Dr. Darla Booth, DC

Chiropractic Registration and History

Patient Information

Name_____Date_____

Sex_____Age_____DOB_____

Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____

Best time and place to reach you_____

Email_____

Occupation_____

Employer/School_____

Employer/School Address_____

_____

Whom may we thank for referring you?_____

Emergency Contact

Name_____Relationship_____

Home Phone_____Cell Phone_____

Notice of Information Practices and Privacy Statement

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We do not give out, barter, exchange or sell information about our patients.

Our practice may use your protected health information (PHI) to treat you, contact you, and share with your other health care providers to assist for purposes related to your treatment. Our practice may use and disclose your PHI in order to bill and collect payment for service sand items you may receive from us. This includes companies for personal insurance, third party insurance, workers' compensation and personal injury representatives. We may use and disclose medical information to notify or help notify a family member, your personal representative or another person responsible for your care.

We may disclose medical information in response to court or administrative order, subpoena, discovery request or our lawful process under certain circumstances. We may disclose your PHI as required by law to public health or legal authorities or when required to do so by federal, state, or local law.

We reserve the right to revise or amend this Notice of Privacy Practices and will make new notice available upon request.

I have read the Notice of Privacy Practices.

_____ _____

Signature Date

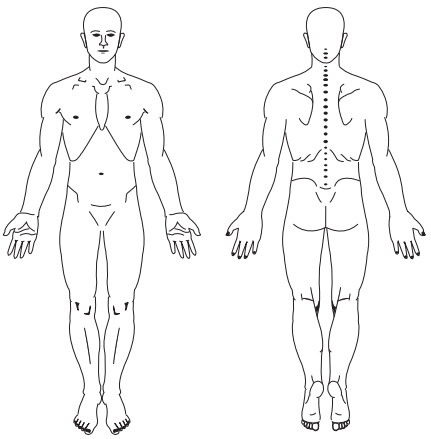
Patient Condition

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of Pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? _____

Is it constant of does it come and go? _____

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform: ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

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Health History

What treatment have you already received for your condition?

❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other_____

Name and address of other doctor(s) who have treated you for your conditions_____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
MRI_____ CT-Scan_____ Bone Scan_____

Are you pregnant? ❑ No ❑ Yes Due Date_____

Place a mark on "Y" for yes or "N" for no to indicate if you have had any of the following:

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV	❑	❑	Chicken Pox	❑	❑	Kidney Disease	❑	❑	Psychiatric Care	❑	❑
Alcoholism	❑	❑	Diabetes	❑	❑	Liver Disease	❑	❑	Rheumatoid Arthritis	❑	❑
Allergy Shots	❑	❑	Emphysema	❑	❑	Measles	❑	❑	Rheumatic Fever	❑	❑
Anemia	❑	❑	Epilepsy	❑	❑	Migraine Headaches	❑	❑	Scarlet Fever	❑	❑
Anorexia	❑	❑	Fractures	❑	❑	Miscarriage	❑	❑	STD	❑	❑
Appendicitis	❑	❑	Glaucoma	❑	❑	Mononucleosis	❑	❑	Stroke	❑	❑
Arthritis	❑	❑	Goiter	❑	❑	Multiple Sclerosis	❑	❑	Suicide Attempt	❑	❑
Asthma	❑	❑	Gonorrhea	❑	❑	Mumps	❑	❑	Thyroid Problems	❑	❑
Bleeding Disorders	❑	❑	Gout	❑	❑	Osteoporosis	❑	❑	Tonsilititis	❑	❑
Breast Implants	❑	❑	Heart Disease	❑	❑	Pacemaker	❑	❑	Tuberculosis	❑	❑
Breast Lump	❑	❑	Hepatitis	❑	❑	Parkinson's	❑	❑	Tumors, Growths	❑	❑
Bronchitis	❑	❑	Hernia	❑	❑	Pinched Nerve	❑	❑	Thyphoid Fever	❑	❑
Bulimia	❑	❑	Herniated Disc	❑	❑	Pneumonia	❑	❑	Ulcers	❑	❑
Cancer	❑	❑	Herpes	❑	❑	Polio	❑	❑	Vaginal Infections	❑	❑
Cataracts	❑	❑	High Blood Pressure	❑	❑	Prostate Problem	❑	❑	Whooping Cough	❑	❑
Chemical Dependency	❑	❑	High Cholesterol	❑	❑	Prosthesis	❑	❑	Other	❑	❑

Exercise

❑ None
❑ Moderate
❑ Daily
❑ Heavy

Work Activity

❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

Habits

❑ Smoking (*if yes, number of packs/day*)_____
❑ Alcohol (*if yes, number of drinks/week*)_____
❑ Coffee/Caffeine Drinks (*if yes, number of cups/day*)_____
❑ High Stress Level (*if yes, reason*)_____

Injuries/Surgeries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

_____
_____
_____
_____

Allergies

_____
_____
_____
_____

Vitamins/Herbs/Minerals

_____
_____
_____
_____

Dr. Darla Booth, DC

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Office Guidelines and Policies

Welcome! Please take the time to review the following office guidelines and policies so that we may better serve you. This information outlines our terms for providing service and will help clarify any questions you may have before your first appointment.

Preparation Guidelines
Prior to your initial visit you need to obtain all the necessary paperwork. We ask you to read and complete this paperwork at home (in non-urgent cases) to give you time to think through your answers and to make the most out of your time in our office. You may also want to visit our website (www.DarlaBooth.com) to learn more about the services offered in our office, what to expect on your first visit, and to find answers to some questions frequently asked by patients.

Medical Records
If applicable, please bring copies of your latest laboratory and imaging (x-ray, MRI, CT) reports—no film required—on the day of your initial exam. If your doctor requires an 'Authorization to Release Medical Records' form please contact our office and we will provide one for you. Often your laboratory and imaging reports can be faxed or emailed directly to you by your doctor.

Fees
Our goal is to provide you with the best personalized health care at an affordable price.

Non-Medicare Health Insurance: We are "out-of-network" for all* insurance companies. To find out about your out-of-network benefits, call the customer service number on your insurance card and inquire about your chiropractic coverage. We do not bill or directly communicate with insurance companies; however, we are happy to provide you with a "superbill" that includes the information you need to file a claim. Any reimbursement will then be mailed directly to you from your insurance company. There is no out-of-network reimbursement for Medicare, Tricare or Kaiser/HMO patients. If you have a Health Savings Account (HSA) or Flexible Spending Account (FSA) the "superbill" will also validate your expenses in our office as healthcare-related to those entities. Payment for each visit is required at the time of service. Outside labs and imaging are performed at our cost, with no added mark-up.

Medicare: We do accept Medicare as a "non-participating physician." This means that we collect the full amount of your visit charges at the time of service and then send in your Medicare billing for you. Medicare and your secondary insurance policy (if you have one in place) will then reimburse you, based on the details of your health coverage, by sending a check directly to you. Medicare is particular on what chiropractic services they will cover and we will go over these details with you during your first visit.

Retail Sales
Many doctors offer supplies (glasses, crutches, supplements, etc.) at their offices for the convenience of their patients. Depending on the nature of your case, the doctor may recommend nutritional and/or support products such as vitamins/minerals, botanicals, joint braces, etc. Although he does suggest commercial products (health food stores, online, etc.), most are recommended from our office for several reasons. Years of clinical experience shows that most commercial products are poor quality, in spite of the label claims. We carefully select 'professional grade' products from various reputable manufacturers. Additionally, California Tax law states that the patient doesn't have to pay sales tax on these products when sold in a chiropractor's office. That is nearly a 10% savings for patients. Please note that no patient is required to purchase products from our office, however if you choose to purchase over-the-counter products of lesser quality, you should not be surprised if you obtain sub-optimal results.

Return Policy
Product returns must be made within thirty (30) days of purchase. Un-opened products (supplements and/or orthopedic supports/supplies) that are returned within 30 days will be given a full refund. All supplement returns must be unopened and sealed inside the original packaging. Opened supplements may not be returned. No refunds are offered on services rendered.

