Elite Care Chiropractic
317 N. El Camino Real, Suite 109 •Encinitas, California 92024
Phone: (760) 634-3701 • Fax: (760) 944-7151

Consent to Treat

The information I have given this office is complete and true to the best of my knowledge. I authorize the doctors and staff of Elite Care Chiropractic Center to administer such procedures and treatment as they deem necessary. The doctors have implied no guarantees of cure.

Patient Signature: _____ Date: _____/ _____/ _____

Consent to treat a Minor Child

In information I have given this office pertaining to _____ (child's name) is complete and true to the best of my knowledge. I authorize the doctors and staff of Elite Care Chiropractic Center to administer such procedures and treatments as they deem necessary to my son, daughter or ward in my legal custody. The doctors have implied no guarantees of cure.

Patient/Guardian's Signature: _____ Date: _____/ _____/ _____

Relationship to Minor Child: _____

Witnessed by: _____

Elite Care Chiropractic
317 N. El Camino Real, Suite 109 ●Encinitas, California 92024
Phone: (760) 634-3701● Fax: (760) 944-7151

INFORMED CONSENT
(EXAMINATION/EVALUATION OF ALL PATIENTS)

By signing this form, you are consenting to an examination by either Dr. Robert Rich or Dr. Linda Jannelli. Drs. Rich and Janelli employ standard chiropractic examination and treatment methods including the following:

1. Observation: General assessment/appraisal in all positions.

2. Inspection: Viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, back and side. All symptomatic (painful) body parts may be viewed.

3. Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity of tissues, integrity and abnormality.

4. Percussion: Using rubber hammer and tapping on bones or tendons.

5. Orthopedic/neurological testing: These are standard tests to access your neuromusculo-skeletal systems.

6. Chiropractic adjustments are the moving of the bone with the doctor's hand or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

7. Use of physical therapy modalities such as: Electrical Muscle Stimulation, Ultrasound and heat and ice therapy.

NOTE: You do not have to submit to any examination or treatment procedures. We ask you to comply to the best of your ability and report changes in your pain. All procedures are accomplished to your tolerance. Chiropractic is a system of health care delivered and therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease or condition as a result of treatment in this clinic. We will always give you our best care. If results are not acceptable, we will refer you to another provider who we feel will assist your situation. If you have any questions on the above, please ask your doctor.

I _____ understand the above statement and agree to submit to the above procedures and accept the risks and consequence of their application.

_____ _____

PATIENT'S SIGNATURE DATE

Elite Care Chiropractic
317 N. El Camino Real, Suite 109 Encinitas, California 92024
Phone: (760) 634-3701 Fax: (760) 944-7151

PATIENT HISTORY FORM

Please fill out the following form with as much detail as possible.

First Name: _____ Last Name: _____

REASON FOR YOUR VISIT:

Cause of complaint: Auto Accident _____ Work Injury _____ Athletic Injury _____ Other Injury: _____

Are you or do you think you may be pregnant? Yes _____ No _____

Have you seen a chiropractor before? Yes _____No _____ When? _____ Doctor's Name _____

Describe your major complaint: _____

What movements, positions, or activities aggravate this condition? Standing ___ Walking ___ Sitting ___
Lying down ___ Bending ___ Lifting ___ Twisting ___ Coughing ___

Are the symptoms: Improving ___ Getting worse ___ About the same ___ Intermittent ___

Have you been treated for this condition before? Yes ___ No ___ If yes, when? What was done? _____
_____

Date when the symptoms first appeared: _____ Circle most appropriate:

What is your pain Right Now? 0 = NO PAIN - 10 = UNBEARABLE PAIN 0 1 2 3 4 5 6 7 8 9 10

PATIENT HEALTH HISTORY

Family History (Please check as many as apply)

Mother:
Cancer ___ Heart Disease ___ High Blood Pressure ___ Diabetes ___ Respiratory Problems ___
Kidney ___ Stroke ___ Arthritis ___ Good Health ___ If deceased - Age of Death _____

Father:
Cancer ___ Heart Disease ___ High Blood Pressure ___ Diabetes ___ Respiratory Problems ___
Kidney ___ Stroke ___ Arthritis ___ Good Health ___ If deceased - Age of Death _____

