The Chiropractic Offices of Doctor Gary R Vitullo
1111 North Brand Blvd Ste 402 Glendale, CA 91202 | (818) 241-7080
729 Mission Street #150B South Pasadena, CA 91030 | (626) 403-0380

About You

Today's Date ___/___/___ **File #** _____

Patient Name _____
LAST FIRST MI

What You Prefer To Be called: _____ Gender M F

Birthdate ___/___/___ SS # _____

Mailing Address _____

_____
CITY STATE ZIP

Home Phone # _____

Work Phone # _____ Ext. _____

Mobile Phone # _____

E-Mail Address _____

Referred By _____

Employer _____ How Long? _____

Employer Address _____

_____
CITY STATE ZIP

Occupation _____

Status Minor [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ]

Spouse Name _____
LAST FIRST MI

Children Yes [ ] No [ ] If Yes, How Many?

Insurance

(Please inform office of secondary insurance)

Primary Carrier _____

Carrier Address _____

_____
CITY **STATE** **ZIP**

Carrier # _____

Insurance # _____

Group # (Plan, Local or Policy #) _____

Insured Name: _____

Relation _____ Birthdate ___/___/___

Insured Employer _____

In Event of Emergency

Emergency Contact: _____

Relation: _____

Contact Phone # _____

Contact Work # _____ **Ext.** _____

Primary Physician: _____

Physician Phone # _____

Physician Address _____

_____
CITY STATE ZIP

Account Information

Information about the person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY **STATE** **ZIP**

Driver's License # _____ **SS #** _____

Work # _____ **Ext.** _____

Payment Method Cash [ ] Check [ ] Credit Card [ ]

Credit Card # _____

CC Expiration _____ CVV _____

_____
INITIALS

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offerred at this office).

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Reason for Visit

The reason for this visit is a result of (*Please check all applicable*): When did the Condition Begin? ____/____/____

Work [ ] Sports [ ] Auto [ ] Trauma [ ] Chronic Pain [ ]

Please explain what happened:

Is this condition getting worse? Yes [ ] No [ ] Constant [ ] Comes and Goes [ ]

Is this condition interfering with your (*Please check all applicable*) Work [ ] Sleep [ ] Daily Routine [ ]

If so, please explain:

Have you had this or similar conditions in the past? Yes [ ] No [ ]

If so, please explain:

Have you been treated by a Medical Physician for this condition? Yes [ ] No [ ]

If yes, by whom? Phone:

Have you been treated by a Chiropractor before? Yes [ ] No [ ]

If yes, by whom? Phone:

Health History

Are you taking any of the following medications?

- [ ] Nerve Pills
- [ ] Pain-killers (including aspirin)
- [ ] Muscle Relaxers
- [ ] Stimulants
- [ ] Blood Thinners
- [ ] Tranquilizers
- [ ] Insulin
- [ ] Other(s)

If Other(s) please specify below:

Do you have or ever had any of the following diseases or conditions?

Y	**N**	Heart Attack / Stroke	**Y**	**N**	Psychiatric Problems
Y	**N**	Congenital Heart Defect	**Y**	**N**	Kidney Problems
Y	**N**	Alcohol / Drug Abuse	**Y**	**N**	Sinus Problems
Y	**N**	HIV / AIDS	**Y**	**N**	Difficulty Breathing
Y	**N**	Frequent Neck Pain	**Y**	**N**	Artificial Bones / Joints
Y	**N**	High / Low Blood Pressure	**Y**	**N**	Heart Murmur
Y	**N**	Severe / Frequent Headaches	**Y**	**N**	Artificial Valves
Y	**N**	Fainting / Seizures / Epilepsy	**Y**	**N**	Hepatitis
Y	**N**	Diabetes / Tuberculosis	**Y**	**N**	Cancer
Y	**N**	Lower Back Problems	**Y**	**N**	Anemia
Y	**N**	Heart Surgery / Pacemaker	**Y**	**N**	Rheumatic Fever
Y	**N**	Mitral Valve Prelapse	**Y**	**N**	Ulcers / Colitis
Y	**N**	Venereal Disease	**Y**	**N**	Asthma
Y	**N**	Shingles	**Y**	**N**	Chemotherapy
Y	**N**	Emphysema / Glaucoma	**Y**	**N**	Arthritis

