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

18500 Via Princessa, Suite 3
Canyon Country, CA 91387
Ph: 661-252-2225 Fax: 661-252-2239

Patient Name: _____ DOB: _____ M/F

Address: _____ City: _____ Zip: _____

Phone#: _____ Cell#: _____ email: _____

Social Security #: _____ Driver's License#: _____

Marital Status: M S W D Minor Name of Spouse: _____

NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name: _____ Phone: _____
Relationship _____

INSURANCE NAME AND ADDRESS: (please have your card ready for copying)

Insurance Company: _____ Effective Date: _____

Address: _____

Subscriber's Name: _____ DOB: _____ SS#: _____

Policy#: _____ Group#: _____ Relationship to Insured: _____

Secondary Insurance: _____ Effective Date: _____

Address: _____

Subscriber's Name: _____ DOB: _____ SS#: _____

Policy#: _____ Group#: _____ Relationship to Insured: _____

EMPLOYMENT

Employer: _____ Occupation: _____

Employer's Address: _____ Phone#: _____

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Father's Name: _____ DOB: _____

Home Phone#: _____ Cell#: _____ Email: _____

Mother's Name: _____ DOB: _____

Home Phone#: _____ Cell#: _____ Email: _____

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 or surgical diagnosis or treatment and hospital care which is deemed advisable, rendered under general or special supervision of KINAN HADAYA D.C., whether such diagnosis or treatment is rendered at HADAYA CHIROPRACTIC INC. (KINAN HADAYA D.C.) or at a licensed hospital. This authorization includes any major surgery deemed as lifesaving but excludes the removal of any limbs without prior approval of the parent or guardian and or specialists in the restoration of the affected limb and/ or limbs. It is understood that every effort shall be made to contact the undersigned before rendering treatment, but that any of the above treatment will not be withheld if the undersigned cannot be reached. 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.

Mother's Signature _____

Father's Signature _____

Guardian's Signature _____

Date _____

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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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/ PARENT OR LEGAL GUARDIAN

_____ TODAY'S DATE _____

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PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

As part of your care I this office a considerable amount of information is recorded 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. Please fill in your name and identification information, read each item, check the appropriate box, cross out the phrase that does not apply, initial at the end of each item, date and sign at the bottom.

Name: _____ Date of birth: _____

Address: _____ Phone: _____

Each of the following authorizations pertains to the Chiropractic office of Kinan Hadaya, DC and the members of his Chiropractic office staff. **(PLEASE INITIAL AFTER EACH ITEM)**

1. I ( ) authorize ( ) do NOT authorize the release of information to my Insurance Company. ____
2. I ( ) authorize ( ) do NOT authorize the writing of my name on the office message/birthday card. ____
3. I ( ) authorize ( ) do NOT authorize the release of my information to any other health care provider that is involved in my care, treatment, and/or therapy. ____
4. I ( ) authorize the discussion of my case/care with ONLY the following persons:

Spouse Name: _____ Ph: _____

Parent/s Name: _____ Ph: _____

Adult Child Name: _____ Ph: _____

Sibling Name: _____ Ph: _____

Friends Name: _____ Ph: _____

5. I ( ) authorize ( ) do NOT authorize Kinan Hadaya, DC and his staff to contact me by telephone at the numbers listed above and 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. ____
6. I ( ) authorize ( ) do NOT authorize the leaving of messages about my appointments and treatment on my voicemail/answering machine. ____
7. If I am not available, his staff ( ) are ( ) are not authorized to speak with the relative(s) and/or friend(s) noted in item 4 above about all the items listed in the item 5 above. ____
8. I ( ) authorize ( ) do NOT authorize the discussion of my case/treatment with an attorney and/or health care provider that represents me or my insurance company. ____
9. I ( ) authorize ( ) do NOT 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.

Name: _____ Date: _____

Signature: _____

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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 E quina 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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APPOINTMENT POLICY

Patient Name/ Parent or Guardian_____ Date_____

At HADAYA CHIROPRACTIC INC., we understand your time is valuable which is why we try to be as flexible as possible for each and every single one of our patient's. We do our best effort to confirm appointments ahead of time, but we do however want all our patient's to know, that you're ultimately responsible for your appointments scheduled.

In an effort to effectively control our schedule, a new policy will be taking effect starting on January 1, 2016. For every missed appointment, there will be a $25 inconvenience fee. For every appointment, there will be a 15 minute grace period in case patient is running late. In order to avoid these fees, please advise our office about your rescheduled appointment or cancellation, at least 24 hours ahead of time. If you are having transportation issues, please advise our office in advanced to better manage your appointments. Reason being is we dedicate our scheduled time to all of our patient's well-being, and by missing an appointment we lose time that could have been used effectively to help another patient on their road to recovery.

By signing below, you understand our new policy, and please note that on your next scheduled appointment, your fee will be collected before treatment is rendered. Thank you for your understanding and cooperation with this matter.

Patient Name_____ Date_____

Signature_____ Date_____

Name of Guardian/Legal Representative_____