New Patient Intake Form Revised

C.A. _____ Date of call: _____ Appt. Time: _____

Is this Work, Auto or Accident related? _____

Date of Injury: _____ State of Accident: _____

Case #: _____

First name: _____

Last name: _____

Nickname: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Sec. #: _____

Gender: _____ Marital Status: _____

Spouse name: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Fax #: _____

Emergency: _____

e-mail addy: _____

Who referred you to our office?

Website: _____

Patient ref: _____

Other: _____

Insurance info: _____

Insurance phone number for Providers: _____

Group #: _____ I.D. #: _____

Occupation: _____

Assigned Provider (treating doctor requested?): _____

Patient review above information and complete if necessary:

Patient signature: _____ Date: _____

Personal Injury Questionnaire

Name _____ Age_____ Phone ( ) _____
Your Ins. Co. _____ Policy # _____ Agent's Name _____
Name on Policy (If other than self) _____ Policy # _____
Responsible Party's Name _____
Address _____ City _____ State ____ Zip _____
Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____
Address _____ City _____ State ____ Zip _____
Were there any witnesses ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____
4. What direction were you heading? ( ) North ( ) South ( ) East ( ) West
   on (name of street) _____
5. What direction was the other vehicle heading? ( ) North ( ) South ( ) East ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
7. Approximate speed of your car _____ mph. Speed of other car _____ mph.
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe accident: _____

DESCRIPTION OF INJURY:

1. Did you have a seat belt on? ( ) Yes ( ) No
2. Did you have a shoulder harness on? ( ) Yes ( ) No
3. Did the seat have a headrest?( ) Yes ( ) No How high was it adjusted? _____
4. Were you head, neck and/or body jerked forcibly backward and forward? ( ) Yes ( ) No
5. Were you head, neck and/or body jerked forcibly side to side? ( ) Yes ( ) No
6. Which direction were you looking upon impact? ( ) Left ( ) Right ( ) Straight
7. Did you strike your head? ( ) Yes ( ) No Where?(e.g. windshield, door) _____
8. Did you strike your body? ( ) Yes ( ) No Where? (e.g. steering wheel,dash) _____
9. Did you strike your knees? ( ) Yes ( ) No Where? (e.g. dash, console) _____
10. Did you strike your arms? ( ) Yes ( ) No Where? (e.g. door, dash) _____
11. Were there any cuts, gashes, or bruises on your body? ( ) Yes ( ) No
    Describe: _____
12. Did you lose your hat, glasses, contact lenses, or earrings? ( ) Yes ( ) No
13. Were you unconscious? ( ) Yes ( ) No How long? _____
14. Were you shaken or stunned? ( ) No ( ) Slightly ( ) Moderately ( ) Severely
15. Were you able to get out of the car under your own power? ( ) Yes ( ) No
16. Were either cars towed from the scene? ( ) Yes ( ) No If yes: ( )Yours ( )Other
17. Please describe how you felt:
    a. IMMEDIATELY AFTER the accident: _____
    b. LATER THAT DAY: _____
    c. THE NEXT DAY: _____

SYMPTOMS:

Check symptoms your have experienced since accident:

( ) Headaches	( ) Head seems too heavy	( ) Dizziness	( ) Loss of memory
( ) Neck pain	( ) Pins & needles in arms	( ) Irritability	( ) Fainting
( ) Neck stiff	( ) Pins & needles in legs	( ) Nervousness	( ) Loss of balance
( ) Mid back pain	( ) Numbness in fingers	( ) Depression	( ) Loss of smell
( ) Low back pain	( ) Numbness in toes	( ) Ears ring	( ) Loss of taste
( ) Chest pain	( ) Lights bother eyes	( ) Shortness of breath	( ) Fever
( ) Fatigue	( ) Sleeping Problems	( ) Upset stomach	( ) Vomiting

Symptoms other than above: _____
Since this injury occurred, are your symptoms:( ) Improving ( ) Getting Worse ( ) Same

MEDICAL CARE:

If you have not received any medical care since the accident, skip this section and check here ( )

