Welcome to Shaygan Chiropractic, Inc.

Patient Information

Thank you for choosing ***Shaygan Chiropractic, Inc.*** for your chiropractic and healthcare needs. Please complete this form in black ink. If you have any questions or concerns, please do not hesitate to ask us for assistance. We are happy to help. *(Please print clearly)*

Name: ____ Social Security #: ___________________
First Middle Initial Last

Address: ___________________________City: _________________State: _____ Zip Code: __________

Sex: ❑ Female ❑ Male Birth date: __________ Age: ____ Email: ________________________________

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partner

Home Phone: (_____) __________Cell Phone: (_____) __________Work Phone: (_____) ____________

Do you prefer to receive reminders at: ❑ Home ❑ Work ❑ Cell ❑ Text ❑ Email

Please Circle Your Cell Phone Carrier for us to send you text reminders:

AT&T Verizon Sprint T-Mobile Cingular Boost MetroPCS US Cell Virgin

Patient Employer/School: ____________________________Occupation: _________________________

Employer/School Address: ____________________City: ____________State: ___ Zip Code: __________

Spouse or parent's name: ______________ Employer: ____________Work Phone: (_____)___________

How did you hear about us?

❑ Advertisement ❑Attorney ❑ Doctor Referral: ___________________ ❑ Health Fair
Doctor's Name

❑ Insurance ❑ Internet ❑ Patient Referral ___________________ ❑ Our Website
Patient's Name

❑ Workshop ❑Other:____

Person to contact in case of emergency: ______________________________ Phone: (_____)_________

Shaygan Chiropractic, Inc.

Family Members

Over 70% of our patients bring in their family members to get adjusted. If you would like to have your children, spouse or significant other checked for subluxations, please check the box below. They can each receive a complimentary examination including computerized surface EMG and X-rays (if necessary) if scheduled within two weeks of you starting care. This exam is no cost to you and does not obligate them to receive future care. We have several convenient and affordable family plan payment options should family members decide to receive care. ***I would like my family members checked for subluxations in the next two weeks.***

Responsible Party

❑ Same as above

Name of person responsible for this account: ____

Relationship to patient: ____Phone: (_____)______________

Address: ______________________________City: _______________ State: _____ Zip Code: __________

Name of employer: ______________________________________Work Phone: (_____)______________

Insurance Information

(Please present your insurance card to the front desk for us to make a copy)

Insurance Co.: _____________________________________ ID Number:____________________

❑ **Check here if you are the insured** **If No, please complete the following:**

Name of insured: ___________________Relationship to patient: _________________________________

Birth date: ____________ Social Security#: __________________

Do you have additional insurance? ❑ Yes ❑ No **if yes, please complete the following:**

Name of insured: __________________________ Relationship to patient: ________________________

Birth date: ______________Social Security#: _______________Date employed: ___________________

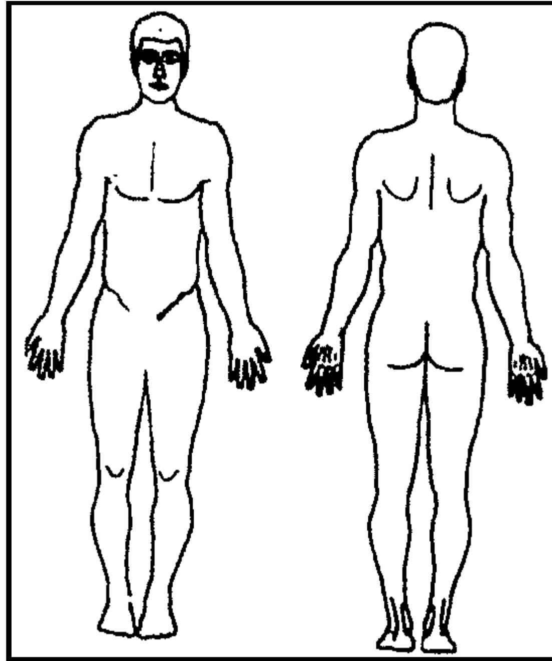
Name of employer: ____ Work Phone: (_____)___________

Address: _____________________________City: ________________State: _____ Zip Code: __________

Insurance Co.:__________________ ID Number:____________________

Symptoms

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Reason for your visit: ____

When did you first notice the symptoms? (Onset Date)____

How did the problem begin? (Injury/Event)____

Is the condition getting progressively: ❑better ❑worse ❑staying the same

Where specifically is the problem(s) located? ____

Nature or Type of Pain:

Please write each symptom below and check the nature of the pain for each symptom.

Symptom 1:________ ❏ Burning Pain ❏ Dull Aching Pain ❏ Numbness ❏Radiating Pain
❏ Sharp Pain ❏ Shooting Pain❏ Tightness ❏ Tingling ❏ Throbbing

Symptom 2:________ ❏ Burning Pain ❏ Dull Aching Pain ❏ Numbness ❏Radiating Pain
❏ Sharp Pain ❏ Shooting Pain❏ Tightness ❏ Tingling ❏ Throbbing

Symptom 3:________ ❏ Burning Pain ❏ Dull Aching Pain ❏ Numbness ❏Radiating Pain
❏ Sharp Pain ❏ Shooting Pain❏ Tightness ❏ Tingling ❏ Throbbing

Intensity Level of Pain: (0 = no pain or discomfort, to 10 = severe unbearable pain)

Please write each symptom and circle a number below to rate the severity of your pain for each symptom.

Symptom 1:__________0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Symptom 2:__________0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Symptom 3:__________0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

Daily Activities Affected Level:

Please circle a number below to indicate how much your pain or symptoms interferes with your daily activities? (e.g. work, social activities, or household chores)

Symptom 1:___________0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Symptom 2:___________0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Symptom 3:___________0 1 2 3 4 5 6 7 8 9 10
No Interference Unable to carry on any activities

Frequency of Symptoms:

Symptom 1:_____________

❏0-25% (Intermittent) ❏26-50% (Occasional) ❏51-75% (Frequent) ❏76-100% (Constant)

Symptom 2:_____________

❏0-25% (Intermittent) ❏26-50% (Occasional) ❏51-75% (Frequent) ❏76-100% (Constant)

Symptom 3:_____________

❏0-25% (Intermittent) ❏26-50% (Occasional) ❏51-75% (Frequent) ❏76-100% (Constant)

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Which activities are difficult to perform?

❏ Sitting ❏ Standing ❏ Walking ❏ Bending ❏ Lying down ❏Other:______________________

What treatment have you received for your condition?

❏Acupuncture ❏Chiropractic ❏Massage ❏Medication ❏ Physical Therapy ❏Surgery

❏ Other: ____

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

____

Have you had spinal x-rays, MRI, or CT Scan taken for your areas of complaint? ❏ Yes ❏ No

If yes, please list the date and areas taken:____

Allergies:

____

List any types of surgeries which you have had and the dates which they occurred:

____

Please list all medications you are currently taking:

____

Dates of last exams:

____

Women: Are you pregnant? ❏Yes ❏No Nursing? ❏Yes ❏No Taking Birth Control Pills? ❏Yes ❏No

Pregnancy Release: This is to certify that to the best of my knowledge that I am not pregnant and Shaygan Chiropractic, Inc. has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: ______________________

____ ________________________________

Signature of Patient, Parent, Guardian or Personal Representative Date

Daily Habits

What type of exercise do you perform on a daily basis? ❏ None ❏ Mild❏ Moderate ❏ Heavy

What do your daily work habits include? ____

What vitamins/nutritional supplements do you currently take? ____

Do you smoke? ❏ Yes ❏ No If yes, How much per day?____

How much alcohol do you consume weekly? ____

How many caffeinated beverages do you consume daily? ____

SHAYGAN CHIROPRACTIC, INC.

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Personal Health History

Check only those conditions which are applicable:

❏ AIDS/HIV
❏ Alcoholism
❏ Allergy Shots
❏ Anemia
❏ Anorexia
❏ Appendicitis
❏ Arthritis
❏ Asthma
❏ Bleeding Disorders
❏ Breast Lump
❏ Bronchitis
❏ Bulimia
❏ Cancer
❏ Cataracts
❏ Chemical Dependency

❏ Chicken Pox
❏ Corticosteroid Use
❏ Depression
❏ Diabetes
❏ Dizziness/Fainting
❏ Emphysema
❏ Epilepsy/Seizures
❏ Fractures_______________
❏ Glaucoma
❏ Goiter
❏ Gonorrhea
❏ Gout
❏ Heart Disease
❏ Hepatitis
❏ Hernia

❏ Herniated Disc
❏ Herpes
❏ High Blood Pressure
❏ High Cholesterol
❏ Kidney Disease
❏ Liver Disease
❏ Measles
❏ Menstrual Problems
❏ Migraine Headaches
❏ Miscarriage
❏ Mononucleosis
❏ Multiple Sclerosis
❏ Mumps
❏ Numbness in Groin/Buttocks
❏ Osteoporosis

❏ Pain at night
❏ Pain unrelieved by position
❏ Pacemaker
❏ Parkinson's Disease
❏ Pinched Nerve
❏ Pneumonia
❏ Polio
❏ Prostate Problems
❏ Prosthesis
❏ Psychiatric Care
❏ Recent Fever
❏ Rheumatoid Arthritis
❏ Rheumatic Fever
❏ Scarlet Fever ____________
❏ Stroke (Date)____________

❏ Suicide Attempt
❏ Thyroid Problems
❏ Tonsillitis
❏ Tuberculosis
❏ Tumors, Growths
❏ Typhoid Fever
❏ Ulcers
❏ Urinary Problems
❏ Vaginal Infections
❏ Visual Disturbances
❏ Venereal Disease
❏ Whooping Cough
❏ Abnormal Weight:
❏ Gain ❏Loss
❏ Other ___________

Family History

	Mother	Father	Sister 1	Sister 2	Sister 3	Brother 1	Brother 2	Brother 3
Cancer	❏	❏	❏	❏	❏	❏	❏	❏
Diabetes	❏	❏	❏	❏	❏	❏	❏	❏
High Blood Pressure	❏	❏	❏	❏	❏	❏	❏	❏
Heart Disease	❏	❏	❏	❏	❏	❏	❏	❏
Stroke	❏	❏	❏	❏	❏	❏	❏	❏
Rheumatoid Arthritis	❏	❏	❏	❏	❏	❏	❏	❏

	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
Cancer	❏	❏	❏	❏	❏	❏	❏	❏
Diabetes	❏	❏	❏	❏	❏	❏	❏	❏
High Blood Pressure	❏	❏	❏	❏	❏	❏	❏	❏
Heart Disease	❏	❏	❏	❏	❏	❏	❏	❏
Stroke	❏	❏	❏	❏	❏	❏	❏	❏
Rheumatoid Arthritis	❏	❏	❏	❏	❏	❏	❏	❏

