Deborah Sampair, D.C., B.A., A.C.N.
1925 Winchester Blvd., Suite 101, Campbell, CA 95008
(408) 371-0068 Office | (408) 871-0733 Fax
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Welcome

Thank you for choosing us to be your partner in creating and maintaining lifelong health and vitality! The doctor and staff of **Hands On Healing Chiropractic** welcome you and want to provide you with the best care possible. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will not accept you as a patient and can refer you to another health care provider, if appropriate.

Insurance

We require payment in full at the time of service and will provide a Super Bill to submit to your insurance company upon request. You are responsible for submitting it to your insurance company unless other arrangements are made. The amount of payment you receive from your insurance company is based upon your individual policy. In the event that your insurance company requires additional information, please let us know and we will be happy to provide available information.

Patient Information

_____
First, Last Name (Nickname)

_____
Street

_____
City, State and Zip

_____ _____ _____
Birth Date Height Weight

Male ( ) Female ( ) Identify As ( ) _____

Today's Date: _____

Cell # (_____)_____

Work # (_____)_____

Email _____

Occupation _____

Best Way to Contact: Email or Cell

How Did You Hear About Us? _____

Emergency Contact: _____

Relationship: _____ Phone # (_____)_____

Name of Parent of Minor Patient (If applicable)_____

Acceptance as Patient

I understand and agree that the doctors of Hands on Healing office have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Signature_____ **Date**_____

Revision 07/03/18

Personal Health History

Name _____ Date_____ Last Physical Exam_____

Many circumstances may interfere with your normal body function. Check the boxes that apply to you:

As an infant or child did you...

❑ Have any memorable accidents, falls, or other traumas?_____

As an adult did/do you...

❑ Smoke
❑ Drink alcohol
❑ Been in accidents
❑ Have teeth problems
❑ Exercise regularly
❑ Eat healthy foods
❑ Have eye problems
❑ Have ear problems
❑ Have physical stress
❑ Have hobbies/sports injuries
❑ Have sleeping problems/nightmares
❑ Have occupational or mental stress

Have you had surgery? _____ What? _____ When?_____

What medications are you taking now?_____

_____

What side effects have you experienced from the medications and/or surgery?_____

_____

What supplements, herb, nutraceuticals, botanicals, or vitamins are you taking?_____

_____

Current Health Condition

Present complaint(s) or reason(s) for your visit today:_____

_____

_____

Date pain or problem started _____ Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain?_____

Is condition worse during certain times of the day? _____ If so, when?_____

Is this condition interfering with: ❒ Work? ❒ Sleep? ❒ Routine? ❒ Other?_____

Is this condition getting progressively worse? _____

List other physicians seen for this condition:_____

Any home remedies used? _____

Other symptoms

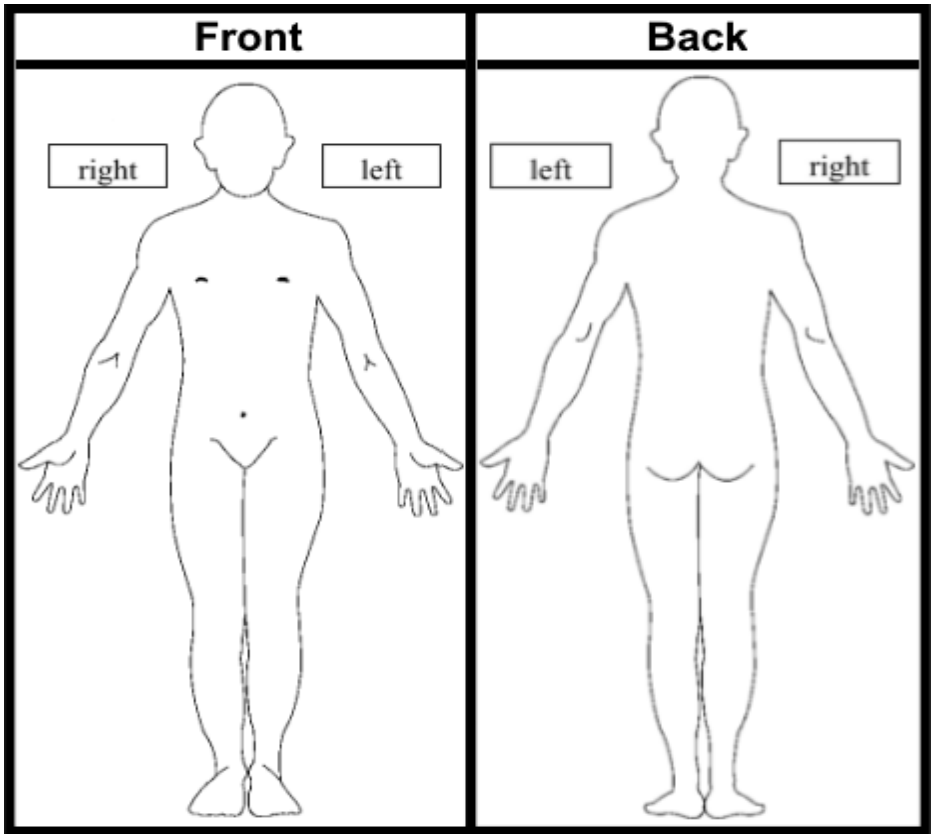
Prioritize symptoms numerically starting with 1 being most severe to least severe:

