RENU
CHIROPRACTIC

1525 Superior Ave Ste 214 Newport Beach, CA 92663 Tel:949-298-5670 Fax:949-298-5664
renuchironb@gmail.com wwww.renuchironb.com

PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, speeding up your office visit and allowing us to better serve your healthcare needs.

1. **First Name:** **Last Name:** **DOB:**

_____ _____ _____

2. **MRN # (Office Use Only):**

_____

ABOUT YOU

Please fill out as much as you can to help us make your initial visit easy and fast for your convenience.

3. **Home Address**

Address 1 Address 2

_____ _____

City State Zip Code

_____ _____ _____

4. **Contact Information**

Mobile Phone Home Phone

_____ _____

Primary Email Address

_____

5. **Demographic Information (circle)**

Sex at birth: Marital Status:

Male Female Single Married Divorced Widowed Other

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6. **Spouse's Name:**

_____

7. **Personal Information**

Height - Feet: Height - Inches: Weight (in pounds):

_____ _____ _____

8. **Do you have insurance?** Yes No

9. **Insurance Payer**

_____

10. **Insurance Policy Information:**

Insurance Plan Name ID/Policy Number: Group Number

_____ _____ _____

Relationship to Patient: Self Spouse Parent Employer Caregiver Other

Insured's First & Last Name: Insured's Date of Birth:

_____ _____

11. **Please provide Insurance Card to Front Staff**

12. **Emergency Contact Information**

Emergency Contact Name: Contact Phone Number: Relationship to Patient:

_____ _____ _____

13. **Employer Information (circle)**

Employment Status: Employed Student Not Employed Retired Unknown

Employer Name: Occupation:

_____ _____

14. **Who Referred you?**

Name:

_____

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How did you hear about us? (circle all that apply)

Word of mouth Google Referring doctor Attorney/Lawyer Yelp Zocdoc

Groupon Social Media Direct mail or email campaign Event Other:

_____

VISIT PURPOSE

Please chose a category that fits best for your reason to visit us today.

15. **Please let us know the reason for this visit: (circle all that apply)**

In Pain Seeking Help Auto Accident Work Injury Want to try Chiropractic

Sports Injury 2nd Opinion X-rays only Massage Only

Other (not related to an auto accident or work injury)

AREAS OF CONCERN

16. **What is your primary area of concern? We will ask about additional complaints after information about this first area of concern.**

_____

_____

_____

_____

17. **What term(s) describes your discomfort after the accident? Choose all that apply.**

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		

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Stiffness		
Tightness		
Tingling		
Numb		
Other		

If other, specify:

_____

18. **What treatment, if any, have you received since the accident? Choose all that apply**

	Yes	No
Hospitalization		
Surgery		
Acupuncture		
Chiropractic Care		
Injection therapy		
Massage		
Naturopathic medicine		
Physical therapy		
Primary care physician visit		
Over the counter medications		
Prescribed medications		
Heat or cold therapy		
None		
Other		

If other, specify:

_____

19. **Are there any additional symptoms which have appeared since the accident Occurred? Choose all that apply.**

	Yes	No
Breathing difficulty		
Muscle spasm		
Chest pain		
Numbness and tingling		
Depression		
Rib pain		
Facial pain		

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Stomach pain		
Genital pain		
Headaches		
Tightness		
Soreness		
Shock		
Dizziness		
Sleeping difficulty		
Stress		
Gluteal pain		
Irritability		
Stunned		
Tiredness		
Loss of appetite		
Anxiety		
Low energy		
None		
Other		

If other, specify:

_____

20. **Have your symptoms changed since the accident? Choose all that apply**

	Yes	No
Improved daily functioning at home/work		
Shown no change in daily functioning at home/work		
Deteriorated daily functioning at home/work		
Symptoms have exacerbated		
Symptoms have disappeared		
Elicited more pain		
Elicited more stiffness		

21. **Rate the severity of your discomfort at its worse, on scale of 0-10 where 0 is no pain and 10 is severe pain**

_____

How often do you feel this discomfort?

_____

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22. **Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)**

_____

_____

_____

_____

23. **What aggravates this condition? Choose all that apply**

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other, specify:

_____

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24. **What improves this condition or gives you relief? Choose all that apply**

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over the counter medications		
Physical therapy		
Other		

If other, specify:

_____

25. **Have other health care provider(s) performed tests related to this condition?**

Yes No If Yes, specify: _____

26. **Have you ever had any previous episodes of this condition?**

Yes No If Yes, specify: _____

27. **Do you have an additional condition?**

Yes No If Yes, specify: _____

ADDITIONAL AREA OF CONCER

28. **Approximate date this condition began (exact date not required)**

_____

What caused this condition?

_____

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Please list the specific activities or movements that cause or affect this discomfort (for example, bending over, getting in/out of car, using a computer, etc.)

_____

_____

31. **What treatment, if any, have you received since the injury (choose all that apply)**

	Yes	No
None		
Chiropractic Care		
Massage		
Medical injection treatment		
Surgical treatment		
Over the counter medications		
Prescribed medications		
Natural or holistic treatment		
Acupuncture		
Physical therapy		
Other		

If other, specify:

_____

32. **What aggravates this condition? (Choose all that apply)**

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		

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Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other, specify:

---

33. **What improves this condition or gives you relief? (choose all that apply)**

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over the counter medications		
Physical therapy		
Other		

If other, specify:

_____

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34. **Have other health care provider(s) performed tests related to this condition?**

Yes No

35. **Have you ever had any previous episodes of this condition?**

Yes No

CURRENT HEALTH

36. **Are you currently taking any medications?**

Yes No

37. **Please list regularly used prescription and over-the-counter medications taken, as well as the dosage and frequency for each medication (e.g. 5 mg once daily)**

	Medication Name	Dosage/Frequency
1		
2		
3		

38. **Other than the condition(s) already shared, do you have any additional health concerns?**

	Yes	No
Muscles, Bones or Joints		
Nerves, Headaches, Dizziness, or Emotional		
Head, Eyes, Ears, Nose or Throat		
Heart, Blood Pressure, or Circulation		
Shortness of Breath, Coughing, Asthma or Lung Condition		
Stomach, Bowels or Digestive Conditions		
Genital, Bladder, or Urinary Conditions		
Diabetes, Thyroid or Glandular condition		
Skin or bleeding Conditions		
Do you have any medication allergies?		

