



## New Client Forms

Please print and sign these forms before your first visit.



**Christopher Bruno, DC**  
 PO Box 3436  
 Redondo Beach, CA 90277  
 Office (310) 374-7482 • Fax (310) 372-2932

**Patient Introduction Form:**

Patient Name			Today's Date		
Address			Home Telephone		
-----			Cell Number		
City	State	Zip	Email Address		
Date of Birth		Age	Employer's Name		
Marital Status			Employer's Address		
Height		Weight	Driver's License:		State

Who referred you to the office? \_\_\_\_\_

Name, address, relationship and telephone number of emergency contact: \_\_\_\_\_

\_\_\_\_\_

**Is this visit related to:**

<input type="checkbox"/> Work-related injury	<input type="checkbox"/> Motorcycle or Bicycle injury	<input type="checkbox"/> No injury symptoms
<input type="checkbox"/> Sports or recreation related injury	<input type="checkbox"/> School or employment physical	<input type="checkbox"/> Check up
<input type="checkbox"/> Automobile collision injury	<input type="checkbox"/> Home Injury	<input type="checkbox"/> Other

Our office will provide insurance billing services for you, if you so desire, as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

In order to keep our office overhead down and keep our patient fees reasonable, we expect payment at the conclusion of each treatment for cash patients and the co-payments for regular insurance patients.

Signature of patient or parent \_\_\_\_\_ Date \_\_\_\_\_

# FINANCIAL AGREEMENT & HEALTH INSURANCE

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

## **Explanation of Insurance Coverage**

Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you.

## **Assignment of Benefits**

Attached is an "Assignment of Benefits" form, which we would like you to sign. This form directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full the assignment need not be signed and the payments will be sent directly to you from the insurance.

## **Release of Information**

If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

## **Benefit Amounts**

The benefit amount paid by the insurance company must meet the per visit minimum of \$ 95.00 (Excluding any mandatory co pay) The balance of any amount less than the per visit minimum will be charged to you at the time of visit unless other billing arrangements are made.

## **Voluntary Termination of Care**

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

## **Cancelled /Missed Appointment Policy**

One of the goals of this of this office is quality service. This limits the available number of appointments per day. We ask that you give a minimum of 24 hours notice for any missed or canceled appointments to allow time to fill the available appointment. If for any reason you are unable to give at least a 24-hour notice for a missed appointment, you agree to pay the missed appointment rate of \$55.00.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

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Signature

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Date

Dear Patient,

Every type of health care is associated with some risk of potential problem. This includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

## **INFORMED CONSENT TO CHIROPRACTIC TREATMENT**

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 below and/or other licensed doctors of chiropractic who now or in the future work at the clinic 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, though extremely rare 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 the doctors best interest. The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted). Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe Injury.

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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.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to 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 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.

**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, 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 or preceptorship 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.

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

**Office Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Adventure Chiropractic.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

### **Changes to this Notice of Privacy Practices**

This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

### **Complaints**

Complaints about your privacy rights, or how [Adventure Chiropractic] has handled your health information should be directed to Claim City by calling this office at 805-474-9053. If Michelle Villa is not available, you may make an appointment for a personal conference by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W. Room 509F HHH Building  
Washington, DC 20201

For additional information about your privacy, please visit: [www.hcfa.gov/medicaid/hipaa](http://www.hcfa.gov/medicaid/hipaa)

## **NOTICE OF PRIVACY PRACTICES**

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

Adventure Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of your Health Care Information**

Treatment We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

“It is our policy to provide a substitute health care provider, authorized by Adventure Chiropractic, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

### **Payment**

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.

### **Workers’ Compensation**

If applicable, we may disclose your health information as necessary to comply with state Workers’ Compensation Laws.

### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

### **Judicial and Administrative Proceedings.**

We may disclose your health information in the course of any administrative or judicial proceeding.

### **Law Enforcement.**

We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

### **Deceased Persons.**

We may disclose your health information to coroners or medical examiners.

**Organ Donation & Research**

Though highly unlikely or probable we must inform you that there may a need to release your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

**Public Safety**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public. Specialized Government Agencies. Z

We may disclose your health information for military, national security, prisoner and government benefits purposes

**Acknowledgement of Notice of Privacy Practices**

I have been presented with a copy of the Notice of Privacy Practices for the office of (Christopher Bruno DC), detailing how my information may be used and disclosed as permitted under federal and state law.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

**Patient:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_