1. Were you seen by paramedics at he accident?( ) Yes ( ) No
2. Did you go to the hospital or doctor following the accident? ( ) Yes ( ) No Name: _____
3. How did you get there? ( ) Ambulance ( ) Car
4. Were you examined? ( ) Yes ( ) No Was it thorough? ( ) Yes ( ) No
5. Were you x-rayed? ( ) Yes ( ) No If yes, what areas of your body? _____
6. What did the doctors tell you? _____
7. Did they give you any treatment? ( ) Yes ( ) No If yes, please describe: _____
8. Did they give you any medication? ( ) Yes ( ) No _____
9. What follow up advice? _____
10. Have you been treated by any other doctors since the accident? ( ) Yes ( ) No
    If yes, please list the doctor's name and address: _____
11. Have you received any other medical care up to this point? ( ) Medication ( ) Physical therapy
    Please describe: _____
    Did it help? _____

PAST MEDICAL HISTORY:

1. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail: _____
2. Do you have any congenital (from birth) factors which relate to this problem?( )Yes ( )No If yes, please describe: _____
3. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
    If yes, please describe: _____
4. Have you had any other accidents which required medical care? ( ) Yes ( ) No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(es) received: _____

DISABILITY:

1. Have you lost time from work as a result of this accident? ( ) Yes ( ) No
    If yes: Last Day Worked: _____ Type of Employment: _____
2. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No
    If yes, please describe in detail: _____

Other pertinent information: _____

_____ _____

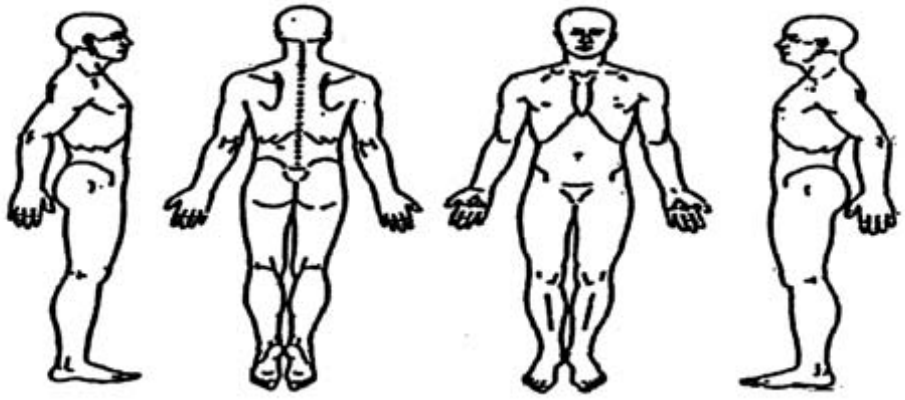
Date Patient's Signature

NEW PATIENT CONFIDENTIAL INTAKE FORM Page 3

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

---

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

Over →

13. What aggravates your problem?

---

14. What concerns you the most about your problem; what does it prevent you from doing?

---

15. What is your: Height_____ Weight _____ Age _____

Occupation _____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite **For Females Only**		
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue	□	□ Tumor
□	□ Muscular Incoordination	□	□ Asthma	□	□ Visual Disturbances
□	□ Chronic Sinusitis	□	□ Dizziness	□	□ Other:_____

20. List all prescription medications you are currently taking:

---

21. List all of the over-the-counter medications you are currently taking:

---

22. List all surgical procedures you have had:

Over →

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

---

25. Have you ever been hospitalized? □ No □ Yes

if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Would you like our doctors to have open oral or written discussion with your other doctors to help your case? YES NO
If so, who is your current "general medical" health practitioner? Give name, city, phone and fax if you can:
M.D. Name:

The doctors and staff of Budincich Chiropractic Clinic (BCC) have my permission to request any and all medical records, x-rays, or diagnostic tests or imaging from my past physicians or surgeons, to fully appraise my condition, and to determine safe treatment protocols. I understand that I must pay any fees, if any are assessed, to prior doctors and clinics to have such records mailed to BCC. I also authorize my personal medical insurance company, or third party insurance company responsible, to pay any and all contracted amounts directly to BCC and this document may be considered a pre-designated "ASSIGNMENT OF BENEFITS" as authorized by my signature below:

Patient Signature:_____ **Date:** _____

Doctor Signature:_____ **Date:** _____

Secondary Doctor/Intern Signature:_____ **Date:** _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

