HANDS OF HEALTH
—CHIROPRACTIC—

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Office (760) 995-4500 Fax (760) 995-4501
www.handsofhealthchiro.com
Dr. Anna Yatsenko, D.C. Dr. Lesley Vance, D.C. Dr. Melissa Vega, D.C.

About You

Name _____

Address (Mailing) _____

City _____ State _____ Zip _____

Cell Phone # _____

Provider _____

Alt Phone # _____

Email _____

Birthdate _____

Age _____ Social Security # _____

Occupation _____

Employer _____

Work Address _____

City _____ State _____ Zip _____

Work Phone _____

Your Family

Marital Status [ ] Married [ ] Single [ ] Divorced

[ ] Separated [ ] Widowed

Number of Children _____

Medications and Surgeries

Please list the year and type of surgery:

_____ _____

_____ _____

_____ _____

Medications you know take:

[ ] Tranquilizers [ ] Stimulants [ ] Insulin

[ ] Pain Killers [ ] Blood Thinners

[ ] Muscle Relaxers [ ] Cholesterol Medicine

[ ] Blood Pressure Medicine

Reason for Visit

Whom may we thank for referring you to our office?

(Circle one) Internet, Friend, Website, Other

_____

Describe the purpose of this visit

_____

The purpose of this visit is related to:

[ ] Work [ ] Sports [ ] Auto [ ] Home Injury

[ ] Chronic Discomfort [ ] Other

Please explain

_____

If work related, have you notified your employer in writing? [ ] Yes [ ] No

When did this condition start?

_____

Has this condition:

[ ] gotten worse [ ] stayed consistent

[ ] comes and goes

This condition interferes with:

[ ] Work [ ] Sleep [ ] Daily Activities [ ] Other

Explain

Has this condition occurred before?

[ ] Yes [ ] No

Explain

Who is your primary care physician?

_____

Office Name _____

Can we contact your PCP? [ ] Yes [ ] No

Have you seen your doctor for this condition?

[ ] Yes [ ] No

Health Conditions

[ ] Headaches	[ ] Heart Defect	[ ] Joint Pain	[ ] Sinus Problems
[ ] Heart Surgery/Pacemaker	[ ] Kidney Problems	[ ] Dizziness	[ ] Insomnia
[ ] Pain in the Shoulders	[ ] High/Low Blood Pressure	[ ] Cancer	[ ] Posture Problems
[ ] Heart Murmur	[ ] Frequent Neck Pain	[ ] Anemia	[ ] Autoimmune Problems
[ ] Numbness/Pain in the arm	[ ] COPD	[ ] Hepatitis	[ ] Psychiatric Problems
[ ] Low Back Problems	[ ] Alcohol/Drug Abuse	[ ] Arthritis	[ ] Thyroid Problems
[ ] Heart Attack/Stroke	[ ] Digestive Problems	[ ] Asthma	[ ] STD
[ ] Ulcers/Colitis	[ ] Allergies	[ ] Diabetes	[ ] Tuberculosis
[ ] _____	[ ] _____	[ ] _____	[ ] _____

Women Only

Are you pregnant? [ ] Yes [ ] No

Are you trying to get pregnant? [ ] Yes [ ] No

Are you nursing? [ ] Yes [ ] No

Are you taking birth control? [ ] Yes [ ] No

Do you have painful periods? [ ] Yes [ ] No

Do you have irregular cycles? [ ] Yes [ ] No

Do you have breast implants? [ ] Yes [ ] No

In an Emergency Contact

Name Relationship

Cell Phone Alternate Phone

Insurance

Do you have insurance?

Insurance Company _____ Id# _____

Insured Name _____ Relationship to Insured _____

D.O.B. of Insured _____

NOTICE: Our initial examination fee is $39.

Authorization for Care

I hereby authorize the Doctor to alleviate my condition through the use of chiropractic adjustments to my spine and/or extremities as he or she deems appropriate.

I clearly understand and agree that all services performed as part of my care are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I understand that if I pause or end my care, any fees for professional services performed or products purchased will become immediately due and payable. I also authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services performed

_____ _____ _____ _____

Patient's Signature Date Parent or Guardian's Signature (If Applicable) Date

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—CHIROPRACTIC—

Patient Name: _____

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 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 procedure which the doctor feels at the time, based upon the facts known is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatments options include, but not limited to, self-administered, over-the-counter analgesics and rest, medical care with prescription drugs such as anti-inflammatory, 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 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.

HIPAA

(Health Insurance Portability Accountability Act)

This is in regards to your right as a patient and the confidentiality of your medical information. We here at Hands of Health Chiropractic are in compliance to the laws of HIPPA and as it pertains to you as our patient. If you are not familiar with your rights and wish to have a copy please inform this office and a copy will be provided.

_____(Initial) I hereby AUTHORIZE Dr. Anna Yatsenko and her associates/assistants to perform chiropractic treatments of their choice and provide additional procedure(s) as they deem reasonable and necessary including, but not limited to x-rays/ therapy.

_____(Initial) I hereby affirm and state that I am fully aware and/or been given a copy of my HIPPA rights. If I have any further questions or concerns I am to contact the privacy of this office.

Chiropractor's Name & Office: Anna Yatsenko D.C. / D.C Lesley Vance /Melissa Vega/Hands of Health Chiropractic

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Signature (Patient, or Parent/Guardian of Patient) **Date**

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Patient Name: _____

Standard Waiver of Liability

I understand I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Hands of Health Chiropractic for review for medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visits may be denied and this may be beyond the office's ability to notify me prior to rendering acute care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

Note: Our office does not bill secondary insurance carriers.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the costs and disbursements of the action.

Assignment of Benefits

- I hereby authorize my insurance benefits to be paid directly to Dr. Anna Yatsenko/ Hands of Health Chiropractic
- I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

_____

Signature (Patient, or Parent/Guardian of Patient) **Date**

Release of Medical Records

I give my permission to Dr. Anna Yatsenko and/or her associates to request medical information from other medical facilities that may help the doctor to accurately assess and treat my current condition.

_____

Signature (Patient, or Parent/Guardian of Patient) **Date**

Patient Photo and Testimonial Release Information

I authorize Dr. Anna Yatsenko & Dr. Lesley Vance, D.C. to use my previous expressed comments and or testimonial for advertisement and/or public review. This is including, but not limited to newspaper, patient newsletters, websites, internet, Facebook, YouTube, Instagram, social media, and/or mailings, etc.

My statements are given freely and without any coercion or incentive. I agree to allow editing as needed for adaptation to different Medias.

I understand that I may revoke my permission to use my personal health information at anytime and will notify Dr. Anna Yatsenko & Dr. Lesley Vance, D.C. in writing.

My statements are given freely and without any coercion or incentive. I agree to allow editing as needed for adaptation to different Medias.

Name (Print): _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Option for Emails

(Please Check One)

_____ I **opt-in** for Dr. Anna Yatsenko & Dr. Lesley Vance, D.C., Hands of Health Chiropractic to use my email to keep me updated.

_____ I **opt-out** for Dr. Anna Yatsenko & Dr. Lesley Vance, D.C., Hands of Health Chiropractic to use my email to keep me updated.