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Review of Systems

Constitutional					
Had	Have		Had	Have	
❑	❑	Fainting	❑	❑	Poor Appetite
❑	❑	Low Libido	❑	❑	Fatigue
❑	❑	Sudden Weight Loss/Gain	❑	❑	Weakness
Eyes					
Had	Have		Had	Have	
❑	❑	Blurry or Double Vision	❑	❑	Specks
❑	❑	Vision Loss	❑	❑	Glaucoma
❑	❑	Glasses or Contacts	❑	❑	Cataracts
Ears, Nose, Throat, Mouth					
Had	Have		Had	Have	
❑	❑	Ringing in Ears	❑	❑	Loss of Taste
❑	❑	Hearing Loss	❑	❑	Loss of Smell
❑	❑	Chronic Ear Infections	❑	❑	Sinus Pain
❑	❑	Sore Throat	❑	❑	Hoarseness
❑	❑	Earache	❑	❑	Dry Mouth
Cardiovascular					
Had	Have		Had	Have	
❑	❑	High Blood Pressure	❑	❑	Chest Tightness
❑	❑	Low Blood Pressure	❑	❑	Chest Palpitations
❑	❑	Chest Pain or Discomfort	❑	❑	Shortness of Breath
❑	❑	High Cholesterol	❑	❑	Poor Circulation
Respiratory					
Had	Have		Had	Have	
❑	❑	Asthma	❑	❑	Emphysema
❑	❑	Apnea	❑	❑	Wheezing
❑	❑	Shortness of Breath	❑	❑	Pneumonia
❑	❑	Cough	❑	❑	Sputum
Gastrointestinal					
Had	Have		Had	Have	
❑	❑	Anorexia	❑	❑	Food Sensitivities
❑	❑	Bulimia	❑	❑	Heartburn
❑	❑	Ulcers	❑	❑	Constipation
❑	❑	Acid Reflux	❑	❑	Diarrhea
❑	❑	Rectal Bleeding	❑	❑	Swallowing Difficulties
Genitourinary					
Had	Have		Had	Have	
❑	❑	Frequency	❑	❑	Urgency
❑	❑	Blood in Urine	❑	❑	Burning Pain
❑	❑	Incontinence	❑	❑	Change in Urinary Strength
Musculoskeletal					
Had	Have		Had	Have	
❑	❑	Osteoporosis	❑	❑	Arthritis
❑	❑	Knee Injuries	❑	❑	Foot/Ankle Pain
❑	❑	Scoliosis	❑	❑	Neck Pain
❑	❑	Shoulder Problems	❑	❑	Elbow/Wrist Pain
❑	❑	Back Problems	❑	❑	Hip Disorders
❑	❑	TMJ Issues	❑	❑	Poor Posture

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Integumentrary					
Had	Have		Had	Have	
❏	❏	Skin Cancer	❏	❏	Hair Loss
❏	❏	Eczema	❏	❏	Rash
❏	❏	Acne	❏	❏	Psoriasis
Neurological					
Had	Have		Had	Have	
❏	❏	Headache	❏	❏	Dizziness
❏	❏	Pins & Needles	❏	❏	Numbness
❏	❏	Seizures	❏	❏	Tremor
Psychiatric					
Had	Have		Had	Have	
❏	❏	Nervous/Anxiety	❏	❏	Depression
❏	❏	Stressed	❏	❏	Memory Loss
Endocrine					
Had	Have		Had	Have	
❏	❏	Heat or Cold Intolerance	❏	❏	Frequent Urination
❏	❏	Sweating	❏	❏	Excessive Thirst
Hematologic/Lymphatic					
Had	Have		Had	Have	
❏	❏	Ease of Bruising	❏	❏	Ease of Bleeding
Allergic/Immunologic					
Had	Have		Had	Have	
❏	❏	Hay Fever	❏	❏	AIDS
❏	❏	HIV Positive	❏	❏	Tuberculosis
❏	❏	Herpes	❏	❏	Syphilis
❏	❏	Staphylococcus Infection	❏	❏	Viral Infection
❏	❏	Bacterial Infection	❏	❏	Streptococcus Infection

Certification

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a healthcare benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I or my minor child have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

____ ______________________________
Signature of Patient, Parent, Guardian or Personal Representative Date

____ ______________________________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Shaygan Chiropractic, Inc.

Assignment of Benefits and Responsibility of Payment

I herby instruct the ______________________________________ insurance co. to pay by check made out to and mailed directly to:

Shaygan Chiropractic, Inc.
❑ Dr. Farnaz Shaygan, D.C.
1209 E. Yorba Linda Blvd
Placentia, CA 92870

