HADAYA CHIROPRACTIC INC.
KINAN HADAYA, D.C, D.A.A.P.M.
Diplomate, American Academy of Pain Management
Qualified Medical Evaluator, State of California

615 West Ave Q, Suite E
Palmdale CA, 93551
Ph: 661-947-2455 Fax: 661-947-2770

PATIENT INFORMATION

Patient Name _____
Address _____ City _____ Zip Code _____
Birth Date _____/_____/_____ Age _____ SSN ____-_____-_____
Sex: M F Home Phone _____ Cell Phone _____
Occupation _____ Marital Status: Single Married Divorced
Emergency Contact Name _____ Relation _____ Phone _____

ATTORNEY's INFORMATION

Office Name _____
Name _____ Phone _____ Fax _____
Address _____ City _____ State ___ Zip Code _____

INSURANCE INFORMATION

3rd Party INSURANCE INFORMATION
Insurance Company _____
Insurance Adjuster _____
Insurance Phone _____
Insured ID _____
Claim Number _____

INFORMATION ABOUT YOUR ACCIDENT

1. Date Of Accident _____ Time of Day _____
2. Were you ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? ____ Were you wearing a seat belt? Yes/No
4. What direction were you headed to? ( ) North ( ) South ( ) East ( ) West
5. What direction was the other car headed? ( ) North ( ) South ( ) East ( ) West
6. Where were you struck from? ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate Speed of your car _____ MPH. Other Car _____ MPH.
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, how long? _____
9. Were police notified? ( ) Yes ( ) No

10. In your own words, please describe the accident _____
    _____
    _____

11. Did you have any physical complaints BEFORE the accident? ( ) Yes ( ) No
    If yes, please explain _____
    _____
    _____

12. Please describe how you felt:

- During the accident: _____

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- Immediately after the accident: _____
- Later that day: _____
- The next day: _____

13. What are your PRESENT complaints and symptoms? _____
_____
_____

14. Do you have any congenital (from birth) factors which relate to this problem? _____
_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
If yes, Please describe _____
_____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No
If yes, please describe, including date(s) and type(s) of accidents as well as injuries received:
_____
_____

17. Where were you taken after the accident? _____
_____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
If yes, names: _____

19. Since this injury occurred, are your symptoms ( ) Improving ( ) Getting Worse ( ) Same

20. Circle ALL symptoms that you have noticed since the accident:
Headaches Irritability Numbness Face Flushed Feet Cold Neck Pain Chest Pain _____
Buzzing in Ear Hands Cold Neck Stiff Dizziness Fatigue Loss of Balance Upset Stomach
Sleeping Problems Head is Heavy Depression Fainting Constipation Diarrhea Back Pain Pins/Needles
Loss of Memory Loss of Taste Fever Tension Ears Ringing
Others? _____

21. Have you lost time from work because of this accident? ( ) Yes ( ) No
- Last day worked_____
- Type of Employment _____
- Are you being compensated for time lost? ( ) Yes ( ) No

22. Have you noticed any activity restrictions due to this injury? ( ) Yes ( ) No
- If yes, please describe: _____
_____

23. Other patient information (If any): _____
_____
_____

_____ _____
Date Patients Signature

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REVIEW OF SYSTEMS

Please review each area, if you are not having any difficulties, please check "**No Problems**".

If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the medical assistants or Dr. Hadaya.

Const. (Health in General) ☐ No Problems, lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaw when eating, scalp tenderness, prior diagnosis of cancer, Other: _____

Ears, Nose, Mouth & Throat ☐ No Problems, difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness, Other: _____

C-V (Heart & Blood Vessels) ☐ No Problems, irregular heartbeat, racing heart, chest pains, swelling feet or legs, pain in legs with walking, Other: _____

Res. (Lungs & Breathing) ☐ No Problems, shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray, Other: _____

GI (Stomach & Intestines) ☐ No Problems, heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence, Other: _____

GU (Kidney & Bladder) ☐ No Problems, painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscle, Bones, Joints) ☐ No Problems, joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain, Other: _____

Integ. (Skin, Hair, & Breast) ☐ No Problems, persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes, Other: _____

Neurologic (Brain & Nerves) ☐ No Problems, frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss, Other: _____

Psychiatric (Mood & Thinking) ☐ No Problems, insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsion, Other: _____

Endocrinologic (Glands) ☐ No Problems, intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive, Other: _____

Hematologic (Blood/Lymph) ☐ No Problems, easy bleeding, easy bruising, anemia, abnormal blood, test, leukemia, unexplained swollen areas, Other: _____

Allergic /Immunologic ☐ No Problems, seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV, Other: _____

Patient Signature _____ Date _____

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NOTICE OF DOCTOR'S LIEN

Patient: _____ Date of Accident: _____

I do authorize KINAN HADAYA, DC (HADAYA CHIROPRACTIC INC.) to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered to me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney (s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney (s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.

_____
DATE:

X _____
PATIENT'S SIGNATURE

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____
DATE:

X _____
ATTORNEY SIGNATURE

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THIRD PARTY MEDICAL LIEN

PATIENT _____
CLAIM# _____
DATE OF INJURY_____

I hereby authorize and direct _____, to pay Dr. Kinan Hadaya such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further request that payment be made directly to said doctor which would otherwise be paid to me, as the result of the treatment charges injured for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctors protection and consideration of his/her awaiting payment. I further understand that such payments are not contingent on any settlement, judgment, or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if I do not wish to cooperate in protecting the doctor's interests, the doctor will not await payment, but may declare the entire balance due and payable by me.

