Kalani
TOTAL HEALTH CENTER

2901 N. Ventura Road, Ste. 220 Oxnard, CA 93036
Phone: 805.604.0881 Fax: 805.604.0883

# CONFIDENTIAL PATIENT INFORMATION

Date:_____

Name: _____ Home Phone:_____
Address: _____ Work Phone: _____
City & State: _____ Zip: _____ Cell Phone: _____
SS#: _____ E-Mail Address: _____
Occupation: _____ Employer: _____
Work Address: _____ City& State: _____ Zip: _____
Birth Date: _____ Age: _____ Sex: **M F** Marital Status: **S M W D**
Spouse's Name & Age: _____
Names of Children & Ages: _____
How were you referred to our office? _____
Have you ever been to a chiropractor before? _____ If so, when? _____
Circle your complaints and write how long you have had it.

| | | | |
|---|---|---|---|
| Neck Pain/Stiffness | _____ | Rib Problems | _____ |
| Headaches | _____ | Low back Pain | _____ |
| Shoulder Pain | _____ | Hip/Groin Pain | _____ |
| Arm/Hand Pain | _____ | Leg Pain (R/L) | _____ |
| High/Low Blood Pressure | _____ | Dizziness | _____ |
| Allergies | _____ | Upper/Mid Back Pain | _____ |

What type of care have you already received for your condition?
Chiropractic ____ Massage ____ Medication ____ Surgery ____ Other _____

Name of Doctor(s) who have cared for you: _____
Circle any conditions you have currently or previously had.

| | | | | |
|---|---|---|---|---|
| AIDS/HIV | Arthritis | Asthma | Anemia | Anorexia |
| Appendicitis | Bulimia | Cancer | Bleeding | Breast Lump |
| Bronchitis | Diabetes | Emphysema | Cataracts | Chemical Dependant |
| Chicken Pox | Goiter | Gonorrhea | Epilepsy | Fractures |
| Glaucoma | Hernia | Herniated Disc | Gout | Heart Disease |
| Hepatitis | Liver Disease | Measles | Herpes | High Cholesterol |
| Kidney Disease | MS | Mumps | Osteoporosis | Miscarriage |
| Mono | Pinched Nerve | Pneumonia | Polio | Pacemaker |
| Parkinson's | Psychiatric Care | Rheumatoid Arthritis | Rheumatic Fever | Prostate Problem |
| Stroke | Suicide Attempt | Thyroid Problems | Tonsillitis | Scarlet Fever |
| Tumors, growths | Typhoid Fever | Ulcers | Vaginal Infections | Vision Problems |
| Fibromyalgia | Migraine | Cold/Flu | Viral Infections | TB |
| Whooping Cough | Vision Problems | Ear Infections | Other _____ | |

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The vast majority of our patients have been involved in dozens of **IMPACTS** that could cause **VERTEBRAL SUBLUXATION** (spinal misalignments); Kalani Chiropractic wants to discover 5 of yours.

1. When was your MOST recent **Auto/Motorcycle Accident**, even as a passenger? Date: _____

Circle: Major / Minor Impact What body part did you injure? _____ Treatment: Medical / Chiropractic

2. When was the accident before that? Date: _____

Circle: Major / Minor Impact What body part did you injure? _____ Treatment: Medical / Chiropractic

**Most people have a slip, strain, twist or fall playing sports, at home or at work, whether it was reported or not.**

1. When was your most recent injury? Date: _____

Describe: _____

What body part did you injure? _____ Treatment: Medical / Chiropractic

2. When was your most recent injury? Date: _____

Describe: _____

What body part did you injure? _____ Treatment: Medical / Chiropractic

3. When was your most recent injury? Date: _____

Describe: _____

What body part did you injure? _____ Treatment: Medical / Chiropractic

**Please list any surgeries, traumas, fractures, etc. that have not been mentioned above.**

Date: _____ Describe/Treatment: _____

Date: _____ Describe/Treatment: _____

Date: _____ Describe/Treatment: _____

Date: _____ Describe/Treatment: _____

| Exercise | Work Activity | Habits |
|---|---|---|
| None | Sitting _____ Hrs/Day | Smoking Packs/Day _____ |
| Moderate | Standing _____ Hrs/Day | Alcohol Drinks/Week _____ |
| Daily | Light. labor _____ Hrs/Day | Coffee/Caffeine Cups/Day _____ |
| Extreme Sports | Heavy. Labor _____ Hrs/Day | High Stress Level Reason |
| Weight Lifting | Other _____ | _____ |
| Other: _____ | _____ | Other _____ |

**For Women Only:** Are you pregnant? Yes No Due Date _____ Last menstrual period _____

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| **Medications/Vitamins/Herbs/Minerals** |
| --- |
| Please list all meds, vitamins, and supplements currently: _____ _____ |

**Goal Question: If you could accomplish one important thing or mission for your life, what would that be?**

_____

**FINANCIAL INFORMATION:** Name of person responsible for this account: _____
Relationship to patient (if other than self): _____Phone #_____

**PRIMARY INSURANCE:** Insurance Co.: _____ Name of *Insured*: _____
Policy #: _____ Group #: _____

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED THE FEE PAID FOR TREATMENT X-RAYS IS FOR ANALYSIS ONLY. THE FILMS ITSELF IS THE PROPERTY OF THIS OFFICE. ONCE FILMS ARE USED FOR TREATMENT PURPOSES, THEY CANNOT BE RELEASE WITHOUT PROPER WRITTEN REQUEST.
2. Method of payment you plan to use for today's services:

