Milam Chiropractic & Sports Therapy
www.GotSpine.net
(714) 731-9355 (WELL)

Date: _____

Patient Application Form

Patients Name: _____ Main Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip_____ Cell Phone: _____

Email: _____

Date of Birth: _____ Age: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Referred By: _____ Insurance: Office will copy insurance card with ID

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury someone else might be responsible for? ___ Yes ___ No

Family Physician: _____ Name of Facility: _____

Person to contact in case of emergency (Name and Phone): _____ _____

What operations have you had? _____ When? _____
_____ When? _____

Serious Illness: _____ When? _____
_____ When? _____

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds ___
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? Corrective Care ___ Relief Care ___ I want the Doctor To Chose ___
Have you ever been to a Chiropractor before: N / Y When? _____ How was your experience? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Milam Chiropractic / Dr. Sean Milam, D.C. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date

Health Conditions

Did You Know???

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass the vertebrae. These misalignments are called **Subluxations (sub-lux-a-shun)**. It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted **POSTURE**. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Please check any health conditions you may be experiencing.

Cervical Spine (Neck):
Postural distortions from **subluxations**, (causing **Forward Head Syndrome**), in your neck will weaken the nerves into your arms, hands and head, and affect these parts of you body. Do you experience….?

___ Neck Pain
___ Numbness/tingling in arms/hands
___ Weakness in grip
___ Dizziness
___ Coldness in hands
___ Sinusitis
___ Fatigue
___ Allergies/Hay Fever
___ Pain into your shoulders/arms/hands
___ Hearing Disturbances/ringing
___ Headaches
___ Visual Distractions
___Thyroid Condition
Explain:_____
___ Recurrent Colds/Flus

Thoracic Spine (Upper Back):
Postural distortions from **subluxations**, (resulting from **Forward Head Syndrome**), in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience….?

___ Pain Between Shoulder Blades
___ Heart Palpitations
___ Heart murmurs
___ Tachycardia
___ Heart Attacks/Angina
___ Recurring lung infections/bronchitis
___ Asthma/wheezing
___ Shortness of breath
___ Pain on deep inspiration/expiration

Thoracic Spine (Mid Back):
Postural distortions from **subluxations**, (resulting from **Forward Head Syndrome**), in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of the body. Do you experience….?

___ Mid-back Pain
___ Pain into your ribs/chest
___ Indigestion
___ Heartburn
___ Nausea
___ Ulcers/Gastritis
___ Hypoglycemia
___ Tired/irritable after eating or when you haven't eaten for a while

Lumbar Spine (Low Back):
Postural distortions from **subluxations** in the low back, (resulting in **Forward Head Syndrome**), will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience….?

___ Low Back Pain
___ Pain into your hips/legs/feet
___ Numbness/tingling in your legs/feet
___ Coldness in your legs/feet
___ Muscle cramps in your legs/feet
___ Weakness/injury in your hips/knees/ankles
___ Recurring bladder infections
___ Frequent/difficulty urinating
___ Constipation/Diarrhea
___ Menstrual irregularities/cramping
___ Sexual dysfunction

Please list any health conditions not mentioned._____

Please list any medications/surgeries. _____

I certify that the above information is accurate to the best of my knowledge.

Date: _____ Patient Signature: _____

Date: _____ Guardian Signature: _____

Protecting Your Health Information

New Regulation Passed

The new regulations are part of the Health Insurance Portability and Accountability Act or HIPPA does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage; although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

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. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes e very attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment, and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request, or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will be given general information about your care and/or appointments unless otherwise specified and noted in your file. We may use an open sign-in sheet, other options are available upon request.

We may also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Also upon becoming a patient, we will be entering your name into our database and you will receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, phone or text unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Milam Chiropractic & Sports Therapy

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any question please feel free to ask one of our staff members.

Women Only:

To the best of my knowledge **I am / am NOT** pregnant and give my permission to x-ray me if necessary for diagnostic interpretation.
(Circle one above)

Missed Appointments:

There may be a $20 fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to who may we do so?

Spouse: _____

Children: _____

Others: _____

May we leave messages on any answering device, i.e. home answering machines, voicemails or via text? Yes [ ] No [ ]

I, _____, have read and fully understand the above statements.

Acknowledgement

I have received the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____ Date: _____

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

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Milam Chiropractic, Inc
P.O. Box 723
Tustin, CA 92781

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

See Above Address

For the professional and/or chiropractic 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 a current manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this Assignment shall be considered as effective and valid as the original.

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

Please note that this office and its representatives will not release any of my information until this form has been signed and returned by the Insurance Company or its representative

this _____ day of _____ 20___.

_____ _____

Signature of policyholder Signature of Claimant, if other than Policyholder

_____ _____

Signature of Insurance Company or Representative Date

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**

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ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic 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 of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I 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, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an 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.

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE