LIV Integrative Health

Name: ________________________________ Date: ___________________

Address: _________________________ City: _______________ State: ____ Zip: ______

Date of Birth: _________ Age: ____ Email: ___________________________________

Cell Phone: ____________ Home Phone: ____________ Social Security #: ____________

Consent to receive text messages: □ Yes □ No Height: _________________

Consent to receive emails: □ Yes □ No Weight: _________________

Employer: _____________________ Occupation: ______________________

Marital Status: ____________ Spouse's Name: ___________________ # of Children: ____

Emergency Contact: _______________ Relationship: __________ Phone #: ____________

How did you hear about us? ____

Current Complaints

Nature of injury: □ Automobile □ Work □ Other

Have you ever had same condition: □ Yes □ No If yes, when? __________________

Have you ever been under chiropractic care? □ Yes □ No

Date of injury: _________________

Other practitioners seen for this injury/condition: ___________________________________

Please describe: ____

____

Insurance Information

Name of party responsible for payment: ___________________ Phone #: ______________

Health insurance company: ____________________ ID #: ________________________

By signing below, I declare the above information is true to the best of my knowledge.

Patient signature: __________________________ Date: ___________________

20201 SW Birch St Ste 100 Newport Beach CA 92660

www.LIVIH.com info@LIVIH.com Phone #949-274-7104 Fax #949-274-7644

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Medical History

Have you been treated for any conditions in the last year? □ Yes □ No

If yes, please describe: ____

____

What activities aggravate your symptoms? ________________________________

Allergies to medication: ____

What medications are you taking and for what conditions? ___________________

____

What vitamins, minerals or herbs do you currently take? ____________________

____

Pregnant? □ Yes □ No Have you had x-rays for this condition? □ Yes □ No

Please check any recent or chronic medical conditions:

□ Alcoholism
□ Allergies
□ Anemia
□ Arteriosclerosis
□ Arthritis
□ Asthma
□ Back pain
□ Breast lump
□ Bruise easily
□ Cancer
□ Chest pain/conditions
□ Cold extremities
□ Constipation
□ Cramps
□ Depression
□ Diabetes
□ Digestion problems
□ Dizziness
□ Ears ringing
□ Excessive menstruation
□ Eye pain/difficulties
□ Fatigue
□ Frequent urination
□ Headaches
□ Hepatitis C
□ High blood pressure
□ HIV
□ Hot flashes
□ Irregular heart beat
□ Irregular cycle
□ Kidney infection
□ Kidney stones
□ Loss of memory
□ Loss of balance
□ Loss of smell
□ Loss of taste
□ Neck pain/stiffness
□ Nervousness
□ Nosebleeds
□ Pacemaker
□ Polio
□ Poor posture
□ Sleep problems/insomnia
□ Spinal curvatures
□ Stroke
□ Swelling of ankles
□ Swollen joints
□ Thyroid condition
□ Vertigo
□ Ulcers
□ Other:

Have you ever:	Yes	No	Briefly explain
Broken bones?	□	□	____________________
Been hospitalized?	□	□	____________________
Been in an auto accident?	□	□	____________________
Had sprains and/or strains?	□	□	____________________
Been struck unconscious?	□	□	____________________
Had surgery?	□	□	____________________

LIV Integrative Health

Medical History Continued

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐

Habits

	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐

Family history

Please list present & past health conditions. (Examples: heart disease, cancer, diabetes, arthritis, etc)

Condition:	Relationship:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

By signing below, I declare the above information is true to the best of my knowledge.