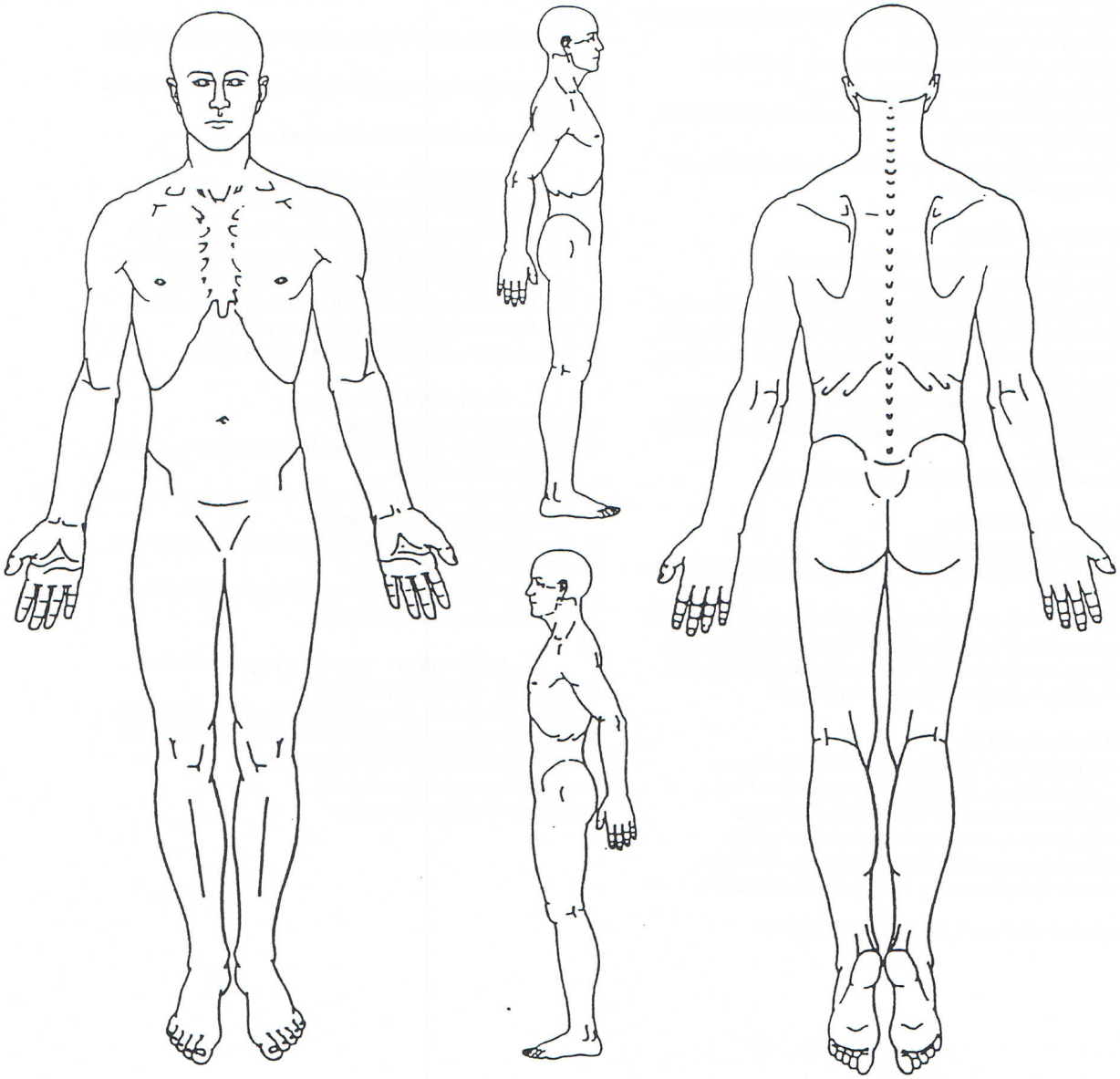
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
P=PINS & NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please just circle the one choice which closely describes your problem *right now.***

SECTION 1--Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
E. Because of the pain, I am unable to do most washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking

A. Pain does not prevent me from walking any distance.
B. I have some pain with walking but it does not increase with distance.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than 1/2 mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

A. 1 can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain pevents me from sitting at all.

SECTION 6 -- Standing

A I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than $^{1}/2$ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social, life to my home.
F. Pain prevents me from social, life at all.