If my current policy prohibits direct payments to the doctor, then I herby also instruct and direct you to make out the check to me and mail it directly to:

Shaygan Chiropractic, Inc.
❑ Dr. Farnaz Shaygan, D.C.
1209 E. Yorba Linda Blvd
Placentia, CA 92870

For the professional or medial 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 and benefits under this policy.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in current manner any balance , deductable , and/or co-pay of said professional service charges over and above this insurance payment.
I further understand that I will be responsible for the payment to any other facilities and /or healthcare providers that I may be referred to by ***Shaygan Chiropractic, Inc. or above mentioned doctor*** and any emergency transporting that may be required thereto. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

This office will gladly prepare insurance forms and reports; however, we cannot render services on the assumption that our charges will be paid by the insurance company or attorney settlement. All professional services are charged directly to the patient, therefore basic responsibility for payment is yours.

_________(INTIAL) I Herby acknowledge and understand that in the event that I do not have insurance that covers chiropractic services or products that all services and products are payable when treatment is rendered and that basic responsibility for payment are mine. I further understand that if I am delinquent on my obligation to pay ***Shaygan Chiropractic, Inc.*** that I will be responsible for any late fees, interest charges, court cost, attorney fees, and collection charges should the balance not be paid in due diligence.

Name:____________________________Birthdate:_____________________________________

Social Security # :________________ ___________ Driver License #:______________________

__________________________________ Patient, Parent, or Guardian Signature

__________________ Date

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Shaygan Chiropractic, Inc.

Informed Consent For Chiropractic & Massage Care

I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, physiotherapy modalities, therapeutic massage, nutritional/diet counseling and diagnostic x-rays, and supportive therapies on me (or on the patient named below, for whom I am legally responsible) by ***Shaygan Chiropractic, Inc.*** and the doctor of chiropractic indicated below and/or other licensed doctor's of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand the results are not guaranteed. I understand and am informed that, as in the practice of medicine and like other health modalities, results are not guaranteed, and there is not promise of cure. I further understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes/death, dislocations and sprains. 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 in which the doctor feels at the time, based on the facts then know, is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above –named procedures. 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.

Shaygan Chiropractic, Inc.
❑ **Farnaz Shaygan, D.C.**

____ __________________
PATIENT'S NAME (PLEASE PRINT) DATE

____
SIGNATURE OF PATIENT (OR GUARDIAN IF PATIENT IS A MINOR)

(PLEASE COMPLETE THE INFORMATION ON THE NEXT PAGE IF THE PATIENT IS A MINOR)

Shaygan Chiropractic, Inc.

Consent to Treatment of a Minor

Name of responsible party: ________________________________Social Security #:___ ___ _____

Relationship to minor: ❑ Father ❑Mother ❑Other________________________________

Address of responsible party: ____

Home phone: ___________________________ Cell phone: __________________________________

Responsible party employed by: _________________________Work phone: __________________

Employer address: ______________________________City:_____________ Zip: _______

I being the parent or guardian of ____________________________, a minor, the age of _______________ do herby consent, authorize and request ***Shaygan Chiropractic, Inc.*** to administer such treatment deemed advisable, necessary or requested on the above minor. I (We) agree to hold ***Shaygan Chiropractic, Inc.*** free and harmless from any claims, suites for damages or complication which may result for such treatments.

__________________________ __________________________________
DATE SIGNATURE OF PARENT/GUARDIAN

__________________________ __________________________________
DATE SIGNATURE OF WITNESS

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Patient Name ____ Date __________________

AUTO ACCIDENT INFORMATION

Date and time of accident: ________________________________ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear passenger

Make and model of the vehicle you were occupying? ____

If a traffic violation was issued, to whom was it issued? ____

Number of people in accident vehicle? _________

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/ they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: ____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: ____

Make and model of the vehicle you were occupying? ____

Name of the location/ street on which you were traveling? ____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? ____________

Did the impact to your vehicle come from the : ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware or ☐ surprised by the impact?

