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 – GENERAL INSURANCE

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 _____

INSURANCE INFORMATION: (PLEASE HAVE YOUR CARD READY FOR COPYING)

Insurance Company: _____ Effective Date: _____
Address: _____
Insurance Phone: _____
Subscriber Name: _____ DOB: _____
Policy/ Insured ID: _____ Group #: _____
Relationship to Insured: _____
Secondary Insurance: _____ Effective Date: _____
Address: _____
Insurance Phone: _____
Subscriber Name: _____ DOB: _____
Policy/ Insured ID: _____ Group #: _____
Relationship to Insured: _____

Employment
Employer: _____ Occupation: _____
Employers Address: _____ Phone: _____

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PERMISSION TO TREAT A MINOR

I/We the undersigned, parent/guardian of _____, a minor for whom the undersigned is legally responsible, do hereby authorize and consent to any examination, x-ray, anesthetic, medical diagnosis or treatment which is deemed advisable, rendered under general or special supervision of KINAN HADAYA, D.C., weather such diagnosis or treatment is rendered at HADAYA CHIROPRACTIC, INC. dba KINAN HADAYA, D.C., or at a licensed hospital. This authorization is given pursuant to the provisions for Section 25.B of the Civil Code of the State of California. This consent shall be effective until revoked in writing and delivered to KINAN HADAYA, D.C.

Parent/Guardian Name _____

Signature _____ Date _____

Please list the names and relationship to the patient of the adults who have permission to bring the above child in for treatment:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

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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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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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PATIENT FINANCIAL RESPONSIBILITY STATEMENT

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amounts, or any other patient responsibility indicated by your insurance carrier or our FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance.

2. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Medical Associates, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Hadaya Chiropractic, Inc. are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Medical Associates; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

3. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Hadaya Chiropractic, Inc. until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize Hadaya Chiropractic, Inc. to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

4. We accept payment by check, cash, debit cards or credit cards (Visa, MasterCard or Discover). a. Payment by Check. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $35.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution.

ONCE I HAVE SIGNED THIS AGREEMENT, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____

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_____