SECTION 9--Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms off travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Disability index score:_____ %

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

SIGNATURE:_____ **DATE:**_____

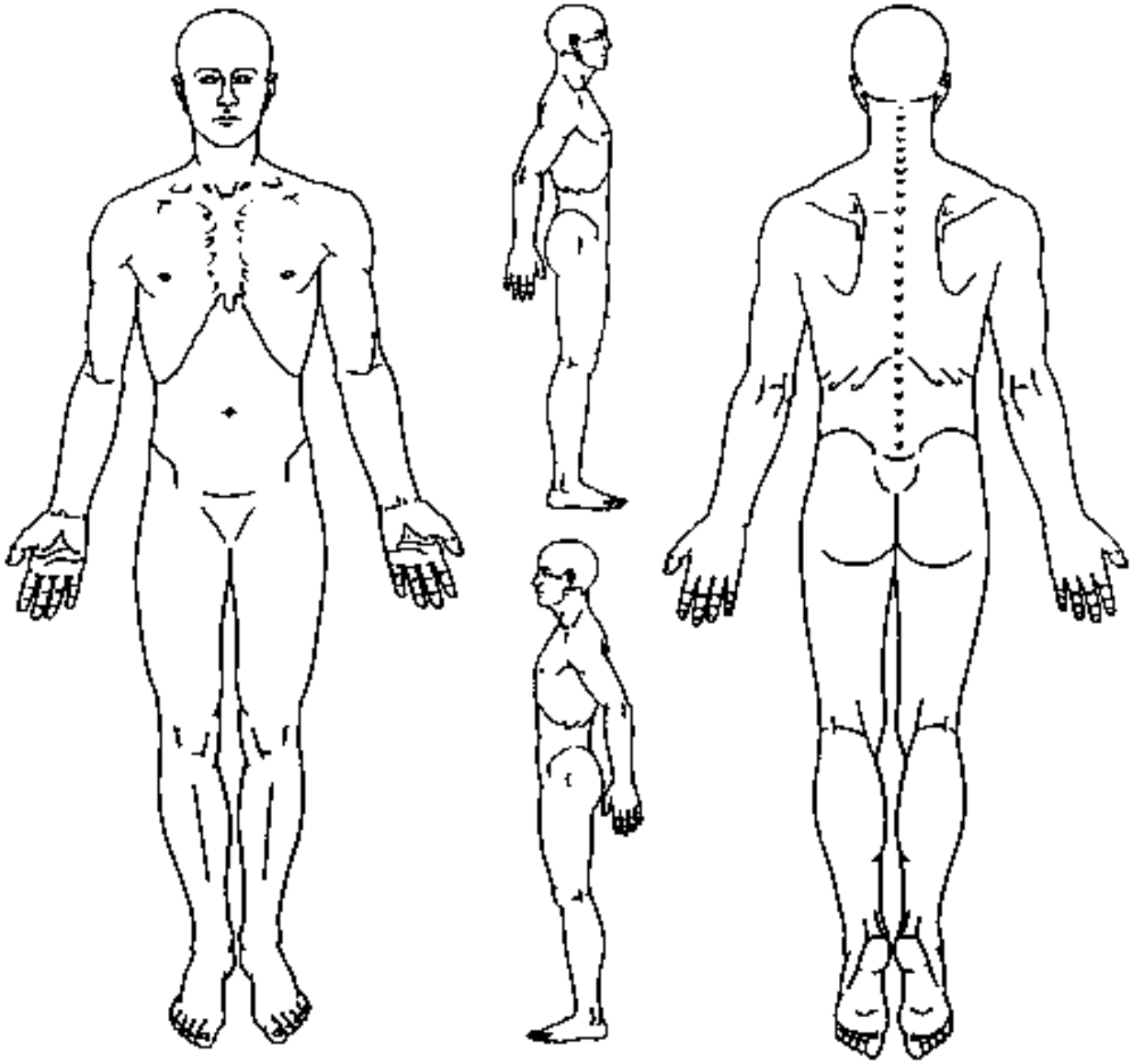
DISABILITY INDEX SCORE: **%**_____

THE NECK DISABILITY INDEX QUESTIONNAIRE

NAME _____ DATE _____

How long have you had neck pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

