KAREN A. COSCOLLUELA, DC
13949 Ventura Blvd., Ste 215, Sherman Oaks, CA 91423
Phone: 818-725-6042 Web: www.drkarenchiro.com

Please fill out the following form in as much detail as possible. Please know that all information will be kept confidential.

Patient Information

Patient name _____

Today's date _____Age:____ Date of birth _____

Social Security # _____

Address _____

City _____

State _____ Zip _____

Gender: ❑ Male ❑ Female Height _____ Weight _____

❑ Single ❑ Married ❑ Partnered ❑ Engaged

❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

Have you ever seen a chiropractor before? ___Yes ___No

When was your last adjustment? _____

How many children do you have? _____

Please list any family members being treated here _____

_____

Occupation _____

Employer/School _____

Employer/School address _____

_____

Employer/School phone number (_____) _____

Spouse's/Partner's name _____

Spouse's/Partner's employer _____

Who referred you? _____

Will you be using health insurance? ___ Yes ___ No

Insurance Provider_____

Insurance ID_____Group No._____

Contact Information

Home phone (_____) _____

Cell phone (_____) _____

E-mail address_____

May we contact you via (please check for all applicable):

❑ Home phone ❑ Cell ❑ Work phone ❑ Email

In case of emergency please contact:

Name _____

Relationship _____

Home phone (_____) _____

Work/Other phone (_____) _____

Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, on me (or on the patient named on this form for whom I am legally responsible) by the Doctor of Chiropractic named below.

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 the chiropractic adjustment and other procedures. I understand that the 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. Risks include, but are 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 be able to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, and is in my best interests.

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.

Treating Doctor: Karen A. Coscolluela, DC

Signature:_____

Date:_____

Patient Condition

(***Please fill out the following form in as much detail as possible. Please know that all information will be kept confidential***)

What is your major complaint *(be as specific as possible)*_____

When did your condition/symptoms/pain first appear? *(specific date, days ago, weeks ago, etc)* _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Since the onset of your problem is it: ❑ Getting worse ❑ Staying the same ❑ Slow to improve

When is it worse? ❑ Morning ❑ Afternoon ❑ Evening ❑ All the time

Does it interfere with: ❑ Work ❑ Sleep ❑ Daily routines Other _____

How long has it been since you really felt good? _____

Other doctors seen for this condition: ❑ MD ❑ DC ❑ DO ❑ DDS ❑ Other_____

Is your condition accident related? ❑ Yes ❑ No If so, was the accident related to: ❑ Work ❑ Auto ❑ Other:_____

Date of accident: _____/_____/_____ Location:_____

Do you have an attorney advising you? ❑ Yes ❑ No If so, which attorney/firm:_____

Does the condition/symptom/pain radiate? ❑ Yes ❑ No

If yes, where and how frequently _____

How long/often does the radiation occur/last? _____

Do you have: ❑ Numbness ❑ Tingling ❑ Weakness

Describe _____

List and mark the severity of your condition/symptoms/pain on the scales below:

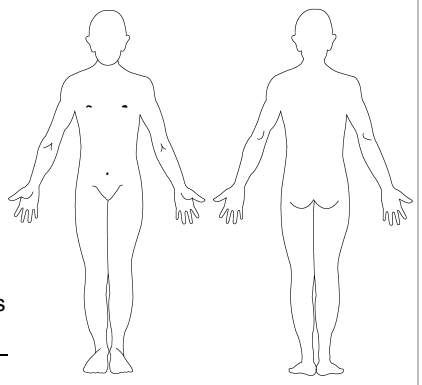
Body part _____ _____

0 (None) 5 (Severe) 10

Body part _____ _____

0 (None) 5 (Severe) 10

Mark all areas on the picture where your condition, symptoms, and/or pain occur.



Type of Pain: ❑ sharp ❑ dull ❑ aching ❑ throbbing ❑ numbness ❑ shooting ❑ burning ❑ tingling ❑ Other _____

What activities or positions aggravate your condition?

❑ bending ❑ coughing ❑ getting up/down ❑ driving ❑ lifting ❑ lying down ❑ reaching ❑ sitting ❑ sneezing ❑ standing ❑ straining at stool ❑ turning head ❑ twisting ❑ walking Other _____

What activities or positions relieve your condition?

❑ heat ❑ ice ❑ lying down ❑ medication ❑ sitting ❑ standing ❑ stretching Other _____

Have you ever had this condition before? ❑ Yes ❑ No If yes, when? _____

Were you treated for this condition or a similar one before? ❑ Yes ❑ No If yes, when/by whom? _____

Health History

Do you have any allergies? (food, contact, environment) _____

List any prescribed medications, over the counter medications, vitamins, herbs, and supplements _____

When was your last: Physical examination? _____ Blood/lab work? _____ X-ray study? _____

