Olivieri Chiropractic inc.

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New Patient Information

Full Legal Name _____ Nick Name _____
Address _____ City _____ St ____ Zip _____
Date of Birth _____Driver's License # _____SSN _____
Sex: M❒ F❒ Marital Status: Married❒ Single❒ Divorced❒
Email Address _____May we send you our e-mail newsletter? Yes❒ No❒
Home Phone _____ Work _____
Cell _____ Fax _____
How were you referred to our office? _____
Occupation _____ Full Time❒ Part Time❒
Employer _____
Employer's Address _____
Spouse Name _____ Number of Children- Boys _____ Girls_____
Insurance Carrier _____ Subscriber ID # _____
Subscriber's Name _____ ❒ (check here if same as Patient)
Subscriber's Date of Birth _____
What is the reason for your visit today? _____
_____
When did this condition start? _____ Is this the first time? Yes❒ No❒
If no, when was the first time? _____ Height_____ Weight_____
Is this a problem related to work or an auto accident? Yes❒ No❒
If yes, please explain: _____
_____
What other problems/complaints have you had in the past? (please describe in detail) _____
_____
_____
Describe all past illnesses, surgeries and/or accidents and dates: _____
_____
Have you been treated by any other doctor? Yes❒ No❒ If yes, who/where/why?
_____
Have you ever been under the care of a Chiropractor before today? Yes❒ No ❒
If yes, why? _____
Who/Where was your previous Chiropractor? _____
Last Adjustment _____ Were you satisfied with him/her? Yes❒ No❒
If No, why? _____
Has anyone in your family died from anything other than old age? Yes❒ No❒
If yes, give name, age, condition & relationship _____
What illnesses and what physical and/or mental impairments do any of your relatives suffer from? Please give name, age, illness/impairment and relationship: _____
_____
Please list all activities that you can not do as a result of your condition: _____
_____
List the vitamins/medications you are taking: _____
Do you smoke? Yes❒ No❒ If yes, how long? _____
Describe your exercise habits _____
Women – Are you pregnant? Yes❒ No❒ If yes, Due Date: _____
Water intake _____ Typical Diet _____
Hours of sleep per night _____ Quality of sleep _____
Are you interested in finding out your body fat %? _____ Are you interested in info on our weight loss program?_____

I agree that I am responsible for all fees charged by this office. I authorize release of this information to my insurance carrier. I authorize payment directly to this doctor's office. I authorize a copy of this authorization to be used in place of an original.

Today's Date: _____ Signature: _____

Privacy Confidentiality Statement

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of Information
We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with Worker's Compensation and Public Health Laws as well as Judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

Appointment Reminder
It is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home we leave a message on your voice mail or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternate contact number please inform us the number you would prefer.

Facility Set Up
While our examination rooms are private, our office utilizes an open adjustment/therapy/exercise/rehabilitation setting. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed, please request to have such discussions in a private room.

Your Rights

- Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or hospitals.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment of health care operations, or the law otherwise restricts the accounting.
- You have the right to inspect and have a copy of your health information. There is no cost for the first copy and any copy thereafter is $25.
- You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement you will be provided with information about our denial of your amendment and how you may appeal the denial amendment.
- You have the right to a copy of the notice upon request.

Complaints
Complaints about your privacy rights or how your privacy is handled at this office can be directed to J.R. Privacy by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201

I have read this Privacy Notice and understand my rights contained in this notice.
By signing this form I provide authorization and consent to use and disclose my protected information as noted above.

Patient Signature (or legal guardian)_____

Print Patient Name_____ Date_____

Informed Consent to Chiropractic Care

Tara Olivieri D.C.
250 Newport Center Drive, Suite 102
Newport Beach, CA 92660

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 doctor of chiropractic named above and/or other licensed doctors of chiropractic 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 above, including those working at the clinic or office listed above.

I will have the opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.

I understand 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, sprains, and burns. 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 procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

I have read, or had it read to me the above consent. I have also had the 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.

Patient Signature (or legal guardian)_____

Print Patient Name_____ Date_____

To be completed by Doctor or Staff:

Witness to Patient's Signature_____ Date_____

Olivieri Chiropractic inc.

Patient Name: _____ Date: _____

Patient Guide to Scheduling Appointments

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your health and well-being and recovery of your optimal health is something everyone in our office takes quite seriously.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your healing process. Therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Please write down the dates and times of your future appointments or put them into your smart phone. We also provide a calendar with your appointment dates circled. It is vitally important that you complete all of the scheduled appointments before the date of your re-examination. Changing your re-examination date is against office policy and will delay in your healing and recovery.

Listed below are the policies regarding all appointments:

1. **No-Show:** This occurs when a patient is scheduled for an appointment and does not call or text to cancel or reschedule and does not show up for their appointment. This will result in an out of pocket no show fee of: **$45**, **$80** or **$110** for Massage Therapy and **$25** for a Chiropractic. (**Initial**) _____

2. **Without 24-Hour Notice**: This occurs when a patient is scheduled for an appointment and a call or text is made to cancel but does not give the office more than 24-hours notice in advance. The cancellation fee is **$45**, **$80** or **$110** for Massage Therapy. Chiropractic patients can re-schedule their appointment within one week without the assessed fee. (**Initial**) _____

3. **With 24-Hour Notice**: There is no fee assessed for Chiropractic and Massage Therapy appointments cancelled with more than 24-hours notice. We understand that things can happen, however, we would ask that patients do everything in their power to make up cancelled appointments in order to get the best results on their current treatment plan. All patients are encouraged to re-schedule their cancelled appointments within one week. (**Initial**) _____

In instances of repeated non-compliance with scheduled visits, we also reserve the right to discontinue care. This type of behavior is disruptive, time consuming, and takes valued treatment time away from other patients, the doctors, therapists, and receptionist.

A confirmation call or text is made the day before each patient's appointment. This is a courtesy service, meant to remind patients of their appointment times. However, failure to receive a call or text does *not* validate a missed appointment, and the appropriate fee will be assessed.

By signing and initialing above, I have read and understand this guide: _____

Signature