



**Confidential Patient Information**

Date \_\_\_\_\_  
E-mail \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_ City, Zip Code \_\_\_\_\_  
Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_ Cell \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male/Female \_\_\_\_\_ Married? \_\_\_\_\_  
Children? Yes/No How Many? \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
Name of Insurance Co. \_\_\_\_\_ (please show card)

Emergency Contact & Relation to you \_\_\_\_\_  
Phone # \_\_\_\_\_

How were you referred to us? \_\_\_\_\_  
Reason for this visit? \_\_\_\_\_

Please check the boxes that correspond to the symptoms you are experiencing.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> low back pain             | <input type="checkbox"/> sciatica              | <input type="checkbox"/> tension                    |
| <input type="checkbox"/> numbness in the legs/feet | <input type="checkbox"/> mid back pain         | <input type="checkbox"/> fatigue                    |
| <input type="checkbox"/> tingling in legs/feet     | <input type="checkbox"/> knee/ankle pain R/L   | <input type="checkbox"/> painful menstruation       |
| <input type="checkbox"/> neck pain                 | <input type="checkbox"/> elbow/wrist pain R/L  | <input type="checkbox"/> depression                 |
| <input type="checkbox"/> headaches                 | <input type="checkbox"/> Hip pain              | <input type="checkbox"/> shortness of breathe       |
| <input type="checkbox"/> shoulder pain R/L         | <input type="checkbox"/> constipation/diarrhea | <input type="checkbox"/> buzzing or ringing in ears |
| <input type="checkbox"/> numb/tingle in arms/hands | <input type="checkbox"/> allergies             | <input type="checkbox"/> dizziness                  |
| <input type="checkbox"/> sacrum/ilium pain         | <input type="checkbox"/> sleeping problems     | <input type="checkbox"/> sinus problem              |

When did symptoms first appear? \_\_\_\_\_  
Any falls, accidents or injuries? Y / N Explain: \_\_\_\_\_  
Is this injury work related? Y / N Date of injury: \_\_\_\_\_ Explain: \_\_\_\_\_  
Have you suffered from:  Anemia  Arthritis  Asthma  Cancer  Diabetes  Digestive disorders  
 Heart trouble  Sinus trouble  Tuberculosis

How would you describe your lifestyle (exercise, diet, health commitment)? \_\_\_\_\_

How would you describe your mental/emotional health? \_\_\_\_\_

*Payment is expected at time of visit.*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's staff will submit claims and assist me in collecting from the insurance company. I authorize the insurance company to pay the doctor, and that such amount will be credited to my personal account upon receipt. However, I clearly understand and agree that all services rendered 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 to me will be immediately due and payable. I further agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may charge a late of \$15 per month, and in event of default, I agree to pay reasonable collection charges and/or attorney fees.

I authorize the release of any information necessary to process this claim and payment for medical benefits directly to the doctor for services rendered.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*We appreciate the opportunity to serve you. So we may always be available for the care of all our patients we do require a minimum of 24 hours notice for cancellation. A 100% cancellation fee will be charged to your account if you cancel with less than 24 hours notice or if you do not appear for your scheduled appointment time.**



**Lynn M.C. Gerner, D.C., FICPA**

**Bryon Cloyd, D.C., CMT**

**Natalie Packer, D.C.**

**Rachel Knight, D.C.**

2043 Anderson Rd, Suite D, Davis, CA 95616

1809 Picasso Avenue, Davis, CA 95616

(530) 297-5683 (LOVE)

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THANK YOU.

In the course of your care as a patient of Dr. Lynn Gerner, Dr. Bryon Cloyd, Dr. Natalie Packer, or Dr. Rachel Knight, we may use or disclose personal or health related information about you in the following ways:

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. Your health records may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer, if they may be responsible for payment of services provided to you. Your name, address, phone number, and your health records may be used to contact you regarding appointment times, information about alternatives to your present care, or other health related information that may be important to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have the right to confidential communications and to request restrictions relative to such contacts. You also may elect to be contacted by alternate means (such as email) or at an alternate location.