OVER PLEASE ⇒

SAVE PRINT CLEAR

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(telephone number)

Employee Name **(please print)**:

_____

Employee's address:

_____

Employee's
Signature_____Date:_____

DWC FORM 9783.1 (March 14, 2006)

Budincich Chiropractic Clinic, Inc.
Michael N. Budincich, D.C. & Associates

140 N. Hill Avenue Pasadena, CA 91106
(626) 792-3390 Fax (626) 792-8302

Notice of Doctor's Lien

Attorney: _____ Patient: _____
Address: _____ Date of injury: _____

I do hereby authorize Budincich Chiropractic Clinic to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc… of myself in regard to the accident dated above.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for medical services rendered to me both by reason of this accident and by reason or any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said clinic. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his/her awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable. A faxed copy of this form is considered as good as the original document.

Signed: _____ Dated: _____
Patient/Guardian's signature

The undersigned being attorney of record for the above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said clinic above named. The attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs. In the event attorney below is "subbed out" by the patient or the attorney stops representing the patient signed above, the undersigned agrees to notify Budincich Chiropractic Clinic in writing within 5 working days by registered mail return receipt requested to the address above.

Signed: _____ Dated: _____

HIPAA Notice of Privacy Practices
Acknowledgement of Receipt

Budincich Chiropractic Clinic, 140 N. Hill Avenue, Pasadena, CA 91106

Michael N. Budincich, D.C., Privacy Officer, (626) 792-3390

I hereby acknowledge that I have read and received a copy of the attached medical practice's **HIPAA Notice of Privacy Practices of the Budincich Chiropractic Clinic.**

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

_____Do not write below this line_____

***For Office Use Only*:**

Signed form received by: _____ C.A.

Acknowledgment refused: _____ C.A.

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Budincich Chiropractic Clinic (BCC) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at Budincich Chiropractic Clinic (BCC) please contact:

Michael N. Budincich, D.C. at (626) 792-3390, drbud@drbud.com or 140 N. Hill Avenue, Pasadena, CA 91106

Effective Date of This Notice: 4/10/06

I. How BCC may Use or Disclose Your Health Information

BCC collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of BCC, but the information in the medical record belongs to you. BCC protects the privacy of your health information. The law permits BCC to use or disclose your health information for the following purposes:

1. Treatment. We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. Example:

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the Budincich Chiropractic Clinic, Inc."

"It is our policy to provide a substitute health care provider, authorized by BCC, Inc., to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

2. Payment. We may disclose your health information to your insurance provider for the purpose of payment or health care operations. Example:

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Budincich Chiropractic Clinic, Inc. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to you for your insurance company for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received"

3. Regular Health Care Operations. We may disclose your health information to a staff member in order that they may process paperwork, input computer information, fill out report forms, for copying or faxing whereby your medical condition, diagnosis and treatment may be visible to them in their day to day work.

"If a staff member is asked to copy records that are to be sent to another doctor at your request."

4. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

5. Required by law. As required by law, we may use and disclose your health information.

6. Public health. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

7. Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

8. Judicial and administrative proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

9. Law enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

10. Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.

11. Organ donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

12. Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

13. Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

14. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

15. Reminders. We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.

16. Charitable Causes. We may contact you to participate in fund-raising activities for blood drives, food bank raising donations or other charitable entities that we may be involved with to benefit those in need.

17. Change of Ownership. In the event that BCC is sold or merged with another organization, your health information/record will become the property of the new owner.

18. Emergencies. We may disclose your health information, to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

II. When Budincich Chiropractic Clinic May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, BCC will not use or disclose your health information without your written authorization. If you do authorize BCC to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. Your Health Information Rights

[Note: Each of these rights should be explained in enough detail so that the individual understands that each right is not absolute and is subject to some limitations and conditions. While some of these rights have been expanded to include the basic limitations provided under the law, each should be considered in light of the permitted conditions under the law and the organization's actual practices.]

1. You have the right to request restrictions on certain uses and disclosures of your health information. BCC is not required to agree to the restriction that you requested.

2. You have the right to receive your health information through a reasonable alternative means or at an alternative location

3. You have the right to inspect and copy your health information.

4. You have a right to request that BCC amend your health information that is incorrect or incomplete. BCC is not required to change your health information and will provide you with information about BCC denial and how you can disagree with the denial.