   Cash_____ Credit Card_____
3. I hereby authorize the doctor, and/or his associates to examine me, and to perform any necessary diagnostic procedures, including x-rays to fully evaluate my condition for the presence of vertebral subluxation.
4. I hereby authorize the office to bill my insurance for the exam, consultation, any necessary x-rays and/or treatment. Complimentary exam, consultation, x-rays and/or treatment do not apply.
5. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Kalani Total Health Center will prepare any necessary reports and forms to assist me in making collections from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

**Patient's Signature:** _____ **Date:** _____

Parent/Guardian *(if under 18)* Signature for
Authorized Care: _____ Date: _____

Name of Minor: _____

In Case of Emergency notify: _____ Relation: _____ Phone _____

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## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we will accept patient for such care, it is essential for both to be working towards the same objective.

**Chiropractic** has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment**: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health**: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the
(print name)
above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore, I accept chiropractic care on this basis.

_____ _____

***Signature*** ***Date***

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# Informed Consent to Chiropractic Care

***Patient**: Please discuss any questions or concerns with the doctor before signing this consent.*

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or the below named minor in which I am legally responsible for) by Dr. Kalani G. Jose, his staff, and/or his associates.

**The Nature of the Chiropractic Adjustment**

I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "pop" your knuckles. You may feel a sense of movement.

**The Material Risks Inherent with the Chiropractic Adjustment**

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

**The Probability of Those Risks Occurring**

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, we look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as "rare".

**Ancillary Treatment**

In addition to chiropractic adjustments, you may be given home instructions to use the following treatments, with the associated risks:

Heat ~ risk of 1st and 2nd degree burns, hemorrhage
Cryotherapy (cold packs) ~ risk of skin reactions
Trigger Point Therapy ~ risk of bruising, release of emboli
Massage ~ risk of deep vein thrombosis

**The Availability and Nature of Other Treatment Options**

Other treatment options for your condition may include:

Self-administered over-the-counter analgesics and rest
Medical care with prescription drugs
Hospitalization
Surgery

**The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include:**

Overuse of over-the-counter medications produces undesirable side effects. If complete rest in impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self discipline is not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain killers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those risks occurring varies according to many factors.

**The Risks and Dangers Attendant to Remaining Untreated**

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had all my questions answered to my satisfaction. 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 (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

_____

Date:

_____ _____

Printed Name of Patient Signature of Patient

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## NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME_____ DATE _____

For any YES answer, please explain under comment and notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Have you tried any medications such as anti-inflammatory? NO YES
    If YES, what kind of medication: _____
    _____
12. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If YES, When? For how long? What kind? _____
    _____
13. Have you had an MRI? NO YES
    If YES: When? Who ordered it? What was it ordered for? _____
    _____
14. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If YES: When? What kind? Who ordered it?
    _____
15. If you have tried any treatment or medications, did this make your problem better? NO YES
    Comment: _____

**NOTE: Your health information will be kept strictly confidential**. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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## CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such case may be contraindicated. It is the responsibility of the patient to make is known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____ _____
Patient's Signature Date

## X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____
_____
_____

Date of last menstrual period: _____

_____ _____
Patient's Signature Date

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## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Kalani Total Health Center (Please initial one of the following options and sign below.)

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@_____

Please initial below:

_____ I acknowledge that it is the policy of Kalani Total Health Center to leave reminder messages or text messages on my answering machine/cell phone or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Office Manager Rhi Mikusky about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

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# Financial Office Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent.
8. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
9. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care, then our standard fees will apply.
10. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.
11. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.

# Non-Assignment of Insurance Benefits Policy

In some cases, the insurance company may issue payments directly to the patient. It is the patient's responsibility to notify the provider's office of this circumstance and to bring the payment into the office. As you receive payments, or an Explanation of Benefits (EOB), our office also receives a copy of what you received, minus any payments.

If we have not received the payment from you, the patient, within seven (7) days, our office will charge that amount that you received from the insurance company to you. NOTE: We will only charge that amount if payment is not brought in within seven (7) days.

If unusual circumstances should arise where you can't bring the payment in, please call the office to let us know. (I.e. you're out of town, emergency, etc.)

You will be responsible to pay your deductible and co-payments that is due for each of your allowed visits by the insurance company.

I have read the above policy and my signature below indicates that I understand and agree to follow this policy.

_____ _____
Patient's Printed Name Date

_____
Patient's Signature

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# MEDICAL RECORDS REQUEST

DATE: _____

To: _____

_____

_____

I, _____ hereby request that my complete medical records be released to:

KALANI TOTAL HEALTH CENTER
2901 N. Ventura Road, Ste 220
Oxnard, CA 93036
**Phone: 805.604.0881**
**Fax: 805.604.0883**

I understand that this authorization allows the release of all information in my medical records to include lab test results, x-rays, and any surgery information. This authorization allows such records to be mailed or faxed. I understand that I may revoke this consent at any time. This consent will automatically expire without my expressed revocation 90 days from the date on this form.

PATIENT NAME:_____

PATIENT ADDRESS:_____

PATIENT'S DATE OF BIRTH:_____

PATIENT/GUARDIAN SIGNATURE:_____