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to:

Please list any past serious accidents with dates:

Family Health History:

Do you take Supplements or Vitamins? [ ] Yes [ ] No

Do you Exercise? [ ] Yes How Often? _____ [ ] No

Do you Smoke? [ ] No [ ] Yes How Much? _____

How Often? _____

Are you wearing:

- [ ] Heel Lifts
- [ ] Sole Lifts
- [ ] Inner soles
- [ ] Arch Supports

What is the age of your mattress? _____

Is your mattress comfortable? [ ] Yes [ ] No

For Women Only

Are you taking Birth Control? [ ] Yes [ ] No

Are you Pregnant? [ ] Yes [ ] No

Are you Nursing? [ ] Yes [ ] No

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Pain Chart

Name _____ **File #** _____
Current Weight _____ lbs Height _____ Feet _____ Inches
Please describe your current condition:

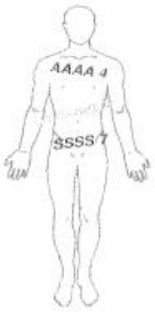
_____

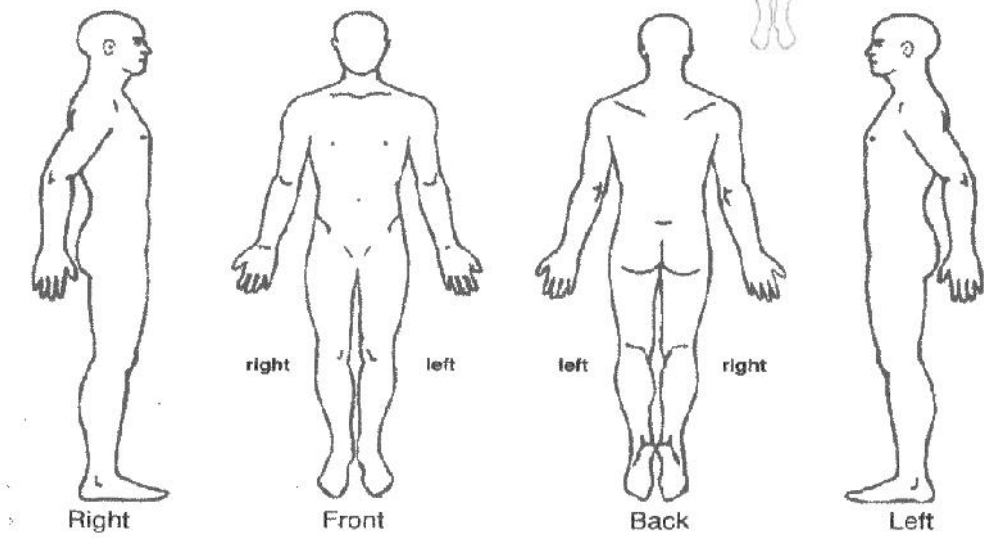
_____

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description	**Symbol**
Numbness	NNNN
Pins & Needles	PPPP
Burning	BBBB
Aching	AAAA
Stabbing	SSSS

EXAMPLE:





Doctor's Notes

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FINANCIAL POLICIES

A. **Cash Patients**:
A cash, check or credit card payment, equal to one-half the normal first visit charges is due on the day of the first treatment. The balance is due within one week of the first visit. Payments for treatments are due on the day of treatment. Patients who are being treated more than one time per week may pay for each week's treatment on the last visit of the week. Weekly or Monthly pre-payment programs may be arranged in some cases.