5. You have a right to receive an accounting of disclosures of your health information made by BCC, except that BCC does not have to account for the disclosures described in parts 1 (treatment), 2 (payment), 3 (health care

operations), 4 (information provided to you), 5 (directory listings) and 16 (certain government functions) of section I of this Notice of Privacy Practices.

6. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please circle the areas of concern and give to the front desk receptionist for follow up.

IV. Changes to this Notice of Privacy Practices

BCC reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, BCC is required by law to comply with this Notice.

Revised notices will be posted in the office and given to each new patient as they come in for care**.**

V. Complaints

Complaints about this Notice of Privacy Practices or how BCC handles your health information should be directed to:

Michael N. Budincich, D.C. in this office.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services (DHHS)
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You may also address your compliant to one of the regional Offices for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html.

CO-PAYMENT POLICY FOR PERSONAL INJURY PATIENTS

I, _____ understand that Budincich Chiropractic Clinic has accepted my personal injury case for treatment of injuries sustained on _____.

_____ Since I do NOT have a medical insurance policy (or am uninsured), I agree to make a payment of $ _____ per visit. to help offset my unpaid balance *OR*

_____ I have "med pay" on my auto insurance policy and would like them billed directly. I will provide my auto insurance card for verification.

My injuries are the result of a 2nd party's negligence.

Since the 2nd Party's insurance ("3rd Party Payer") will not pay Budincich Chiropractic Clinic directly, I agree to the following provision:

____ If the insurance company pays me directly, I agree to endorse the check over to Budincich Chiropractic Clinic and bring the check to the office within 24 hours of receipt of the check. *OR*

____ My attorney will send Budincich Chiropractic Clinic all fees due and payable within 10 days of receipt of payment by "2nd Party's" insurer.

** ANY APPOINTMENTS THAT NEED TO BE RESCHEDULED OR CANCELLED MUST BE DONE 24 HOURS IN ADVANCE. WE RESERVE THE RIGHT TO CHARGE YOU $25.00 PER VISIT THAT IS NOT RESCHEDULED OR CANCELLED PRIOR TO THE 24 HOUR NOTICE

I clearly understand that I am fully responsible for all bills incurred before, during, or after my treatment program for injuries sustained in this accident.

Patient's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

***** Send copy of this form to patient's attorney*****

CO-pay policy 2/05 Light Blue Paper

FINANCIAL POLICIES FOR PERSONAL INJURY PATIENTS
Budincich Chiropractic Clinic, Inc.

The following is documented to outline the Budincich Chiropractic Clinic's financial policies in regards to third party personal injury cases, and first party medical payment cases where an attorney may or may not be involved. This must be read, understood, and signed by all patients wishing to have our clinic bill and await payment for injury cases.

The Budincich Chiropractic Clinic is willing to accept your case on a "personal injury" basis with certain understanding and conditions regarding your financial policies with us. The patient must understand first and foremost that the clinic is extending "credit" to the patient whenever the bills are not initially and fully being paid as the patient receives services. The doctor often times has to wait 1-4 years in order to collect his fees on a personal injury matter. This is long after overhead has been paid, and insurance collection personnel have been working regularly on these cases awaiting payment. It must also be understood, that the doctor gets no initial "interest" for this money loaned to you.

For this reason, the Budincich Chiropractic Clinic charges full fees for all services performed in personal injury cases. Full fees include the normal undiscounted values for any spinal or extremity manipulation, physical therapy, deep tissue massage, durable medical equipment, supports, supplements, any other items which are outside services required to evaluate or treat the patient's case. There will be no discounts given in these cases since they are financially "high risk", and take a year to four years or more to be resolved. The patient must also understand that the insurance companies that ultimately pay on these claims can be very stubborn starting reimbursement for any injuries. They frequently want to litigate these cases, and unfortunately, most attorneys do not want to get into trial actions in the court room due to the high cost of litigation, depositions, and court costs. Most personal injury cases settle without a court trial, and many settle far below what they are worth. Attorneys do not wish to "try" these cases, since it would cost more than the end settlement value. Personal injury accident cases will not make a patient "get rich quick". These cases mostly end up a long, "dragged out" process, which ultimately, if you are lucky, gets all of your medical bills paid and a little bit extra to cover your pain, suffering, and inconvenience of having to receive treatment after your injuries. Unless you were seriously disabled, dismembered, or have other serious neurological complications, it is unlikely that your personal injury case will yield more than $15,000.00 - $20,000.00 once settled. This statistic is based on hundreds of cases settled over the last several years within our two offices.