_____ _____
Date Patients Signature

The undersigned insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

_____ _____
Date Signature of Insurance Company Representative

_____
Print First and Last Name

Please sign, date, and return to the office below:

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HIPAA COMPLIANCE

Health Insurance Portability and Accountability Act
AUTHORIZATION FOR RELEASE OF INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

By signing this form, you are authorizing the release of you/or your dependents' healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent for the purpose of complete medical treatment.

You are entitled to a copy of this Authorization after you sign it.

PATIENT SIGNATURE_____ TODAY'S DATE _____

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Informed Consent for Chiropractic Care

The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific Vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by Chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.
Listed below are summaries of both common and rare side-effects/ complications associated with Chiropractic care:
Common:

- Reactions most commonly reported are local soreness/ discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%) , dizziness, the vast majority of which resolve within 48 hours

Rare:

- Fractures or joint injuries in isolated cases with underlying physical side defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have ever felt.

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral maybe necessary if a course of chiropractic care does not help or improve my condition.
Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks.
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery.
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition.

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

Patient Consent Signature_____ Date_____

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Financial Agreement Personal Injury

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

Party Responsibility
If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion to personal injury protection portion of your automobile insurance policy to cover the treatment changes incurred in our office.

Med Pay: If you were a passenger in another vehicle, the insurance company, which insures the automobile, may be billed for your medical services incurred.

PIP: If you were a passenger in another vehicle, and your own a car, which has PUP coverage, the insurance company, which carries your policy, will be responsible to pay your medical bills.

3rd Party: If another vehicle has caused the accident, we will first bill your automobile med pay or PIP policy for coverage prior to submitting a claim to the insurance carrier of the party at fault. If we rely solely on a 3rd party settlement for payment, please understand that the insurance carrier will pay you directly upon settlement. By signing this form, you are agreeing to pay your balance in full within 3 days of receiving your settlement.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

Attorney's Liens
If you hire an attorney to represent you in a lawsuit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your law suit we retain the right to first submit all charges to your private and/or auto insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

Responsibility for Payment
As a courtesy to you, we will gladly submit your charges to your insurance company (ies) and/or your attorney; however, all services rendered by this office are charged directly you, and ultimately you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial agreements. If at any time, you have further questions about your care, please don't hesitate to ask

By signing below, you have read and agree to the financial agreement

Patient Signature_____ Date_____

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PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

As part of your care this office obtains a considerable amount of information about you. We take it very seriously that this information MUST be kept strictly confidential. For this reason, only you can authorize the release of this information. Without your authorization, absolutely NO information will be released to anyone under any circumstances, unless there is a court order forcing the release of that information.

Each of the following authorizations pertains to the Chiropractic office of Kinan Hadaya, DC and the members of his Chiropractic office staff.

(PLEASE INITIAL EACH ITEM & SIGN BELOW)

1. _____I authorize the release of information and discussion of my case/treatment with an attorney, health care provider and/or Insurance Company.
2. _____I authorize the release of my information to any health care provider that is involved in my care, treatment, and/or therapy.
3. _____I authorize Kinan Hadaya, DC and his staff to contact me by telephone at the number provided and/or by email at _____ to discuss my appointments, treatment information, and/or other details related to my therapy, treatment, and/or care in his office. This includes but is not limited to financial issues (Insurance, balance due, etc) related to my care as well as anything related to the treatment that has or will be provided to me.
4. _____I authorize the leaving of messages about my appointments and treatment on my voicemail/answering machine.

5. _____ I authorize the submission of my diagnostics studies (including but not limited to X-ray, CT scan, MRI, Sonogram, Blood Test, Doppler, etc.) to an independent health care provider and/or diagnostics evaluation service for the purpose of obtaining a second opinion and/or more in-depth evaluation of my condition.

   The above authorizations are valid until I rescind them with written notice and a photocopy of these authorizations is to be considered as valid as the original.

Patient Signature: _____ Date: _____

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LATE ARRIVAL/RE-SCHEDULE APPOINTMENT POLICY

* **LATE ARRIVAL** If you arrive late for your appointment, we reserve the right to reschedule the appointment. We allow up to a 10-minute grace period. Late arrivals will cause a delay in seeing patients who are on time. If you find you are running late, we recommend you call our office to determine if we can hold your appointment time.

* **RE-SCHEDULING** We require at least 24 hours' notice for re-scheduling any appointment. You must contact our office via phone or text at 661-947-2455. If you must re-schedule, we will offer you the next available appointment time, which may possibly be a few weeks out.

** Any patient arriving within the 10-minute grace period will still keep their appointment but will have to cut into their service time.

*** Any patient arriving after the 10-minute grace period from their scheduled appointment will forfeit the session resulting in an automatic cancellation.

In the event of excessive tardiness, we reserve the right to refuse further service as this action affects our business and prevents willing clients from utilizing that time slot.

We know things come up and emergencies happen, we simply ask that you be mindful of our time. We are here to help you relief stress, not give you more stress.

Patient Consent Signature_____ Date_____