B. **Insurance Patients:**
Dr. Vitullo's Chiropractic office will bill primary insurance companies directly for treatment charges at the time of treatment until applicable insurance deductibles are met. Insurance co-payments, deductibles and predetermined non-covered charges are due at the time of treatment. Patients who are being treated more than one time per week may pay for each insurance co-payments, deductible and predetermined non covered charges on the last visit of the week. Patients are responsible for any charges not covered by their insurance.

C. **Collection Policy:**
If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

I have read the above Financial policies and understand that I am personally responsible for payment of treatment charges.

Signature _____
Printed Name _____
Date _____

ASSIGNMENT OF BENEFITS

I authorize the direct payment to the Chiropractor, of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your charges or otherwise obligated to pay to me or you based in whole or in part upon the charges made for your services.

In the event any insurance company, obligated by contractual agreement to make payment to me or to Chiropractor for the charges made for Chiropractic services rendered refuses to make payment upon demand by you, I hereby assign and transfer to the Chiropractor the cause of actions that exists in my favor against such company and authorize Chiropractor to compromise, settle or otherwise resolve said claim as Chiropractor sees fit. I understand whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due, I personally owe Chiropractor.

Signature _____
Printed Name _____
Date _____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature _____
Printed Name _____
Date _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
2) We are required to abide by the terms of this Notice currently in effect.
3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.
Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. [Delete if inapplicable:] You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

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You have certain rights regarding your health record information, as follows:

1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to Dr Gary Vitullo, 729 Mission Street #150B South Pasadena, CA 91030

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INFORMED CONSENT TO CHIROPRACTIC MANIPULATION AND CARE

PATIENT INITIALS

☐ **Chiropractic Care and Treatment**. I have and have had an opportunity to discuss with the chiropractic doctor, or other office or clinical personnel named below, the nature and objective of chiropractic care, the physical examination and other diagnostic tests and procedures used by chiropractors including any necessary orthopedic, neurological, laboratory tests, imaging studies (X-rays, CT scans, MRIs, etc) and other procedures; chiropractic care and treatment protocols, including chiropractic adjustments, manipulation, mobilization and other therapies utilized by this office/practice in the care of may condition. Taken together, these procedures and protocols will be referred to as the office/practice's "chiropractic examination and treatment methods." Furthermore, it also has been communicated to me and I understand that every patient reacts differently to care, and that treatment results and outcomes cannot be guaranteed.

☐ It also has been explained to me that if any tests were performed outside of this office/practice (e.g., laboratory or other diagnostic procedures), that the doctor or other staff member or clinician will notify me of the results at my next scheduled appointment.

☐ **Nature of Chiropractic Treatment**. I have been informed that, on occasion, some patients experience increased discomfort following chiropractic care and treatment. Chiropractic physical examination and treatment may involve bending, twisting, mechanically challenging your joints and testing your muscle strength, and it can possibly lead to temporarily feelings soreness or pain. During treatment, the doctor may use his or her hands or mechanical devices to move, adjust, manipulate your joints and mobilize soft tissues (e.g. muscles, ligaments). A "crack" or "pop" sound is often produced in some of the joint manipulation procedures and is caused by a separation of the smooth joint surfaces in much the same way a suction cup produces a popping sound when it is removed from glass or other smooth surface. Although a popping sound is not necessary, it is often a natural effect of joint movement.

