affecting your claim, that you can obtain free information at the Division of Workers' Compensation, and that you can consult an attorney. {(LC § 5401(a)}.

B5 ☐ You have not been informed by your employer or its insurance company that they have rejected liability for your claim {CCR 9767.6 (c)}.

B6 ☐ Your employer did not post current notices in the work place which told you the name and telephone number of the person to contact concerning any work related injury, your rights under the workers' compensation laws of California, and the posted notice told you the name of your employer's workers' compensation carrier, or that your employer did not have workers' compensation insurance {LC § 3550}

B7 ☐ When you were first hired, your employer did not give you a written notice in Spanish and English that told you the name and telephone number of the person to contact concerning any work related injury, your rights under the workers' compensation laws of California, and the written notice told you the name of your employer's workers' compensation carrier, or that your employer did not have workers' compensation insurance {LC § 3551}.

B8 ☐ When your employer switched to a Medical Provider Network (MPN), or when you were hired, and again when you were injured, you were never given a detailed written explanation from your employer in English and Spanish, that included a description of the MPN, a toll-free telephone number to contact the MPN, information on how to get the list of doctors in the MPN, how to choose a MPN doctor, what to do if you have trouble making an appointment with an MPN doctor, how to change your MPN doctor, how to receive a referral to a specialist doctor, how request a second or third opinion from a doctor in the MPN, and how to request an independent medical review {CCR 9767.12}.

I hereby declare under the penalty of perjury that the above information provided is true and accurate to the best of my knowledge.

_____ Date: _____

Patient's Name *(please print)*

_____

Patient's Signature

FOR 2005 WORK INJURIES AND FORWARD

ROUTINE ACTIVITIES OF DAILY LIVING

Has your injury interfered with or cause problems for you in any of the following activities: (Circle all that apply)

1. Self-care, Teeth, Personal Hygiene.
2. Communication
3. Physical Activity
4. Sensory Function
5. Non-Specialized Hand Activities
6. Travel
7. Sexual Function
8. Sleep

Explain how the activities you circled are affected by your injury:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Injured Worker's Signature: _____ Date: _____