Confidential Patient Information

DATE

HOW DID YOU COME TO THIS CLINIC? WHO REFERRED YOU? _____

IS YOUR VISIT DUE TO AN ACCIDENT? ☐YES ☐NO (IF YES, PLEASE COMPLETE THIS AND THE ACCIDENTAL INJURY REPORT)

PATIENT INFORMATION

NAME_____ HOME PHONE _____ WORK PHONE_____

CELL PHONE _____ EMAIL ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTHDATE _____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

OCCUPATION _____ DRIVER'S LIC. # _____ SS# _____

EMPLOYER _____ EMPLOYER ADDRESS _____

SPOUSE _____ OCCUPATION _____ WORK PHONE _____

EMPLOYER _____ EMPLOYER ADDRESS _____

NAME OF EMERGENCY CONTACT _____ PHONE _____

PRESENT COMPLAINT

BRIEFLY DESCRIBE YOUR SYMPTOMS _____

LIST OTHER DOCTORS SEEN FOR THIS CONDITION _____

MEDICAL HISTORY **(If any of the following are relevant to your medical history, please check the accompanying box.)**

☐CANCER	☐MUSCULAR DYSTROPHY	☐RHEUMATIC FEVER
☐POLIO	☐MULTIPLE SCLEROSIS	☐SCARLET FEVER
☐TUBERCULOSIS	☐CONVULSIONS	☐NERVOUSNESS
☐HIGH BLOOD PRESSURE	☐EPILEPSY	☐ASTHMA
☐HEART TROUBLE	☐CONCUSSION	☐DIGESTIVE DISORDERS
☐DIABETES	☐DIZZINESS	☐SINUS TROUBLE
☐HEPATITIS	☐ARTHRITIS	☐BACKACHES
☐GERMAN MEASLES	☐NEURITIS	☐NUMBNESS
☐VENEREAL DISEASE	☐RHEUMATISM	☐ANEMIA

DESCRIBE ANY OPERATIONS YOU HAVE HAD _____ WHEN? _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐YES ☐NO

DESCRIBE CONDITION _____ DATE OF LAST PHYSICAL EXAM _____

ARE YOU ALLERGIC TO ANY MEDICATION? ☐YES ☐NO WHAT KIND? _____

ARE YOU TAKING ANY MEDICATION? ☐YES ☐NO WHAT KIND? _____

IF FEMALE, ARE YOU PREGNANT? ☐YES ☐NO DATE OF LAST MENSTRUAL PERIOD? _____

INSURANCE DATA **(Clinic policy requires payment arrangements be made on the first visit)**

NAME OF PARTY RESPONSIBLE FOR PAYMENT _____ PHONE (_____)_____

DO YOU HAVE INSURANCE? ☐YES ☐NO COMPANY _____

PLEASE LIST ALL SOURCES OF INSURANCE

PATIENT'S INSURANCE _____ SPOUSE'S INSURANCE _____

WORKER'S COMPENSATION _____ CLAIM NUMBER, IF OPEN _____

OTHERS _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE OR GUARDIAN'S SIGNATURE _____ DATE _____

If yours is an accident/injury, please complete the Accidental Injury Report as well

ACCIDENTAL INJURY REPORT

NAME: _____

TYPE OF ACCIDENT: ☐ WORK RELATED ☐ TRAFFIC ☐ OTHER _____ DATE: _____

DATE OF ACCIDENT: _____ HOUR OF ACCIDENT: _____ AM PM LOCATION OF ACCIDENT: _____

IF WORK RELATED ACCIDENT, COMPLETE THE FOLLOWING SECTION:

EMPLOYER: _____ TYPE OF BUSINESS: _____

WAS ACCIDENT REPORTED TO SUPERVISOR AND/OR EMPLOYER? Y N WHO? _____

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? Y N

IF TRAFFIC RELATED ACCIDENT, COMPLETE THE FOLLOWING SECTION:

WHAT KIND OF VEHICLE WAS INVOLVED IN ACCIDENT? ☐ CAR ☐ TRUCK ☐ MOTORCYLCE ☐ OTHER

WERE YOU A: ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN

WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED? Y N IF YES, MPH_____

DID YOU VEHICLE HIT OTHER VEHICLE(S)? Y N WHERE? _____

DID OTHER VEHICLE(S) HIT YOUR VEHICLE? Y N WHERE? _____

WAS ACCIDENT REPORTED TO POLICE DEPARTMENT? Y N CASE/CLAIM NUMBER? _____

WERE TRAFFIC CITATIONS ISSUED? Y N TO WHOM? _____

DESCRIBE ACCIDENT INCLUDING CAUSE/S AND SURROUNDING CIRCUMSTANCES:

_____

_____

_____

PRESENT COMPLAINT-CHECK ALL THAT APPLY:

- ☐ HEADACHE
- ☐ HEAD SEEMS TOO HEAVY
- ☐ HEAD & SHOULDERS TIRED AND HEAVY
- ☐ MENTAL DULLNESS
- ☐ LOSS OF MEMORY
- ☐ EQUILIBRIUM PROBLEMS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ TREMORS
- ☐ PALPITATIONS
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ NECK MOTION RESTRICTED
- ☐ UPPER BACK PAIN/STIFFNESS
- ☐ MID BACK PAIN/STIFFNESS
- ☐ LOW BACK PAIN/STIFFNESS
- ☐ PINS & NEEDLES IN ARMS/LEGS
- ☐ NUMBNESS IN FINGERS/ARMS/LEGS
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ EYE STRAIN
- ☐ PAIN BEHIND EYES
- ☐ EYES SENSITIVE TO LIGHT
- ☐ EYES LOSS OF FOCUS
- ☐ DOUBLE VISION
- ☐ EARS BUZZING/RINGING
- ☐ LOSS OF TASTE
- ☐ LOSS OF SMELL
- ☐ SINUS TROUBLE
- ☐ EXTREME NERVOUSNESS
- ☐ TENSION
- ☐ IRRITABILITY
- ☐ ANXIETY
- ☐ EXTREME FATIGUE
- ☐ INSOMNIA
- ☐ NEURITIS
- ☐ FACE FLUSHED
- ☐ FACE PALE
- ☐ EXCESS PERSPIRATION
- ☐ DIGESTIVE DISORDERS
- ☐ NAUSEA, VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ SWOLLEN _____
- ☐ FEET/HANDS COLD
- ☐ DIFFICULTY IN PRO-LONGED CAR RIDING

☐ DIFFICULTY IN EXCESSIVE ☐ STANDING ☐ WALKING ☐ RIDING ☐ BENDING

☐ NECK, LOW BACK PAIN & STIFFNESS UPON RISING

☐ PAIN RADIATING INTO ☐ NECK ☐ BASE OF SKULL ☐ SHOULDER ☐ HIPS
☐ RIGHT ARM ☐ LEFT ARM ☐ BOTH ☐ RIGHT LEG ☐ LEFT LEG ☐ BOTH

DID YOU REQUIRE POST ACCIDENT HOSPITALIZATION? Y N IF YES, WHERE? _____

HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? Y N SYMPTOMS OTHER THAN ABOVE _____

HAVE YOU MISSED ANY TIME OFF WORK DUE TO THIS INJURY? IF YES, WHEN? _____

INSURANCE COMPANIES INVOLVED

INSURANCE COMPANY OF PARTY RESPONSIBLE FOR PAYMENT _____ CLAIM # _____

HAVE YOU BEEN CONTACTED BY AN INSURANCE ADJUSTER OR COMPANY REPRESENTATIVE ABOUT CLAIM? Y N

HAS YOUR ATTORNEY ADVISED YOU IN THIS CASE? Y N

ATTORNEY'S NAME, ADDRESS & TELEPHONE # _____

PATIENT'S SIGNATURE: _____ **DATE:** _____

Gilroy Chiropractic Center
7888 Wren Ave, Ste B-123
Gilroy, CA 95020
(408)848-3666

HIPPA Privacy Practices Consent

Name of Patient: _____

Date of Birth: _____

I acknowledge that I have read and understand the Gilroy Chiropractic Center HIPPA Notice of Privacy Practices and have received a written copy if requested. If I am not the patient, I represent that I am authorized by law to act on the patient's behalf.