From our statistics, there is a 40% chance that our clinic will collect at or below our cost in providing these services for you, or possibly less. Also, there is a small 5% chance that nothing at all can be collected from the insurance company, and the full burden of the bill will fall upon the patient's shoulders. If the case "goes bad", the attorney may "drop the case", or the insurance companies may "stonewall" and possibly demand to go to court before releasing a single penny in settlement. All parties can wait a long time to ever get paid. The doctor also poses an added risk if our patient receives a check for services rendered from the insurance company, (for both the doctor's portion of treatment, and their portion for pain and suffering), and decides to ignore the doctor's bills permanently. This leaves the doctor "stuck with the bill" and unable to track down the patient for payment. Many (40% of these cases) are expected to be non-profitable or a loss. This is why our full fees will apply to any services rendered if we accept your case on a personal injury matter; it is due to the high financial risks.

Remember, that as you are receiving these services, the doctor will eventually need to be paid by either the insurance company directly, through your attorney (if you have one), or by yourself personally. If you decide to accept treatment on a personal injury basis in this clinic, please understand that our full fees will apply, and no discounts will be given at the completion of the case unless there are extreme extenuating circumstances. Each case is evaluated on a case-by-case basis. Only the Clinic Director will decide whether any discounts will be applied, not the associate doctor who may be treating you at any one of our clinics. Only the Clinic Director has the authority to negotiate your outstanding balance. The patient is ultimately and personally responsible for any services rendered, the patient must be certain the treatment they are receiving is needed and approved by them, and benefiting them on a regular basis.

Patient's Initials _____

If you feel that your symptoms are greatly improved to the point where you no longer feel that treatment is necessary, please discuss this with your treating doctor. Especially if it is at a time that is mid-way during treatment when more treatments are scheduled ahead than what you feel you need to receive. Please have an open discussion with your doctor regarding the need for ongoing services, whether it is for the actual initial symptoms of your injury, or the long-term damage that the injury caused to the curves of your spine (subluxation complexes). Subluxation ultimately can cause degenerative disc disease and arthritis in your spine later on.

You will be accepted on a "personal injury basis" as long as you comply with the doctor's recommendation for treatment, and keep an open dialogue with the doctor. If you discontinue your treatment early, repeatedly miss or "no show" scheduled visits, or otherwise fail to comply with your recommended treatment program as agreed to, our clinic doctors may option to discontinue your personal injury case, and return you to a "cash as goes" patient status. When you become a "cash patient", your balance will be immediately due and payable, but will be discounted to cash fees so that you can take care of the balance immediately. This is typically not done unless the patient is non-compliant with treatment by numerous NO SHOWS, or habitually tardy for appointments, which gives the impression that they are not sincere about getting better.

Your timely attendance in keeping regular appointments, will tell us the sincerity level you have and the pain that you actually suffered. We sincerely want you to get well, and in order to do so, you must treat with us regularly during the initial phase of care, at a minimum, to ensure timely relief, return to work, and return to normal function.

It is our experience that the patient's who miss and no show many appointments at the beginning of their case, are having a hard time settling their cases later on, because the records will show these inconsistencies in your treatment. This leads the insurance companies to believe that the treatment may have not been necessary in the first place. We do not want this to happen in your case because it is neither good for you, or for us to have a non-compliant patient. We know that many situations may come up which may delay or postpone certain treatment. You need to keep a dialogue open with your doctor, and make sure that notes are written in your chart to outline any "breaks" you have in treatment if you need to leave town for family health reasons, scheduled vacations, or other reasons. Simply having a "busy schedule" and missing appointments for this reason, will not convince your attorney or your insurance company, that you were sincerely actually hurt, and that you were willing to make changes in your lifestyle to receive the treatment that you need.