No Show & Cancellation Policy
We are committed to offering exceptional patient care during every visit. He has invested in equipment, training, and systems to make your visit comfortable and effective. He prides himself on consistently running on time. He will be ready for your appointment with his full attention and energy. We ask that you prepare for your appointment accordingly. Please silence your cell phone prior to your visit. Please come dressed appropriately for the area to be treated (ex: don't wear tight jeans if we are going to be working on your knee). We have a 24-hour cancellation policy on all appointments. No-shows or cancellations with less than a 24-hour notice will be billed the full fee of the appointment. Our staff will make every attempt to remind you of your appointment, but it is ultimately your responsibility to remember.

If you are running late please call to let us know when you anticipate arriving for your visit. We will do our best to accommodate your revised visit time into the doctor's schedule. However, our office makes a policy of not pushing the entire day's schedule out because a single patient is late to their appointment. We will run on time as a rule and we ask that you show up on time for your appointments.

Payment Agreement
Payment for the initial consultation and treatments is required at the time of service. For your convenience, we accept cash, checks, Mastercard, and Visa.

Additionally, regarding insurance, please be sure to note:

Your insurance policy is a legal contract between you, your employer, and the insurance company. We, as healthcare providers, are NOT a party to that contract.

Darla Booth, DC is not a member of any HMO, PPO, or other provider networks. Therefore, any coverage you may have for services provided in this office will be deemed "out of network coverage" by your insurance company.

Many insurance companies will advise you that your coverage will be a percentage of the office fees (e.g. 80% of treatment charges) after a yearly deductible amount has been fulfilled. What is often not specified by the insurance company are plan fee schedules, annual maximums, and other limitations that will have a direct bearing on the reimbursement they allow. For details on your health insurance "out-of-network" chiropractic benefits please contact your insurance company directly.

Release of Information: I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare.

I, the undersigned, agree to all the above Office Guidelines and Policies. I have asked, and had answered to my satisfaction, any questioned I have regarding these policies.

Signed _____ Date _____

Dr. Darla Booth, DC

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Informed Consent

I, the undersigned, have voluntarily requested that Darla Booth, DC, (herein 'the doctor'), assist me in the management of my health concerns. I have understood and agree to all policies and terms provided in the Office Policies and Procedures. I understand that the doctor is a chiropractor and that her services are not to be construed or serve as a substitute for standard medical care. The doctor recommends that I undergo regular routine medical check-ups by my medical doctor.

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. I, the undersigned, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Physiotherapy modalities (ex: Graston Technique, motor never stim, cold laser, etc), in-office exercises, taping, nutritional supplements/dietary recommendations, among others, may also be used.

Routine chiropractic examination and treatment involve some of the following methods:

- *Observation and Inspection*: Viewing/looking at body parts. Visualization includes general body viewing in a standing position from the front, back, and side. All symptomatic (painful) body parts may be viewed. Although not usually required, if clothing interferes with examination or treatment of an area patient gowning will be utilized. Patients may request an observer of the opposite sex be present at any time during examination and/or treatment.
- *Auscultation*: Using a stethoscope to listen for blood pressure and other body sounds.
- *Palpation*: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
- *Percussion*: Using a rubber hammer and tapping on bones or tendons
- *Orthopedic/neurological testing*: These are standard tests to assess your neuromusculoskeletal systems.
- *Muscle testing*: testing muscles for weakness and/or pain with contraction.
- *Myofascial and/or Graston Technique*: muscle work sometimes involving tools to increase flexibility and break up adhesions in muscle or myofascial tissues.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Risks from Treatment
Soreness: I am aware that like exercise it is possible to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform the doctor if you experience these symptoms.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. A 2009 study of 100 million person-years found "no evidence of excess risk of stroke associated with chiropractic care compared to primary care." If you have any questions about this please ask the doctor. We would be happy to discuss other options and answer any of your questions.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available
Reasonable alternatives to these procedures include rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible injections and/or surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks. We cannot advise you regarding any medication/s. Please consult your M.D.

Rest/Exercise: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Patient's Signature: _____ Date: _____

I discussed the procedures, alternatives, and risks in conference with the patient.

Doctor's Signature: _____ Date: _____