_____ _____
Signature **Date**

If not signed by patient, indicate authority to act for patient: _____

FOR OFFICE USE ONLY

COMPLETE IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient or patient's authorized representative because:

_____ Individual refused to sign
_____ Other (please describe) _____

_____ _____
Signature Date

Gilroy Health & Wellness Center
Robert W. Kovacs, D.C.
7888 Wren Ave Ste. B-123
Gilroy, CA 95020

Informed Consent Document

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument 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 "crack" your knuckles. You may feel a sense of movement.

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Chiropractor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Chiropractor's attention, it is your responsibility to inform the Chiropractor.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Robert Kovacs, DC, to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other chiropractors and/or office staff members and is intended to include radiographic examination at the chiropractor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I herby give my consent to that treatment.

Dated: _____

_____ _____

Patient's Name **Patient's Signature**

_____ _____

Parent or Guardian's Name (if a minor) **Signature of Parent or Guardian (if a minor)**

GILROY CHIROPRACTIC CENTER

Dr. Robert W. Kovacs

PERSONAL INJURY POLICY

I understand that I am being treated for injuries sustained in a personal injury/motor vehicle accident. Because of the laws governing treatment in cases such as mine, the treatment plan, which has been recommended in my case, must be strictly adhered to. I understand that failure to present for care as recommended may lead to dismissal from treatment and may jeopardize future treatment and/or benefits, such as an insurance carrier's responsibility for medical costs and/or compensation.

I further understand that I will be treated until I have reached a level of maximum medical improvement, at which time I will be released from treatment as a result of the injuries sustained in the accident. This is not meant to imply that I will not need further treatment but only that the injuries sustained in the accident have reached maximum medical improvement.

NAME: _____

DATE: _____

WITNESS: _____

POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint the Gilroy Chiropractic Center clinic and any of its duly authorized agents and employees as and to be the undersigned's true and lawful Attorney In Fact for and in the undersigned's name, place and stead to **endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said** Gilroy Chiropractic Center clinic which checks, drafts or money orders are to **pay for Chiropractic services** or the like which have been made by Gilroy Chiropractic Center clinic at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these present does thus give and grant unto the said Gilroy Chiropractic Center clinic the full power and authority to do and preform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the **endorsing** and **cashing** of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by Gilroy Chiropractic Center clinic as Attorney In Fact, in accordance with this special power of attorney and shall do or cause to be done by virture of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 20 _____

_____
Witness to Patient's Signature

_____
Patient's Full Name (Typed)

_____
Signature of Patient

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ✱ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ✱

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Gilroy Chiropractic Center
7888 Wren Ave. Ste B-123
Gilroy, CA 95020
408-848-3666

PI Payment Assignment Form

Date:

_____
_____
_____

Patient Name: _____

CLAIM#: _____

POLICY#: _____

To Whom It May Concern:

Please make all medical payments directly to:
Dr. Robert Kovacs of Gilroy Chiropractic Center (Tax ID# 770104716)
7888 Wren Ave B123
Gilroy, CA 95020

Thank you,

_____
Patient Signature

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

I do hereby authorize Robert W. Kovacs, D.C. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated _____ _____

Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this Lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated _____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: Robert W. Kovacs, D.C.
Address: 7888 Wren Ave, Suite B123
Gilroy, CA 95020

NOTICE OF DOCTOR'S LIEN

Patient: _____

Date of Accident: _____

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Attorney's Signature

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