Patient Registration

CONTACT INFORMATION

Full Name: _____ Date of Birth:_____

Street Address:_____

City: _____State:_____ Zip: _____

Phone Number: _____Type: Mobile _____ Home _____ Work_____

Email Address: _____ Gender :M _____F_____

Employer's Name: _____ Occupation _____

Employer's Phone:_____ Employer's Address:_____

Spouse's Name: _____ Spouse's Occupation:_____

Names of Children:_____ Ages of Children:_____

How did you find out about Dr. Val?_____

EMERGENCY CONTACT

Contact Name:_____Contact Phone Number: _____

Contact Address:_____Relationship:_____

CURRENT HEALTH PROFILE

Height_____ Weight_____

Primary Reason for Visit:_____

Other Doctors Seen for this Condition:_____

When did this condition begin?_____

How did it start?_____

Describe the symptoms (e.g. achy, diffuse, tight, etc):_____

What types of medications do you currently take?_____

On a scale of 0-10 (10 being the worst), rate your discomfort: _____

Do your symptoms occur more in any of the following?

morning afternoon night w/activity constant

What daily activities are affected by this condition?_____

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____ _____
Signature Date

DR. Valerie Vicent
447 Encinitas Blvd Encinitas, CA 92024
Phone: 619-884-2721

OUR FINANCIAL POLICY

Thank you for choosing us as your Chiropractic health care provider. We are committed to your treatment being successful. The following is a statement of our *Financial Policy*, which we require you read, and sign prior to any treatment.

Patients

All Patients are responsible for payment at the time of service. It is requested that 100% of your first visit be paid at the time of your visit.

New Patient Appointments: range in prices depends on the time required and the condition of the patient. The fees account for the scope of assessment, depth of case management, and services rendered. I customize my services for each patient, so I will determine the specific time and cost for these appointments. I reserve the right to provide an alternative fee schedule based upon whether we are providing services to an individual/pregnant mom/kids/family all at once.

Payment and Billing

I do accept insurance if they accept me and I will work to get your services covered based on your plan. Patients are responsible for all charges. Payments for services are accepted and processed by check, cash, or debit/credit card on the patient's file. For your convenience, we accept all credit cards.

Missed Appointments and Fees

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of **24 hours in advance** if you are unable to do so.
At Dr. Val Chiropractic, your scheduled appointment time is reserved just for you. We do not overbook appointment times in order to provide you with personalized and quality care.

Failure to comply with this policy will necessitate the assessment of the following fees:

- **First missed appointment**: Our staff will call to reschedule your next appointment. We understand things happen and you will not be billed for your first missed appointment.
- **Second missed appointment**: You will receive a note via e-mail/mail/text **(select which you prefer)** stating this is your second missed appointment and that you have been charged a **cancellation fee. A fee of $40 will be charged** as well as a credit card kept on file for any future missed appointments that are cancelled or rescheduled with less than 24-hour's notice.

We offer several methods of payment for our Chiropractic care at our office. Please read carefully and choose the plan, which applies, to you. Our main concern is your health and well being, and we will do our best to help accommodate and serve you.

_____ **PLAN #1** INSURANCE – If you have insurance which covers Chiropractic care, we will bill your insurance directly. Please bring us your insurance information, on or before your second visit. Until we have verified your Chiropractic coverage, you will be required to pay for your care. Most patients will pay a co-pay, in addition to meeting their yearly deductible. In the event the check should come to you, you are expected to bring the check to us. Remember, insurance companies balk at "maintenance" and "long-term rehabilitation." Most "health" policies are designed and intended to only take care of acute problems, they want you to eventually "get off" insurance. At this point, we will present affordable cash plans.

_____**PLAN # 2 CASH** – Fees are to be paid at the time services are rendered or prior. After payment for the initial visit, you will only be responsible for payments for all future services.

Professional Fees are as follows:

1. Comprehensive Initial Exam/X-rays	$70-$350
2. Established Patient Office Visit/Re-exam	$50-$150
3. Full Spine/Extremity Spinal Manipulations	$65- $140
a. Pediatric 0-10 yrs.	$25
b. Pediatric 11-18 yrs.	$35
4. Deep Muscle Stimulation	$25
5. Myofascial Release	$25
6. Kinesiology Taping	$25
7. Therapeutic Exercise/Stretching/Rehabilitation	$25
8. Instrument Assisted Soft Tissue Mobilization	$25
9. Radiology Report Second Opinion	$30
10. Craniosacral Therapy	$68

_____**PLAN # 3** AUTO INJURY – You will supply us with the accident report, your car insurance, health insurance, and liable parties insurance, and attorney if applicable. Until the insurances are verified, you will be required to pay for your care. We will bill your insurance directly after we verify coverage.

_____**PLAN #4** MEDICARE – Per established Medicare guidelines, please bring us your Medicare information on or before your second visit. We will bill your Medicare directly. In the event the check should come to you. You are expected to bring the check to us.

Patient Accountability

You are expected to be an active participant in your care. Your chiropractor's recommended treatment plan, exercises, stretches, ice/heat applications, life-style changes, or other active processes must be followed to ensure optimum progress.

I have read and understand this Policy Agreement.

By signing below, I will abide by its terms.

Patient Name:_____ Date: _____

Patient Signature:_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date: