



# chiropractic health & wellness center

Chiropractic Health Care  
Massage Therapy  
Acupuncture

1042 N. Fairfax Avenue, West Hollywood, CA 90046

(t) 323.656.4194

(f) 323.656.4151

## REGISTRATION FORM

(REQUIRED FIELDS IN **BOLD>**)

<b>TODAY'S DATE</b>	Primary care physician:	Referred by:
---------------------	-------------------------	--------------

### PATIENT INFORMATION

<b>PATIENT'S NAME (LAST, FIRST MIDDLE):</b>			<b>BIRTH DATE:</b>		Marital status: Single Married Divorced Widowed Domestic Partner
Is this your legal name? <input type="checkbox"/> Y <input type="checkbox"/> N	If not, what is your legal name?	Former Name:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
<b>STREET ADDRESS:</b>			<b>SOCIAL SECURITY #:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP CODE:</b>	<b>HOME PHONE:</b>	<b>CELL PHONE:</b>	
<b>OCCUPATION:</b>	<b>EMPLOYER:</b>		<b>EMPLOYER PHONE:</b>		
Other family members seen here:					

### IN CASE OF EMERGENCY

<b>NAME OF LOCAL FRIEND OR RELATIVE:</b>	<b>RELATIONSHIP:</b>	<b>HOME PHONE:</b>	<b>WORK PHONE:</b>
--	----------------------	--------------------	--------------------

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

<b>PATIENT/GUARDIAN SIGNATURE:</b>	<b>DATE:</b>
------------------------------------	--------------

**NOTES (FOR OFFICE USE ONLY)**

**CO-INSURANCE PAYMENTS**

CMT	
MASSAGE (30 Min.)	
MASSAGE (1 Hr.)	
MASSAGE (1.5 Hrs.)	
CMT / MASSAGE (30 Min.)	
CMT / MASSAGE (1 Hr.)	
CMT / MASSAGE (1.5 Hrs.)	



## PRIVACY NOTICE AND PRACTICE REQUIREMENTS

**THE PRACTICE:**

- (a) Is a requirement by federal law to maintain the privacy of your Protected Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- (b) Under the Privacy Rule, we may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

**EFFECTIVE DATE:** This notice is in effect as of 04/15/2003

**PATIENT ACKNOWLEDGEMENT:** By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

PATIENT/GUARDIAN SIGNATURE:

DATE:

## CLINIC POLICIES

**1. CANCELLATION** - KINDLY GIVE US 24 HOURS NOTICE OF CANCELLATION FOR ALL APPOINTMENTS. IF NO ARRANGEMENTS HAVE BEEN MADE TO CANCEL YOUR APPOINTMENT, PLEASE NOTE THAT A **\$25.00 CANCELLATION FEE** WILL BE APPLIED TO YOUR ACCOUNT.

**2. COMMUNICATION** - Please communicate any physical problem areas to the massage therapist before starting the massage session as well as letting him or her know if there is too little or too much pressure or any discomfort during the massage so he or she can accommodate you.

**3. SEXUAL INUENDOS** - Verbal and physical innuendos are NOT TOLERATED. If reported, we will ask the individual to leave the premises.

**4. MASSAGE TIMES** - Half-hour massages are 20 minutes in length, Hour massages are 50 minutes in length and Hour and a half massages are 80 minutes in length. This will allow adequate time for individuals to undress/dress and for the therapist to prepare their rooms.

Thank you for your your cooperation and understanding regarding these policies.

PATIENT/GUARDIAN SIGNATURE:

DATE:

WITNESS (FOR OFFICE USE ONLY)

DATE:



# chiropractic health & wellness center

Chiropractic Health Care  
Massage Therapy  
Acupuncture

1042 N. Fairfax Avenue, West Hollywood, CA 90046

(t) 323.656.4194

(f) 323.656.4151

## INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD AND IDENTIFICATION TO THE FRONT DESK)

### ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I understand that I am financially responsible for any balance and authorize my insurance benefits be paid directly to the physician. I hereby direct my insurance company to pay by check made out and mailed directly to:

**Chiropractic Health & Wellness Center  
1042 N. Fairfax Ave.  
West Hollywood, CA 90046.**

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows to:

**Chiropractic Health & Wellness Center  
1042 N. Fairfax Ave.  
West Hollywood, CA 90046**

For the professional or medical expense benefits allowable, and otherwise payable to me, under my current insurance policy as payment toward the total charges for professional services rendered.

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS & BENEFITS UNDER THIS POLICY.**

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand the above doctor has a financial interest in any diagnostic testing.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

SIGNATURE OF POLICY HOLDER:

DATE:

SIGNATURE OF CLAIMANT: (if other than Policy Holder)

DATE:



# chiropractic health & wellness center

Chiropractic Health Care  
Massage Therapy  
Acupuncture

1042 N. Fairfax Avenue, West Hollywood, CA 90046

(t) 323.656.4194

(f) 323.656.4151

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

### LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

--

### SURGERIES

YEAR	REASON	HOSPITAL

### OTHER HOSPITALIZATIONS

YEAR	REASON	HOSPITAL

### LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

NAME OF DRUG	STRENGTH	FREQUENCY TAKEN

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT/GUARDIAN SIGNATURE:	DATE:
-----------------------------	-------