After one year from the date of your last treatment, if your case is not yet settled, you will be responsible to remit your balance in full by small payments. We will begin AT ONE YEAR assessing interest on your balance each month of 1% COMPOUNDED DAILY until your account is paid in full. You may keep your credit card number on file as we will bill each month automatically after the one year anniversary date. Ten percent (10%) of your total outstanding balance will be charged to your credit card acct until your balance is paid in full.

Of course, even if you are injured in a personal injury matter, you may elect to be a cash patient and pay as you go at our cash fees which are due and payable at the time of service. The doctor will still cooperate with your insurance company and legal council in order to get you reimbursed later on. You may do this if you feel uncomfortable running a balance in our office. We want to inform you that once a personal injury case has been treated, and has been on the books awaiting payment, that our policy is not to discount these services routinely or by any settlement formula (IE: 1/3,1/3,1/3. three way splits between the lawyer, you, and the doctor). Please let your attorney know this, (if you have one) so they will be aware of our office policies.

In closing, we thank you very much for choosing the Budincich Chiropractic Clinic for the healthcare needs for you and your family. We promise to cooperate fully with both the insurance companies and any attorney you may have chosen to bring about a fair resolution of your case. Negotiation of your outstanding "legal lien" can only be made by total cooperation on the part of your attorney, by disclosing all outstanding bills from other doctors and labs, and "paid out" checks by the insurance company to him. The patient, at this point, should not involve themselves in trying to cut their own deal with the doctor. They hired a lawyer and they should let them do their job.

Patient's Initials _____

Should you have any further questions regarding our policies on the treatment plan and/or financial policies of personal injury cases, please do not hesitate to ask our Office Manager or the Clinic Director personally.

Statement of Understanding and Agreement

I understand the above policies of the Budincich Chiropractic Clinic as applied to "personal injury", auto crash, and "slip-and-fall" cases. My signature below indicates my intention to fully comply with these above policies, and to see to it that the doctor is paid, regardless of the ultimate legal outcome of my case. The doctor is not taking my case on a contingency basis, but has agreed to "delayed payment" as a service to me so I can get treatment I need now without paying in full as I am receiving it.

I agree that since I will be receiving a "line of credit", that I am applying for credit here at the clinic. I give my permission for the officers of this Clinic to have my credit report examined to see how much "treatment on credit" I may be eligible for through Experian or other credit bureau. My account balance still owed after 1 year from my initial visit will be subject to a 10% annual interest rate compounded daily, or $25.00/ month, whichever is greater. No interest charges will be applied before the one year anniversary date of my first exam or treatment.

My signature below signifies my agreement and understanding of all of the above policies.

_____

Patients Full Printed name

_____Date_____

Patient's Signature

_____Date_____

Witness (printed name and signature)

Budincich Chiropractic Clinic, 140 N. Hill Avenue, Pasadena, CA 91106 (626) 792-3390

Budincich Chiropractic Clinic, Inc.

Michael N. Budincich, D.C. & Associates

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Budincich Chiropractic Clinic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some extremely rare risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. For instance, recent 2007 research showed that the risk of getting a stroke from chiropractic treatment is the probability of 1 chance in 3.5-4.5 million treatments. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Budincich Chiropractic Clinic, Inc to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from any doctor at Budincich Chiropractic Clinics, Inc.

_____ _____

Patient's Name (Please Print) **Date**

_____

Patient or Guardian's Signature

INSTRUCTIONS TO COUNSEL

I, _____ clearly understand that all past,
Patient Name
present and future bills incurred at Budincich Chiropractic Clinic, Inc. are my responsibility for payment.

I hereby ratify my agreement to pay all bills incurred during my health care at this clinic.

I also, hereby irrevocably instruct you _____
Attorney's name
to pay the doctor in full from any such proceeds of settlement, judgment or enforcement of judgment actions. You are to pay the doctor prior to disbursing any proceeds to me.

I also understand that if the settlement does not cover the doctor's entire bill, I am still responsible for the remainder.

I do hereby waive any applicable statute of limitations on the collection of my account with this clinic.

I instruct you, _____, not to attempt to
Attorney's Name
negotiate my doctor's bill, who has provided all services billed for, and I agree to pay in full.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

Budincich Chiropractic Clinic, 140 N. Hill Avenue, Pasadena, CA 91106 (626) 792-3390