Welcome to
Yen Chiropractic

Patient Information

Today's Date:_____
First Name:_____
Last Name:_____
Name preferred to be called:
_____
Address:_____
City:_____State:_____Zip Code:_____
Cell Phone:_____
Home Phone:_____
Date of Birth:_____/_____/_____Age:_____
Sex: ☐ Female ☐ Male
E-mail:_____
Occupation:_____
Employer/Business:_____
How did you hear about us?
☐ Internet ☐ Mailer ☐ Sign/Location
☐ Referred By:_____
☐ Other:_____

Medical History

Injuries/Surgeries you've had, and when:
Falls:_____
Head Injuries:_____
Broken Bones:_____
Dislocations:_____
Other: _____

Medical History

Family History:
Mother: ☐ Back ☐ Heart ☐ Stroke ☐ Cance
☐ Diabetes ☐ High Blood Pressure
Father: ☐ Back ☐ Heart ☐ Stroke ☐ Cance
☐ Diabetes ☐ High Blood Pressure
No. of Sisters: _____No. of Brothers:_____
☐ Back ☐ Heart ☐ Stroke ☐ Cance
☐ Diabetes ☐ High Blood Pressure

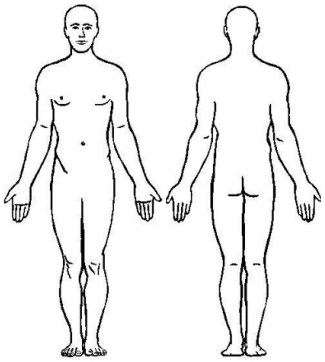
Your own condition checklist:

☐ Alcohol/Drug Addiction	☐ High BP
☐ Anemia	☐ High Cholesterol
☐ Arthritis	☐ Joint/Back Pain
☐ Asthma	☐ Kidney Disease
☐ Bleeding Disorder	☐ Liver Disease
☐ Bowel Problems	☐ Lung Disease
☐ Broken Bones	☐ Mental Disorder
☐ Cancer	☐ Osteoporosis
☐ Cataracts	☐ Pneumonia
☐ Chicken Pox	☐ Polio
☐ Diabetes	☐ Prostate Problems
☐ Emphysema	☐ Rhematic Fever
☐ Epilepsy	☐ STD's
☐ Glaucoma	☐ Stroke
☐ Gout	☐ Suicidal Tendencies
☐ Headaches	☐ Thyroid Disease
☐ Heart Disease/Attacks	☐ Tuberculosis
☐ Hepatitis	☐ Ulcers
☐ Other:_____	☐ Other:_____

Patient Condition

Reason for Visit:_____
When did you symptoms appear:_____
Is this condition getting worse? ☐ Yes ☐ No ☐ Unknown
Rate the severity of your pain from 1(least pain) to 10 (severe pain)_____
How often do you have pain?_____
Is it constant or does it come and go?_____
Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Movements painful to preform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down
Medication(s) – List them below and provide reaseon(s) for taking:
_____
_____
_____

Mark an X on the picture where you continue to have pain, numbness or tingling



For Doctors Use Only: _____
_____
_____
_____
_____
_____
_____
_____

See Next Page

YEN CHIROPRACTIC HIPAA PRIVACY PRACTICES, FINANCIAL POLICY, AND TERMS OF ACCEPTANCE

HIPAA

This Notice of Privacy Practices describes how Yen Chiropractic ("we") may use and disclose your Protected Healthcare Information ("PHI") to carry out treatment, payment, or healthcare options, and for purposes that are permitted or required by law. PHI is information about you, including demographic information, which may identify you or relates to your past, present, or future physical or mental health and related healthcare services.

Your protected health information may be used and disclosed, as needed, by your Chiropractor, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, for insurance or case settlement reasons, and other reasons as required by law. We are allowed or even required to disclose your PHI in certain situations without your authorization. These situations include: as required by law, public health reporting, to work with a medical examiner, in matters of national security, in workers' compensation proceedings, and in other legal proceedings.

We must make disclosures to you when you request them. Uses and disclosures, other than those described above, will be made only with your written request and approval. You may revoke this approval at any time in writing, and may also request a copy of your prior authorization forms. You have a right to request restrictions on the use of your PHI, which we may deny if it will affect your care. You have a right to receive an accounting of any disclosures we have made, if any, of your PHI. You also have the right to have your legal guardian, or someone you have given a medical power of attorney for your health matters, to make choices about your PHI and its disclosure.

We will not release your PHI to any individual or company, without your written permission, that does not pertain to your health, healthcare treatment, or the payment of your medical bills. We may also call you regarding your appointment with us or other necessary information. If we cannot reach you directly, you agree that we will leave a message either on the answering machine or with the person who answers the phone. We will state only our name and number, revealing no further information in the message. We are required by law to maintain the privacy of, and provide every patient with this notice of our legal duties and privacy practices with respect to PHI. If you feel that your privacy rights have been violated we urge you to contact a HIPAA Compliance Officer, and we will not retaliate against you for exercising those rights.

Financial

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks (with a valid, current I.D.) Visa, Master Card, American Express, and Discover. **We do not accept or bill any insurance except some Med Pay.** Your personal health insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract, and are more than happy to provide you with the information needed for you to file your own insurance claim. Medicare beneficiaries will have to review a separate ABN form to make an informed decision on whether or not to receive care at this office as we do not bill Medicare, and Medicare will not pay for maintenance or wellness care. **If a Medicare beneficiary has recently sustained an acute injury, one which would involve an active insurance claim, he/she will be referred to another healthcare facility.**

Balances older than 30 days may be subject to additional collection fees and interest charges of one and one-half percent (1.5%) per month. Returned or canceled checks are subject to a $25.00 returned check fee. Charges may also be made for broken appointments and appointments canceled without 24 hours advance notice. If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

TERMS OF ACCEPTANCE FOR YEN CHIROPRACTIC

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working toward 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 manual adjustments of the spine. At Yen Chiropractic your adjustment will be a full spine adjustment.

HEALTH AND WELLNESS

This means you are in 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 vertebrae 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 in particular, we 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 treatments prescribed by others. Our only practice is to eliminate a major interference to the expression of the body's innate wisdom and healing. Our method is specific adjusting of the spine to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Chiropractic maintenance care on this basis. Signature below is only acknowledgment that you have read and understand our HIPAA, Financial Policy, and Terms of Acceptance. Your signature also constitutes your permission for Yen Chiropractic to contact you with information via mail, e-mail, fax and phone.

Yen Chiropractic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Yen Chiropractic does not exclude people or treat them differently because of race, color, national origin, age, disability or sex; provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters or written information in other formats (e.g., large scale print or audio format); and also provides free language services to people whose primary language is not English, such as interpreters or written materials in another language. Further information is available in Yen Chiropractic's Notice of Non-Discrimination & Accessibility.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-702-685-8776
注意 : 如果您使用繁體中文 , 您可以免費獲得語言援助服務。請致電 1-702-685-8776

Patient Name _____ Signature _____ Date Signed _____

Legal Guardian if under 18 _____ Signature _____ Date Signed _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “Informed Consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing and adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustments include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____Signature:_____Date:_____

Parent or Guardian: _____Signature:_____Date:_____

Witness Name:_____Signature:_____Date:_____