If accident vehicle made impact with another vehicle…

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Approximate Speed of the other vehicle? ______________

In your words, please describe the accident:

____

____

____

____

____

Patient Name ______________________________ Date ______________

After Injury

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? ________________

Please describe how you felt immediately after the accident: ______________________________

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/ or attending doctor: ______________________________

Was he/she a: ☐ D.C. ☐ M.D ☐ D.O ☐ D.D.S

Describe any treatment you received: ______________________________

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/ shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Numb hands/ fingers	☐ Lower back pain
☐ Blurred vision	☐ Tension		☐ Back stiffness
☐ Buzzing in ear	☐ Neck pain	☐ Chest pain	☐ Leg pain
☐ Ears ringing	☐ Neck stiff	☐ Shortness of breath	☐ Numb feet/ toes
		☐ Stomach upset	

☐ Other ______________________________

____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Patient Name ____ Date __________________

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back………………………………	☐	☐	☐
Lying on side………………………………	☐	☐	☐
Lying on stomach…………………………	☐	☐	☐
Sitting………………………………………	☐	☐	☐
Standing……………………………..……	☐	☐	☐
Stretching……………………………………	☐	☐	☐
Lovemaking………………………………..	☐	☐	☐
Walking………………………………………	☐	☐	☐
Running………………………………………	☐	☐	☐
Sports………………………………………..	☐	☐	☐
Working………………………………………	☐	☐	☐
Lifting…………………………………………	☐	☐	☐
Bending……………………………………...	☐	☐	☐
Kneeling……………………………………...	☐	☐	☐
Pulling………………………………………..	☐	☐	☐
Reaching…………………………………….	☐	☐	☐

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom? ____

His/ Her phone #:____

Recovery

How many hours are in your normal workday? _______________

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Work with arms above head
☐ Walking	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

☐ Other ____

Patient Name ____ Date __________________

What positions can you work in with minimum physical effort and for how long?

____ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____ Date _______/_______/_______

☐ Adult patient ☐ Parent or Guardian ☐ Spouse

Notice of Privacy Practices

Shaygan Chiropractic, Inc.
1209 E. Yorba Linda Blvd
Placentia, CA 92870
714-827-3833

Protecting Your Confidential Health Information Is Important To Us

This notice describes how health information about you may be used and disclosed at **Shaygan Chiropractic, Inc**. and how you can get access to this information. Please review it carefully.

Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPPA- Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed?
Why a privacy policy now?
Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valued patient.

We will use and communicate your HEALTH INFORMATION only for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

Patient Acknowledgement

Thank you very much for taking time to review how we are carefully using your PROTECTED HEALTH INFORMATION. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our Notice of Privacy Practices by signing and returning this form. We look forward to seeing you again soon!

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR SHAYGAN CHIROPRACTIC, INC. WITH AN EFFECTIVE DATE OF APRIL 14, 2003.

____
Patient Name (Printed)

____
Patient Signature

____
Date Signed

Notice of Privacy Practices

Shaygan Chiropractic, Inc.
1209 E. Yorba Linda Blvd
Placentia, CA 92870
714-827-3833

ORGANIZED HEALTH CARE ARRANGEMENT

This Practice includes the health care providers whose names appear at the top of this Notice. Although they share office space, medical personnel, office staff, equipment and supplies, they are not legally related, in that they are not partners, owners, or employees with or of each other. However, for purposes of compliance with the HIPAA Privacy Rules, they are deemed to be an Organized Health Care Arrangement, which means: that they operate as an integrated unit; that they will share protected health information in order to carry out treatment (including coverage for each other), payment for treatment and health care operations; that this Notice is provided as a joint notice made by each of them; and, that each of them will abide by the terms of this Notice.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED

To Provide Treatment

We will use your PROTECTED HEALTH INFORMATION within our Practice to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between chiropractic assistant, massage therapist, physical therapist, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing your treatment.