You have the right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this establishment.

We are permitted and may be required to use or disclose your health information without your authorization in the following circumstances: 1) If we provide health care services to you in an emergency, 2) if we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so, 3) if there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care, and 4) if we are ordered by the courts or another appropriate agency.

You have the right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide authorization for release of information, you have the right to revoke that authorization at any time. Information that we disclose based on the privacy notice may be subject to redisclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person, at the time chiropractic care is rendered. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information in a specific form, please advise us in writing as to your preference.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing. We are required by state and federal law to maintain the privacy of your patient files and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. Furthermore, we are required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible. Any change in our privacy notice will apply for all of your health information in our files.

Contact Dr. Gerner if you have a complaint, or if you would like further information regarding our privacy notice, our privacy practices or any aspect of our privacy activities.

You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. If you choose to file a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner. This notice is effective as of 01/01/15. Any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received and read a copy of this notice.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

Date \_\_\_\_\_

If you are a minor, or if you are being represented by another party:

\_\_\_\_\_  
Personal Representative (print)

\_\_\_\_\_  
Signature

Date \_\_\_\_\_



## Our Policy Regarding Your Health Insurance and Cancellation Notice

If you are covered by insurance, we will be happy to process your claims for you. It is important that you understand your policy clearly. We will do our best to provide you with an interpretation of your insurance as it applies to chiropractic coverage but it is a GUIDELINE from which to work until final payment is received from your insurance company.

Please read and initial to following disclosure statements:

I \_\_\_\_\_ agree to the following arrangement for chiropractic services rendered:

\_\_\_\_\_ \*Initial\* All copayments are due at time of service.

\_\_\_\_\_ \*Initial\* As a convenience to you, we will process your chiropractic claims for you. You should be aware that our estimate of your insurance coverage is only an estimate, and based on known insurance coverage as of this date and does not reflect any complications that may arise or change in insurance coverage and/or eligibility. Professional services are rendered to a person, not to an insurance company. Thus, the insurance company is responsible for payment made to the patient, and the patient is responsible for payment made to the doctor. We cannot render services on the assumption that the charges will be paid for by the insurance company. However, we will help in every way that we can in filing your claim.

\_\_\_\_\_ \*Initial\* We will do our best to give you the most accurate estimates possible, however is it ultimately your responsibility to know your insurance plan, what it will cover, what benefits you have utilized and how much you have remaining.

\_\_\_\_\_ \*Initial\* Any estimates that are quoted are based on limited information obtained from your insurance company. We will allow 90 days for your insurance company to make a payment, after this time, all inquiries (follow-up) on payments become your responsibility and we will ask that you pay off the remaining balance of your visit.

\_\_\_\_\_ \*Initial\* I agree to be responsible for all charges for services and materials not paid by my insurance plan, unless treating provider has a contractual agreement with my plan prohibiting all or a portion of such charges.

\_\_\_\_\_ \*Initial\* I authorize release of any information relating to this claim to the extent permitted under applicable law.

\_\_\_\_\_ \*Initial\* I hereby authorize payment of the benefits otherwise payable to me directly to the named health care provider.

*We are here to help you...no question is too small to ask, whether it is regarding your treatment, insurance, or a bill.*

Thank you.

The Good Life Chiropractic

X \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

### ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, including 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 California 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

**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, as to whether this agreement is unconscionable, and any procedural disputes, 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, preceptors, or 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. This agreement is intended to create an open book account unless and until revoked.

**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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). 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 of 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** \_\_\_\_\_ (Date)

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

OFFICE SIGNATURE **X** \_\_\_\_\_ (Date)

**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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff 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 or 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 and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further 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 further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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.

CHIROPRACTOR NAME:

(Date)

PATIENT SIGNATURE

X

(Or Patient Guardian/Parent/Representative)

(Provide name and relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**