☐ **Permission for Physical Contact**. It has been explained to me, and I understand that, in the course of various chiropractic examination procedures and treatment methods, the doctor of chiropractic or other clinical staff may have to examine and physically contact portions of my body. I understand that any contact of an intimate or sexual nature is illegal, unethical, never a part of chiropractic professional examination or treatment, and is prohibited. Nevertheless, I also realized that some chiropractic procedures may require that the doctor or clinician contact me in some physically sensitive areas – such as during a procedure known as a "lumbar roll" where the doctor may contact with my rump (the posterior, superior spine of the Ilium) to adjust my sacroiliac joint, or some other similar or analogous procedure. I understand, however, that before any sensitive contact or procedure occurs the doctor or other clinical staff member will explain to me ① what is to be done, ② how it will be performed, ③ why it will be performed, ④ that I may refuse that particular test or procedure, or alternatively that I may request that another member of the staff be present for my safety and protection, and finally, ⑤ that I will be given the opportunity to signal the doctor or clinician when I am ready to receive the test or procedure. I also agree that if I ever have any questions, doubts or misgivings about the appropriateness of such contact I can discuss my concerns with the doctor, or other office or clinical staff

member. If for any reason I am reluctant to discuss these concerns directly with my doctor or clinician, or if I feel unsatisfied with the explanation given, I agree to seek a professional, third-party consultation from another licensed chiropractor mutually agreed upon by me and my chiropractor or clinician, or alternatively, I may contact the California Chiropractic Association (916-648-2727) or the state licensing agency – the California Board of Chiropractic Examiners (916) 263-5355). The doctor, clinician, and I agree to these stipulations to ensure that no misunderstandings or uncomfortable feelings arise as a result of physical contact between me and the doctor or other office/practice clinician. Finally, it is my understand that I may revoke this permission at any time by a mutual exchange of written acknowledgments indicating that permission for any further physical contact by the doctor or other staff member with my person is prohibited. After having the foregoing information explained to me I hereby request, consent and submit to the office/practice's chiropractic examination and treatment methods performed as explained to me.

☐ **Risks of Chiropractic Care and Treatment**. I understand and have been informed that there is risk of side effects and complications anytime a doctor, provider or other clinician is asked to intervene in a healthcare encounter with a patient. I have been informed by the office/practice of the following: that although the risk of serious complication from chiropractic treatment is rare and unlikely, nonetheless, rare events ranging from relatively minor muscle soreness, aches, sprains and strains, to injuries to the spinal discs, nerves and cord, or an occasional fracture or dislocation in compromised patients with certain concomitant diseases and illnesses have been reported in the scientific literature; that cerebrovascular accidents, such as a stroke, have also been reported; that these are generally attributed to an underlying defect in a vertebral or basilar artery known as a spontaneous dissection and that these have been estimated to occur in one-to-a-million to one-in-forty-million cases of chiropractic, osteopathic, physical therapy and medical manipulation; about the same probability of stroke from turning your head or having your hair washed in a salon ("beauty parlor stroke'). In some of these instances, however, these dissections were not proximate in time or location to the treatment rendered, and consequently, it cannot be said with any certainty that the specific treatment caused the stroke, aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke.

It was explained to me and I do not expect the doctor to be able to anticipate all the potential risks or complications. Nor do I expect that the doctor or other clinician to provide me assurances that I will not experience a negative outcome. Nonetheless, I wish to rely on the doctor to exercise his or her best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time.

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☐ It was explained to me that the most common and likely side effect of treatment will be muscular stiffness or soreness, described by some as akin to the ache people experience after exercising the first time in a long time; and that these effects are often transient and temporary. I was instructed that if I experience any increased discomfort following treatment, that I should apply ice to, and rest the affected area. I was also told that if I become concerned about any post-treatment discomfort or, I should develop of any new or unrelated symptoms, I should call the number listed below for emergency attention available twenty-four (24) hours a day. I also understand that if for some reason I am unable to reach or contact that doctor, that I should telephone my personal, primary care doctor or present myself to the nearest hospital emergency room.

☐ **Consent**. By initialing each paragraph above in conjunction with the doctor, or other office or clinical personnel, acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning. By signing below, I agree to submit to the above named chiropractic examination and treatment methods. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment from Dr Gary Vitullo, 729 Mission Street #150B South Pasadena, CA 91030

Signature _____
Printed Name _____
Date _____