To Obtain Payment

We may include your PROTECTED HEATLH INFORMATION with an invoice used to collect payment for treatment you receive in our Practice. We may do this directly or through a billing service with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your PROTECTED HEALTH INFORMATION may be used in order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile and/or disclose your PHI during performance evaluation of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our Practice. As a result, health information may be included in the training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. These communications may include the following: postcards, folding postcards, letters, newsletters, flyers, telephone reminders (the practice may leave you a message if you are not available) or electronic reminders such as email, text message, and/or fax (unless you tell us that you do not want to receive these reminders).

Abuse, Neglect or Domestic Violence

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient’s agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities your PROTECTED HEALTH INFORMATION necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

Federal Drug Administration
We may disclose your PROTECTED HEALTH INFORMATION if required by the Food and Drug Administration to report adverse events, product defects or problems or biological product deviations, or to track products, or to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.

For Law Enforcement
As permitted or required by State or Federal law, we may disclose your PROTECTED HEALTH INFORMATION to a law enforcement official for certain law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.

Family, Friends, Caregivers or Personal Representatives
We may share your PROTECTED HEALTH INFORMATION with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Health Oversight Activities
Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.

Judicial and Administrative Proceeding
The Practice may be required to disclose your PROTECTED HEALTH INFORMATION in response to a court order or a lawfully issued subpoena.

To Coroners, Funeral Directors and Medical Examiners
We may be required by law to provide information to coroners, funeral directors and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

Organ, Eye or Tissue Donation
We may disclose your PROTECTED HEALTH INFORMATION, if you are an organ donor, to the entity to whom you have agreed to donate your organs.

Specialized Government Functions
When the appropriate conditions apply, the Practice may use PROTECTED HEALTH INFORMATION of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

Inmates
The Practice may disclose your PROTECTED HEALTH INFORMATION to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.

Workers' Compensation
If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PROTECTED HEALTH INFORMATION to an individual or entity that is part of the Workers' Compensation system.

Business Associate
We may disclose your PROTECTED HEALTH INFORMATION to a business associate which is someone who the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and health care operations such as billing service or transcription service. The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

Disaster Relief Efforts
The Practice may use or disclose your PROTECTED HEALTH INFORAMTION to a public or private entity authorized to assist in disaster relief efforts.

Medical Research
Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Required by Law
If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State, or Local law requires us, we will not disclose your PROTECTED HEALTH INFORMATION other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your PROTECTED HEALTH INFORMATION.

Restrictions

Your have the right to request restrictions on certain uses and disclosures of your PROTECTED HEALTH INFORMATION. Our practice will make every effort to honor reasonable restriction preferences from our patients. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your PROTECTED HEALTH INFORMATION privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Protected Health Information

You have the right to read, review, and copy your PROTECTED HEALTH INFORMATION, including your complete chart, x-rays and billing records. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice has 30 days to respond to your request. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Amend Your Protected Health Information

You have the right to ask us to update or modify your records if you believe your PROTECTED HEALTH INFORMATON records are incorrect or incomplete. We will be happy to accommodate you as long as our Practice maintains this information. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice has 60 days to respond to your request. The Practice may deny your request if it is not in writing, if you do not provide a reason and support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.

Documentation of Protected Health Information

You have the right to ask us for an accounting of how and where your PROTECTED HEALTH INFORMATION was used by our practice for any reason other than treatment, payment or health care operations. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12-month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12-month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our Practice at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Avenue, S. W., Room 509F HHH Building, Washington, D.C. 20201. Or you may contact a regional office of the Office of Civil Rights, which can be found at www.hhs.gov/ocr/regmail.html. To file a complaint with our Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Dr. Farnaz Shaygan, D.C., at Shaygan Chiropractic, Inc., 1216 E. Yorba Linda Blvd. Placentia, CA 92870, phone 714-572-9999 or via email at farnazdc@yahoo.com

Effective Date: This Notice is effective as of April 14, 2003