Siblings:
Cancer ___ Heart Disease ___ High Blood Pressure ___ Diabetes ___ Respiratory Problems ___
Kidney ___ Stroke ___ Arthritis ___ Good Health ___ If deceased - Age of Death _____

Elite Care Chiropractic
317 N. El Camino Real, Suite 109 Encinitas, California 92024
Phone: (760) 634-3701 Fax: (760) 944-7151

PATIENT HISTORY FORM Page 2

SOCIAL HISTORY

Do you exercise: Daily ___ Regularly ___ Occasionally ___ Never ___

Do you eat a balanced diet? Yes ___ No ___

How many hours do you sleep? ___

Do you smoke? No ___ Yes ___ How many packs a day _____

Do you drink alcohol No ___ Yes ___ How often _____

MEDICAL HISTORY

Personal History:
Illness or Conditions _____

Surgeries _____

Fractures _____ Previous Injuries _____

Medications _____ Supplements _____

Last Medical Exam (dd/mm/yy) _____

Elite Care Chiropractic
317 N. El Camino Real, Suite 109 Encinitas, California 92024
Phone: (760) 634-3701 Fax: (760) 944-7151

PATIENT HISTORY FORM Page 3

SYMPTOMS

Have you had or do you have any of the following symptoms: (check all that apply)

Headaches	_____	Frequent Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping	_____	Loss of Taste	_____
Back Pain	_____	Pain with Bowel Movement	_____
Nervousness	_____	Diarrhea	_____
Tension	_____	Cold Feet	_____
Irritability	_____	Cold Hands	_____
Chest Pains	_____	Arthritis	_____
Dizziness	_____	Muscle Spasms	_____
Shoulder/Neck Pain	_____	Frequent Colds	_____
Pins & Needles Arms	_____	Stomach Upset	_____
Pins & Needles Legs	_____	Constipation	_____
Numbness in Toes	_____	Cold Sweats	_____
Sinus Problems	_____	Numbness in Fingers	_____
Diabetes	_____	High Blood Pressure	_____
Buzzing in Ears	_____	Difficulty Urinating	_____
Leg Cramps	_____	Allergies	_____
Colitis	_____	Weakness in Arms	_____
Gall Bladder	_____	Weakness in Legs	_____
Indigestion	_____	Shortness of Breath	_____
Belching	_____	Fatique	_____
Vomiting	_____	Depression	_____
Shoulder Pain	_____	Does Light Bother Eyes	_____
Swelling Joints	_____	Loss of Memory	_____
Knee Pain	_____	Ears Ring	_____
Hay fever	_____	Face Flushed	_____

Use this space for any additional information you may wish to discuss: _____

_____

_____

Elite Care Chiropractic
317 N. El Camino Real, Suite 109 Encinitas, California 92024
Phone: (760) 634-3701 Fax: (760) 944-7151

PATIENT INFORMATION

First Name: _____ M.I. _____ Last Name: _____

Sex: M ____ F ____ Date of Birth: _____

Marital Status: S ____ M ____ W ____ Spouse's Name: _____

E-mail: _____ Home Phone: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

City: _____ Work or Alternate Phone: ( ) _____

Job Title or work responsibilities: _____

Referred by: _____

Cause of complaint: Auto Accident _____ Work Injury _____ Athletic Injury _____ Other Injury: _____

Are you or do you think you may be pregnant? Yes _____ No _____

Method of Payment:

Cash: _____ Medical Insurance: _____ Worker's Comp: _____
(We take cash , checks or Visa/Mastercard/Discover cards)

Auto Insurance: _____ Med Pay: _____ Lien: _____

Person Responsible for Account: _____ Relation to you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Phone: ( ) _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection cost and reasonable attorney fees as may be required to effect collection.

Signed: _____ Date: _____

Elite Care Chiropractic
317 N. El Camino Real, Suite 109 •Encinitas, California 92024
Phone: (760) 634-3701 • Fax: (760) 944-7151

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Physician is not required to agree to a restriction that you request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the secretary of health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature: _____ Date: _____