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39. **Medication Allergies**

	Medication Name	Reaction	Onset Date	Additional Comments
1				
2				
3				

PERSONAL AND FAMILY HISTORY

40.

	Yes	No
Have you had any surgical procedures?		
Are there any past illness or conditions we should be aware of?		
Do you have a past history of accidents or trauma?		
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological disease that we should be aware of?		

WORK, SOCIAL, HABITS

41. **Current work habits- Circle all that apply**

Permanently fully disable Permanently partially disable Student

Cannot work due to current condition Full-time (20-40+ hours/week) Unemployed

Part-time (1-19 hours/week) Retired Homemaker

42. **Personal social habits**

	Yes	No
Smoke or use tobacco products		
Drink alcohol		
Drink caffeine		
Use recreational drugs		
Other, to be discussed with doctor		

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43. **Present exercise habits**

	Yes	No
No current exercise		
Exercise daily		
Exercise 3+ times per week		
Cannot return to exercise due to current condition		

44. **Diet and nutrition habits**

	Yes	No
Vegan or vegetarian		
Daily supplements		
Other		

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 the doctor of chiropractic named below and/or other licensed doctors of chiropractic 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.

I have had the 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 other procedures.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, 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 known, is my best interest.

I have read, and 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 form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

To be completed by patient:

_____
Print Patient's Name

_____
Signature of Patient

_____
Date Signed

To be completed by doctor or staff:

Name and address of clinic/office: Print name (s) doctor (s) treating this patient:

1525 Superior

HIPAA 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 CAREFULLY.

If you have any questions about the above notice, please contact our Office at

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,
we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's
privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health
related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Stiffness		
Tightness		
Tingling		
Numb		
Other		

If other, specify:

18. What treatment, if any, have you received since the accident? Choose all that apply

	Yes	No
Hospitalization		
Surgery		
Acupuncture		
Chiropractic Care		
Injection therapy		
Massage		
Naturopathic medicine		
Physical therapy		
Primary care physician visit		
Over the counter medications		
Prescribed medications		
Heat or cold therapy		
None		
Other		

If other, specify:

19. Are there any additional symptoms which have appeared since the accident occurred? Choose all that apply

	Yes	No
Breathing di"culty		
Muscle spasm		
Chest pain		
Numbness and tingling		
Depression		
Rib pain		
Facial pain		

!

"#$#!%&'()*+)!,-(!%.(!$"/!0(1'+).!2(3456!7,!8$99:!!!!!!! ;(<=8/8<$8?>#9@!A!B3C=8/$8?>#99/!
)(D&45*)+DEFGH3*<I4+H 1111I)(D&45*)+DEI4+H

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date

24. What improves this condition or gives you relief? Choose all that apply

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over the counter medications		
Physical therapy		
Other		

If other, specify: _____

25. Have other health care provider(s) performed tests related to this condition?

Yes No If Yes, specify: _____

26. Have you ever had any previous episodes of this condition?

Yes No If Yes, specify: _____

27. Do you have an additional condition?

Yes No If Yes, specify: _____

ADDITIONAL AREA OF CONCER

28. Approximate date this condition began (exact date not required)

_____

What caused this condition?

_____

Office Name: _____

Office Address: _____

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

_____ _____

Patient Name Date

_____

Patient Signature

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We will work diligently with your insurance company to ensure your claims are processed and paid. Ultimately, if the insurance company denies payment, it may become your responsibility to render payment for services. We work hard to ensure you receive the best treatment possible and working together is necessary for this approach. Please notify ReNu Chiropractic when a credit card number has changed or expired.

PLEASE READ EACH BULLET POINT

- If my insurance company does not make payment to ReNu Chiropractic for services rendered, I will become personally responsible for the charges. I will have **15 days** to clear my account by calling my insurance company after being notified by this office. If the account is not cleared **within 15 days**, I hereby authorize ReNu Chiropractic to charge any outstanding amount to my credit card.
- Insurance checks that I receive will be promptly brought to the office. Inability to do so **within 30 days of receipt of insurance checks** authorizes ReNu Chiropractic to charge the credit card on file for the unpaid charges on my account.
- Cash balance on my account will be paid within **30 days of notification** of the amount owed. If a balance remains past 30 days, I hereby authorize ReNu Chiropractic to charge the full amount to my credit card on file. • When not using health insurance for my treatment, I authorize the use of this card ***for payment of services rendered at ReNu Chiropractic at the time services are rendered until written notice is provided to terminate.*** (i.e. Physical Therapy, Acupuncture and Chiropractic copays, massages, medical payments, etc.)
- I understand there is a **$35.00 NO SHOW / SAME DAY CANCELLATION FEE** for all services except chiropractic, unless a 24-hour notice is provided prior to appointment.

I authorize the above named business to charge the credit card indicated in this authorization form for services rendered. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company when charged for services rendered.

I understand and agree to all the information written above.

_____

_____ _____

Client Signature Date