Injuries/Fractures (i.e. broken bones) you have had and when?_____

Surgeries you've had and when? _____

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below.***

Anxiety	❑ Yes	❑ No	Cushing's disease	❑ Yes	❑ No	Knee surgery	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Cystic medial necrosis	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Depression	❑ Yes	❑ No	Marfan syndrome	❑ Yes	❑ No
Bleeding disorder	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Multiple sclerosis	❑ Yes	❑ No
Blurred vision	❑ Yes	❑ No	Digestive/Bowel problems	❑ Yes	❑ No	Osteoporosis/penia	❑ Yes	❑ No
Bowel/Bladder problems	❑ Yes	❑ No	Dizziness or vertigo	❑ Yes	❑ No	Parkinson's disease	❑ Yes	❑ No
Buzzing in ears	❑ Yes	❑ No	Fibromuscular dysplasia	❑ Yes	❑ No	Prosthesis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Fibromyalgia	❑ Yes	❑ No	Rotator cuff problem	❑ Yes	❑ No
Carpal tunnel	❑ Yes	❑ No	Fusions (spinal, joint, etc)	❑ Yes	❑ No	STI/STD	❑ Yes	❑ No
Celiac disease (gluten)	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Shoulder surgery	❑ Yes	❑ No
Chest pains	❑ Yes	❑ No	Heart disease	❑ Yes	❑ No	Spinal surgery	❑ Yes	❑ No
Chronic fatigue	❑ Yes	❑ No	Hepatitis (A, B, C, etc)	❑ Yes	❑ No	Stroke/TIA	❑ Yes	❑ No
Cold hands or feet	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Thyroid problems	❑ Yes	❑ No
Colitis/Diverticulitis	❑ Yes	❑ No	High blood pressure	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Compression fractures	❑ Yes	❑ No	Hip replacement	❑ Yes	❑ No	Concussions	❑ Yes	❑ No
Connective tissue issues	❑ Yes	❑ No	HIV/AIDS	❑ Yes	❑ No	Other _____		
COPD (bronchitis/emphy)	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No	Other _____		

Are there any conditions that run in your family? ❑ Yes ❑ No If yes, what condition(s) and which family members? _____

_____

For Women Only

Do you currently or have you ever used birth control? ❑ Yes ❑ No If yes, what brand(s), dosage, when, and for how long?

_____

Do you currently or have you ever taken hormone replacement medication? ❑ Yes ❑ No If yes, what brand(s), dosage, when, and for how long? _____

Are you currently pregnant, or do you think you may be pregnant? ❑ Yes ❑ No If yes, for how many weeks? _____

Personal and Social Health History

How many hours per week do you typically work/attend school? ❑ <20 hrs ❑ 20 hrs ❑ 30 hrs ❑ 40 hrs ❑ 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc)? _____

Do you exercise? ❑ Yes ❑ No If yes, how often and what type? _____

_____

How would you rate your eating habits? ❑ Excellent ❑ Pretty good ❑ Could be better ❑ Needs improvement

Do you follow a specific nutritional program? ❑ Yes ❑ No If yes, what type? _____

Would you like help with your diet or have a nutritional program developed for you? ❑ Yes ❑ No

Habits? ❑ Tobacco: Packs/Day _____ ❑ Alcohol: Drinks/Week _____ ❑ Caffeine: Cups/Ounces/Day _____

Other habits? _____

How well do you sleep? ❑ Excellent ❑ Pretty good ❑ Restless ❑ Can't Sleep How many hours do you sleep daily? ____

Do you feel well rested in the morning? ❑ Yes ❑ No How is your energy overall? ❑ Full power ❑ Ok ❑ Low

❑ Generally fatigued How do you feel your immune system is? ❑ Strong ❑ Ok ❑ Low

In your own words, what do you think chiropractors do? _____

What do you hope to receive from our program? _____

Other than the current condition(s) for which you are here today, are there any other conditions that you have that you would like to have checked by the doctor? ❑ Yes ❑ No If yes, describe? _____

Please add any comments here _____

_____

Under penalty of perjury, I attest that my answers to the above questions are complete and true:

Signature:_____ ***Date:***_____

Karen A. Coscolluela, DC
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FINANCIAL POLICY

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.

1. 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.

2. 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. 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.

Our fees are considered usual, customary and reasonable by most companies and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of are in this area. If you 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.

Signature: _____ Date: _____

Print name: _____

Karen A. Coscolluela, DC
13949 Ventura Blvd., Ste 215, Sherman Oaks, CA 91423 Phone: 818-725-6042

Non-Covered Services Waiver

We may use additional modalities or therapy devices in conjunction with your chiropractic manipulations/adjustments that are deemed to be non-covered services by health insurance companies. These services are not billable through insurance and as a result, as in many offices and practices, come at an additional cost for each individual office visit. It is our goal to keep your health and well-being as affordable as possible. **The non-covered services fee is $30.00 per office visit regardless of the number of additional modalities/ devices used during the office visit.**

Non-Covered Services and Fee:

Physiotherapy Modalities (aka *Elements* modalities)

- Low Level Laser Therapy (LLLT), Kinesiology Taping, Compression Therapy, Neurosage, PEMF Therapy, Vibration/Percussion therapy etc.

Patient Agreement

I understand that the services and treatments above are not a covered benefit by my insurance company. By signing this waiver, I agree that I am informed of the $30.00 charge and will be responsible to self-pay for the aforementioned services. I am aware that I may request a super bill for the charges, in an attempt to seek reimbursement from my insurance personally.

_____
Print Name

_____ _____
Signature Date

KAREN A. COSCOLLUELA, DC
Doctor of Chiropractic

Notice of Cancellation / No-Show Policy

We ensure that anyone with a scheduled appointment will be seen in a timely manner. **Please note that there will be a $35 fee for late cancellations (i.e. less than 24 hours notice and/or late arrival of beyond 15 minutes resulting in rescheduling of the appointment) and no-shows (failing to arrive to the appointment).** It is our goal to provide you the best care during your appointment time.

Thank you for understanding.

I hereby authorize and and understand these terms and conditions.

_____

Name (Printed)

_____ _____

Signature Date

KAREN A. COSCOLLUELA, DC

13949 Ventura Blvd., Ste 215, Sherman Oaks, CA 91423
Phone: 818-725-6042 Fax: 818-285-4244 DrKCchiro@gmail.com

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to accessand control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician’s practice.
Following are examples of the types of uses and disclosures of your protected health information that your physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider(e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.
We will share your protected health information with third party “business associates” that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable
federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.
Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: 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 health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.
You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement(as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact your doctor if you have any other questions about privacy practices.

_____

Print Name

_____

Signature

_____

Date