Romo Chiropractic

1101 Standiford Ave, Suite D-2 • Modesto, CA 95350 • (209) 571-1999

New Patient Confidential Health Questionnaire

Romo Chiropractic welcomes you and wants to provide you with the best possible care. This information is needed so we can better serve you. Please fill in ALL portions of the form. If you need assistance, please ask and we will be happy to help you.

☐ Mr. ☐ Mrs. ☐ Ms.. ☐ Dr. ☐ Miss. **Name:** _____

Street: _____ **City/Sate/Zip:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female **Marital Status:** ☐Married ☐ Single ☐Other

Social Security Number: _____ Diver License Number: _____

Home Phone: _____

Cell Phone: _____ Carrier: ☐AT&T ☐Verizon ☐Sprint ☐T-Mobile ☐Metro ☐Cricket

E-mail: _____

Preferred contact Method: ☐Text* ☐Email* ☐ Cell Phone ☐Home Phone ☐Work Phone

Preferred Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ White ☐ Hispanic ☐ Asian ☐ Black / African ☐ American Indian ☐ Other ☐ I choose not to specify

Work Status: ☐ Student ☐ Employed ☐ Retired ☐ Other **Occupation:** _____

Employer: _____ **Work Phone:** _____

Emergency Contact: _____ **Phone:** _____

Do you have any Insurance? ☐ **YES** ☐ **No** Note*: You will be considered as a cash patient until insurance information is provided.*

Insurance Name: _____ **Claim / Policy Number:**_____

Insurance Phone Number: _____

Whom may we thank for referring you to Romo Chiropractic? ☐ Facebook ☐ Google ☐ Yahoo ☐ Bing ☐ Yelp ☐ Twitter
☐ Sign & Location ☐ Attorney ☐ Doctor ☐ Friend ☐ Family ☐ Other: _____

Female Only
Is there any chance that you are pregnant? ☐Yes ☐ No Date of last menstrual cycle: _____
Are you planning to get pregnant in the next 12 Months? ☐Yes ☐ No

What is the purpose for the visit today? ☐Auto Accident ☐Work injury ☐Slip and Fall ☐Wellness ☐Massage ☐ Don't know

How many servings of these beverages and foods do you consume each day?
Water: _____ **Pop/Soda:** _____ **Coffee:** _____ **Fruits:** _____ **Vegetables:** _____ **Meat:** _____ **Dairy:** _____

On a scale of 1-10, (*1 = very poor / 10 = excellent*) describe your:
Eating Habits: _____ **Exercise Habits**: _____ **Sleep Habits:** _____ **General Health:** _____ **Mind-set:** _____

Exercise ☐None ☐Moderate ☐Daily ☐Heavy **Work Activity** ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor

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Please check to indicate if you have any of the following:

☐AIDS / HIV	☐Cataracts	☐Heart Disease	☐Multiple Sclerosis	☐Seizures
☐Alcoholism	☐Chemical Dependency	☐Hepatitis	☐Mumps	☐Sexually Transmitted Disease
☐Allergy Shots	☐Chicken Pox	☐Hernia	☐Osteoporosis	☐Sleeping Problems
☐Anemia	☐Coughing up blood	☐Herniated Disk	☐Pacemaker	☐Stroke
☐Anorexia	☐Diabetes	☐Herpes	☐Parkinson's disease	☐Suicide Attempt
☐Appendicitis	☐Digestive problems	☐High Blood Pressure	☐Pinched Nerve	☐Thyroid Problems
☐Athirst	☐Double Vision	☐High Cholesterol	☐Pneumonia	☐Tonsillitis
☐Asthma	☐Emphysema	☐Kidney Disease	☐Polio	☐Tumors Growth
☐Bleeding Disorders	☐Epilepsy	☐Liver Disease	☐Prostate Problem	☐Typhoid Fever
☐Blood in stool or urine	☐Fractures	☐Loss of energy	☐Prosthesis	☐Ulcers
☐Brest lump	☐Glaucoma	☐Measles	☐Psychiatric Care	☐Unconsciousness
☐Bronchitis	☐Goiter	☐Migraine Headaches	☐Rheumatoid Arthritis	☐Vaginal infection
☐Bulimia	☐Gonorrhea	☐Miscarriage	☐Rheumatic Fever	☐Whooping Cough
☐Cancer	☐Gout	☐Mononucleosis	☐Scarlet Fever	

Any previous Surgeries: ☐Yes ☐ No
Any known Allergies (drugs, chemicals, foods): ☐Yes ☐ No
Have you been hospitalized overnight ☐Yes ☐ No

Family History	Arthritis	Cancer	Heart Disease	Diabetes	Other
Father's side	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	_____
Mother's side	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	_____

AUTHORIZATION AND RELEASE: I certify that I'm the patient or legal guardian listed above and authorize payment of insurance benefits directly to Romo Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this Romo Chiropractic to use his/her Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

I will notify Romo Chiropractic of any changes in my health status during my care. It is also my duty to daily inform the doctor, therapist or assistant of any possible complication prior to the initiation of my daily rehabilitation or treatment.

*** I give Romo Chiropractic permission to electronically send me appointment reminder via text or email.**

Patient's Name: _____ **Age:** _____

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

Legal Guardian's Signature: _____

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Informed Consent Part I of II

Name: _____ Date of Birth: _____

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.

Romo Chiropractic, Inc. use trained staff personnel to assist with portions of your consultation, examination, x-rays, physical therapy applications, exercise instruction, massage, etc. Occasionally, when your chiropractor is unavailable, another qualified doctor of chiropractic may treat you.

SPECIFIC RISK POSSIBILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

STROKE: Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 per 10 million treatments. The most recent studies (Journal of the CCA, Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

SORENESS: Chiropractic adjustments, massage therapy, Myofascial release or physiotherapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care. If you experience soreness or discomfort with the treatment, please advise the staff or doctor of Romo Chiropractic, Inc.

SOFT TISSUE INJURY: Occasionally Chiropractic adjustments, massage therapy, Myofascial release or physiotherapy procedures treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury. While these are rare, they should be reported to Romo Chiropractic staff immediately.

RIB INJURY: Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

PHYSICAL THERAPY BURNS: Physiotherapy or Physical therapy modalities sometimes will generate heat that may cause minor burns to the skin. While these are rare, they should be reported to staff immediately.

OTHER PROBLEMS: There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your Doctor of Chiropractic promptly.

Massage or Myofascial Release: Massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, and the promotion of circulation, lymph activity, and flexibility.

The massage therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch.

I understand that potential risks of massage include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session.

I understand that I may be refused treatment if appear obviously intoxicated or under the influence of drugs.

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Informed Consent Part II of II

Romo Chiropractic, Inc. uses a health care delivery system and therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

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, on me_____ (or on the patient named below, for whom I am legally responsible) by the Romo Chiropractic, Inc. Doctor of Chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the Romo Chiropractic, Inc.
Or office listed below or any other office or clinic.

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 other procedures. I understand that results are not guaranteed.

I 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

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) f) or which I seek treatment.

If you have any questions concerning the above, please ask doctor or staff of Romo Chiropractic. When you have full understanding and consent to have cared provided, please print your name and sign and date below.

I certify that I'm the patient or legal guardian and have carefully read the above; I hereby give my informed consent to treatment administered at Romo Chiropractic.

Patient's Name: _____ **Age:** _____

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

Legal Guardian's Signature: _____

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Financial Policy Part I of II

Name: _____ Date of Birth: _____

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are **considered a cash patient** until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier. (Exceptions may be made for family plans)

Fee Disclosure for Chiropractic Manipulation

1-2 Spinal Regions	$ 45.00	5+ Spinal Regions	$ 85.00
3-4 Spinal Regions	$ 65.00	Extremity	$ 35.00

Fee Disclosure for Therapeutic Procedures

Electrical Stimulation	$ 35.00	Cox Distraction / Flexion	$ 50.00
Traction – Mechanical	$ 35.00	Manual Therapy	$ 50.00
Cryotherapy	$ 20.00	Spinal Decompression	$ 50.00
Moist Heat Therapy	$ 20.00	Exercise 15 minutes or less	$ 50.00
Massage 30 minutes	$ 40.00	Massage 60 minutes	$ 70.00

If You Have Insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated.
MEDICARE - We do not accept Medicare

HEALTH / GROUP INSURANCE - As a courtesy we will call to get "**quoted benefit**" from your insurance company. This is not a guarantee of benefits or payment.

PERSONAL INJURY - As a courtesy we will call to get "**quoted benefit**" from your insurance company. This is not a guarantee of benefits or payment. If you are covered by personal injury insurance you must have a **signed lien** on file in our office prior to receiving treatment.

ATTORNEY - If represented by an attorney you must have a **signed lien** on file at the office.

THIRD PART CLAIMS - You are responsible for full payment to Romo Chiropractic, Inc. when you receive your settlement from the insurance company.

COURTESY BILLING - we will file claims with your insurance and will not be involved in any disputes between you and your insurance company regarding **deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc**., other than to supply factual information as necessary

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Financial Policy Part I of II

CONTRACT – the insurance contract is between **you** and **your insurance company** and we are **NOT** a party to this contract. (We will inform you if we are a party to the contract, and will handle your claims according to our agreement with the insurance company, if one exists.)
I understand that I am required and responsible to pay for the **co-payments, patient portions** and **annual deductible** at the time of treatment. It is my responsibility for payment on my account regardless of any insurance coverage. If an **overpayment** occurs on my account, Romo Chiropractic, Inc. will refund the correct party.

If your carrier has not paid a claim within sixty **(60) days** of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety **(90) days** of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you **discontinue care** for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

If my account should go unpaid for over **30** days I agree to the late fees of **$35** per month and monthly interest of **1.5%** (not to exceed **18%** annually). Should legal action be necessary to collect the account I agree to pay the Attorney fees and Court costs incurred for collection.

BALANCE - over **30 days** old is also subject to late fees of **$25** per month & / or **1.75%** interest monthly (**21%** annually), whatever is the greater to be added monthly until balance is paid in full. Any balance over 90 days will be forwarded to collection agency

I understand that if I have a **balance for medical services** not paid, I will make a minimum payment of **$75.00** each month or **25%** of the outstanding balance whichever is greater.

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility before you receive your care.

I have read the above codes and fee's and understands the cost of my care at Romo Chiropractic, Inc. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case.

I certify that I'm the patient or legal guardian and understand that **my signature** below confirms that the above **office policy & Fee Disclosure Statement** has been read and explained to me. I further acknowledge, understand and accept my responsibilities set forth.

Our payment plans make care an affordable part of your family budget.

Patient's Name: _____ **Age:** _____

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

Legal Guardian's Signature: _____