



New Patient Information

Date: ___/___/___

Welcome! Please allow our staff to photocopy your insurance card (if applicable)

PLEASE PRINT CLEARLY

Full Name: _____ Gender: M F Age: _____ Birth Date: ___/___/___

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (____) _____

E-mail: _____ Work phone: (____) _____

Cell Phone: (____) _____

Social Security #: _____ - _____ - _____ Drivers License #: _____ Fax: (____) _____

Marital Status: S M D W # of Children: _____ Work Status: Full-time Part-time Retired

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Females: Last Menstrual Period: _____ Pregnant? Y N Nursing? Y N

Name of Spouse, Parent or Guardian: _____ Employer: _____

Occupation: _____ Work Phone: (____) _____

In Case of an Emergency Contact: _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

How did you hear about our clinic? Who may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow SOL Santa Cruz to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy. We have taken all precautions that are known by SOL Santa Cruz to assure that your records are not readily available to those who don't need them.
6. Patients have the right to file a formal complaint about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patients Signature: _____ **Date:** _____

Spouse's or Guardian's Signature: _____ **Date:** _____



HEALTH CONCERNS: Please list your top health concerns in order of priority

- 1) _____
- 2) _____
- 3) _____
- 4) _____

TREATMENT: What type of treatment are you looking for?

- I am looking for the most minimal amount of care to “patch up the symptoms” of my problem.
- I am looking to resolve my symptoms and then go on to “fix the cause” of my problem.
- I am looking to take care of my problem and then go on to “achieve optimal health and wellness”

COMPLAINT/PROBLEM: In relation to your primary complaint:

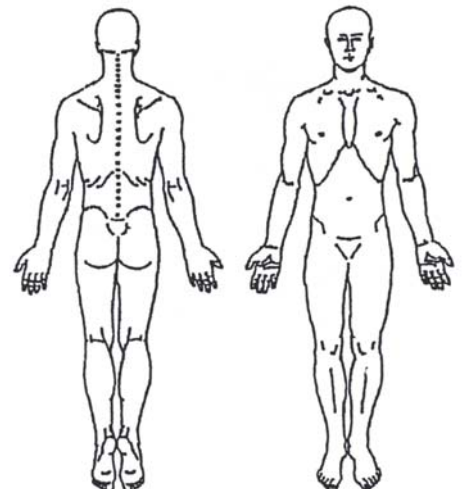
When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: Y N
 If yes, whom? _____ Treatment(s): _____
 Have you had any intolerance or reactions to treatments? Y N Describe: _____
 Is this a recurrence, when was the first time you noticed this problem? _____
 How did it originally occur? _____ Has it become worse recently? Y N describe: _____
 How frequent is the condition? Constant Daily Intermittent Night Only.
 How long does it last? All day Few hours Minutes
 Is this condition interfering with your : Work Sleep Daily routine Recreation Other: _____
 How long has it been since you really felt good? Days Weeks Months Years > 10 years
 Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other
 Is there anything that you can do to relieve the problem? Y N If yes, describe: _____
 If no, what have you tried to do that has no helped? _____
 What do you believe is wrong with you? _____
 Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? _____
 Have you been in an auto accident? Past year Past 5 years Over 5 years Never
 Describe: _____

Please check all of the symptoms that apply. (P=Past / C=Current)

- | P/C | P/C | P/C |
|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Sweating | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Menstrual irregularities |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Elbow/ Hand Pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tingling in Hands |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Clammy Hands |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Nausea/ vomiting | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Fullness of Bladder | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Urination Difficulty | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Constipation | <input type="checkbox"/> Joint Stiffness |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Unpleasant Taste | <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Ankle/foot Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tingling in Feet |
| <input type="checkbox"/> Persistent Coughing | <input type="checkbox"/> Swallowing Pain | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Unsteady Voice | <input type="checkbox"/> Lump in Throat | <input type="checkbox"/> Sore muscles |
| <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Weak Muscles |
| <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Irritability | <input type="checkbox"/> Shaking |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Impatience | <input type="checkbox"/> Feel Loss of Control |
| <input type="checkbox"/> Other _____ | | |

Please use the legend symbols below to accurately mark the areas in which you Feel these sensations

Stabbing/Cutting -/// Tingling - T
 Burning – XXX Cramping - C
 Numbness - ~ ~ Dull - ###





ALLERGIES: Please check and list all allergies.

- Food: _____
- Medications: _____
- Seasonal / Other: _____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	<u>Medication Name</u>	<u>Date started</u>
<input type="checkbox"/> Antacids		
<input type="checkbox"/> Antibiotics		
<input type="checkbox"/> Antidepressants		
<input type="checkbox"/> Anti-Diabetics		
<input type="checkbox"/> Anti-Inflammatory		
<input type="checkbox"/> Blood Pressure Lowering Meds.		
<input type="checkbox"/> Cholesterol Lowering Meds.		
<input type="checkbox"/> Hormone replacements (HRT)		
<input type="checkbox"/> Oral Contraceptives		
<input type="checkbox"/> Other		

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had.