Patient signature: ________________________________ Date: ______________________

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Informed Consent

I hereby consent to the performance of examination and treatment by the licensed Doctor of Chiropractic, medical doctors, physician's assistants, physical therapists, Pilates instructors, acupuncturists and/or licensed therapists who may be employed by or engaged in practice in this clinic.
Additionally, as is the case with most health care interventions, there is a certain inherent risk of complication associated with physical examination, physiotherapeutic, spinal manipulation procedures, home and in office exercises, use of medical equipment (in office and home use), Chinese herbal medicine and medications. These complications include but are not limited to muscle strains, dislocations, skin irritation, costovertebral sprains, bruising, electrical shock, fractures, disc trauma, minor burns, stroke and nerve injury. I understand my doctor will not be able to anticipate all potential complications, but elect to rely on his/her clinical expertise and judgment to determine reasonable courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time. I also hold LIV Integrative Health and its staff harmless for injuries caused by the use of durable medical equipment due to improper use or manufacture defects. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment based upon facts known that is in my best interests.
I have read and understand the preceding statements and hereby consent to voluntarily participate in treatment at LIV Integrative Health deemed appropriate by my doctor. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

Print Name: ______________________________

Signature: _______________________________ Date: ________________

Notice of Information Practices

Protecting the privacy of your personal health information is important to us. By signing below you understand how information about you may be used and disclosed and how you can get access to this information.
Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. The provision does not apply to the transfer of medical records for treatment.
You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable fee for photocopying, postage and preparation.
You may request changes to your records. Our practice has the right to accept or deny your request.
In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.
Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

Signature: _______________________________ Date: ________________

LIV Integrative Health

Financial Responsibility

I understand and agree that health insurances policies are an arrangement between an insurance carrier and myself. As a courtesy to you, LIV Integrative Health will call your insurance company to verify your benefits. We assume no liability for errors made by your insurance company in this quote. We will review the coverage with you. It is then your responsibility to pay any balance remaining after your insurance carrier has paid its portion of the bill. If you have a deductible that is not yet met, we will collect payment from you directly. Once your deductible has been met, we will collect your co-pay or co-insurance at the time of services.

Your insurance company may send insurance checks for your treatment directly to you, the patient, rather than to us, the provider. The amount of these checks is due to us in addition to any co-pay or co-insurance. Please ensure that this amount is promptly paid to us for services rendered.
If you do not pay the amount of the insurance checks issued within 6 months of the date of service, we will require payment in full whether or not you have received the insurance payments. If you refuse to pay your bill, we may initiate collections proceedings.

Whether or not my insurance company is billed for services rendered, I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable.

By signing below, I acknowledge that I understand and agree to the terms of the Financial Responsibility.

Print Name: ______________________________

Signature: _______________________________ Date: ________________

Assignment of Insurance Benefits / Authorization of Information

I instruct and direct my insurance company to pay LIV Integrative Health the professional and medical expense benefits allowable under my current insurance policy for services rendered. This is a direct assignment of my rights and benefits under this policy. I understand and agree that I am ultimately responsible for the balance on my account for any services rendered.

Signature: _______________________________ Date: ________________

LIV Integrative Health

Patient – Physician 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 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 California 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 the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator’s fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

Conclusion

I understand that I have the right to receive a copy of this agreement. By my signature, I also acknowledge that a copy which will be added to my medical record for review at any time.

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: ________________

Doctor’s/Doctor’s Representative Signature: ______________________ Date: ________________

LIV Integrative Health

Cancellation Policy

In order to serve all of our patients and provide the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

We realize circumstances occur and you may need to change an appointment. We ask that you notify us at least **24 hours** in advance for **all** appointments. If at least a 24-hour notification is not given for any appointment type, no-shows and cancellations will be charged $30.

The more notice you provide, the better we can serve all patients. If you reach our voicemail, please leave a voicemail or text and we will get back to you. Thank you in advance for your cooperation!

By signing below, I acknowledge that I understand and agree to the terms of the Cancellation Policy. I give LIV Integrative Health my consent to charge the credit card below in the amount of $30 if I do not abide by the cancellation policy.

Print Name: ______________________________

Signature: __________________________________ Date: _______________________

Credit Card Information:

Card Type: _______________

Credit Card #: ____

Expiration Date: _______________

Security Code: _______________