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? Y N If yes, who recommended them? _____

<u>HABITS:</u>	Heavy	Moderate	Light	None	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Exercise</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8+ hrs	7-8hrs	6-7 hrs	5-6hrs	<5hrs	
Soda / Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Sleep</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5+	4	3	2		
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Meals/day</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	64+oz	32-64 oz	16-32 oz	<8 oz		
					<u>Water/day</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

WORK ACTIVITY: Heavy Labor Light Labor Mostly sitting Mostly standing Walking / Moving Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:

(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

___ Alcoholism	___ Eczema	___ Miscarriage(s)	___ Tumor(s)
___ Anemia	___ Emphysema	___ Mumps	___ Ulcer(s)
___ Cancer	___ Epilepsy	___ Pleurisy	___ Other: _____
___ Cold sores	___ Goiter	___ Pneumonia	_____
___ Deep Vein Thrombosis	___ Gout	___ Polio	_____
___ Detached retina	___ Heart disease	___ Rheumatic fever	_____
___ Diabetes	___ HIV/AIDS	___ Stroke	

Patient's Printed Name

Patients Signature

Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I, the undersigned, hereby acknowledge and understand that I am a patient of Karen K. Roitz D.C., or Donald Kelley, D.C., Doctors of Chiropractic located at 1510 Seabright Avenue, Santa Cruz, CA 95062. I further understand that the chiropractic services provided at this location are not a part of a group practice or partnership. My chiropractic care is exclusively provided by Karen K. Roitz, D.C., or Donald Kelley, D.C. and no other individual entity providing other services at this location. Should you require treatments or services other than those provided by Karen K. Roitz, D.C, or Donald Kelley, D.C., separate agreements and consent forms with such practitioners and professional will be required prior to treatment. Dr Roitz and Dr. Kelley are not responsible for any treatments or services provided by other licensed practitioners or professionals—even if such treatments or services are provided in the Shared SÖL Santa Cruz facility.

I hereby request and consent to the performance of Chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays and physiotherapy techniques, on me (or the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors or Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as a backup for the doctor(s) or Chiropractic named below.

I understand that, as with all health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications may include, but are not limited to, fractures, disk injuries, dislocations, muscle strain, Horner’s Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation or the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below the nature, purpose, and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

[continued on next page]

_____ (Initial Here)

Please check the appropriate box:

I have read or have had read to me the above explanation or the Chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment, and have myself, decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Karen K. Roitz, D.C., D.A.C.B.S.P.

Donald Kelley, D.C.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE AND HAVE CHECKED AND INITIALED THE APPROPRIATE BOXES ON THE 1ST PAGE

Printed Patient Name

Date

Signature of Patient

Date

Signature of Patient's Representative

Date

Witness to Patient's Signature

Date

Translated By

Date



Financial Policies & Agreement

Cash or Insurance patients

We would like to take a moment to welcome you to our office and familiarize you with our financial policy.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors recommendations. A complete list of services is available at the front desk.

As a courtesy, our office will bill your insurance company for you. Within the first week of treatment we will verify your insurance benefits. In the interim you will be responsible for 20% of the charges due. Any credit or balance will be determined after payment is received from your insurance company. The verification is only an estimated summary of benefits provided by your insurance company and does not guarantee payment. **We will only bill your insurance; we do not provide collection services.**

You are responsible for payment of any deductibles, co-payments, and/or patient portions at the time services are rendered. If your insurance company does not pay within 60 days from the dated billed, you will be responsible for payment in full at that time. If your account becomes grossly past due (120 days) there will be a *20% annual interest rate charge, which will accrue on a monthly basis until the balance is paid in full.*

As a courtesy, our office will notify you the day before your scheduled appointment to remind you of the time and type of appointment scheduled. If you cancel your appointment with less than 24 hours notice, or do not show up for any scheduled appointment you will be billed for the doctor's time (\$35.00 for every standard (15 minute) office visit or \$45.00 for massage).

My signature denotes that I have read, understand and agree to the above.

Patient or guardian signature

Date



HIPAA REGULATIONS

Privacy Practices

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

The law requires us to: 1) Keep your medical information private. 2) Give you notice describing our legal duties and privacy practices. 3) Notify you of any changes in our privacy practices. This is listed on our Web site: www.solsantacruz.com.

Use and Disclosure

To follow are different ways that we are permitted to use and disclose medical information. We will not use or disclose any medical information not listed without specific written authorization from you.

Treatment: We may use medical information about you to provide you with medical treatment or other services related to your care. We may disclose medical information about you to doctors, nurses, technicians or other people involved in your care. We may also share medical information about you to *your* other health care providers to assist them in treating you.

Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer (i.e., insurance company, attorney, consulting physician). We may also disclose information to your health plan about treatment or possible treatment to help determine if your health plan will pay for certain services.

If you have any question about any of our policies or your rights, please feel free to speak with your physical therapist or any of our staff.

Your signature below indicates your understanding of and compliance with the above privacy practices.

Printed Name

Date

Signature

SÕL SANTA CRUZ DISLOCURE FORM

Welcome to SÕL Santa Cruz, located at 1510 Seabright Avenue, Santa Cruz, California 95062. For my treatment I am seeking the following:

Please initial on the appropriate line below:

_____ Chiropractic services provided by Karen K. Roitz, D.C., D.A.C.B.S.P., and/or Donald Kelley, D.C.

_____ Physical Therapy services provided by Sports + Orthopedic Leaders Physical Therapy, Inc.

_____ Massage Therapy Services

_____ Pilates Fitness Services

_____ Athletic Training Services

By signing below, I hereby acknowledge and understand that SÕL Santa Cruz: (a) is the trade name under which various independent medical practitioners and professionals market their services and share office space; (b) does not provide any patient or other services; and (c) is not a group practice or partnership. All of the services offered at this location and provided by independent licensed practitioners or professionals, who will each require my individual consent prior to providing treatment or providing services, and who are solely responsible for my treatment of well being while at this facility. I further acknowledge and understand that I should require treatment by more than one named individual or entity above, I will be required to sign a separate agreement and consent forms with such individual or entity prior to treatment. No other practitioners or professionals shall be responsible for my care or well being – even if such treatments or services are provided in the shared SÕL Santa Cruz facility. _____ (Initial Here)

Print Name

Date

Signature