___ Headaches
___ Headache unlike any you've ever had before
___ Change in a mole or wart
___ Nagging cough or hoarseness
___ Ever been diagnosed with cancer
___ Change in bowel/bladder control
___ Numbness in fingers or toes
___ Numbness on one side of face or body
___ Stomach upset/digestive problems
___ A sore that doesn't heal
___ Night sweats
___ Nervousness
___ Pins & needles in legs
___ Pins & needles in arms
___ Shortness of breath
___ Chest pains
___ Depression
___ Light bothers eyes
___ Loss of memory
___ Coughing up blood
___ Sleeping problems
___ Face flushed
___ Tension
___ Irritability
___ Neck pain
___ Dizziness
___ Fatigue
___ Allergies
___ Stiff Neck
___ Back pain
___ Asthma
___ Fever
___ Ears ring or buzz
___ Fainting
___ Cold sweats
___ Loss of smell
___ Loss of taste
___ Diarrhea
___ Feet cold
___ Hands cold
___ Loss of balance
___ Constipation
___ Hormone issues

Mark the areas on these diagrams below where you feel PAIN or any UNUSUAL FEELING now.

Use the symbols below to mark areas of pain and discomfort if any.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /



Neck-Shoulder-Arm-Pain

Rate discomfort level you now feel

0 5 10
(no pain) (severe pain)

Mid-Back Pain

Rate discomfort level you now feel

0 5 10
(no pain) (severe pain)

Low Back and Leg Pain

Rate discomfort level you now feel

0 5 10
(no pain) (severe pain)

Upon the completion of this visit, you will receive a verbal report. During that report, we will let you know if further tests are needed to proceed with your chiropractic care.

What outcome would you like from this chiropractic care? (Mark all that apply)

- ❑ Feel better and be out of pain
- ❑ Have a healthier spine
- ❑ Improve my nutrition/diet
- ❑ Have a healthier body by keeping my nerve system healthy
- ❑ Feel younger and more energetic
- ❑ Prevent future problems

Patient Consent Form

Patient Name: _____

Read the entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before signing if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment this doctor uses as a Doctor of Chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you, the patient. The doctor may use hands and/or mechanical devices in such a way as to move your joints. That may cause an audible 'pop' or 'click', much like something you have experienced when you 'crack' your knuckles. You may feel a sense of movement. These are all normal.

Analysis/Examination/Treatment:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures, based on necessity, and necessity will be determined by your doctor.

Please initial each procedure you are consenting to receive:

_____ Spinal Adjustment	_____ Touch Skin/Spine/Joints	_____ Ultrasound
_____ Joint Movement Tests	_____ X-Ray Studies	_____ Vital Signs
_____ Muscle Strength Testing	_____ Hot/Cold Therapy	_____ Massage
_____ Orthopedic Testing	_____ Nutritional Advice/Counseling	_____ Hair Analysis
_____ Basic Neurological Testing	_____ Blood/Urinalysis Tests	
_____ Posture Analysis	_____ Muscle Stimulation with Electricity	

The material risks inherent in chiropractic adjustment:

Although spinal adjustments are considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, there are certain complications which may arise during chiropractic adjustment and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, or serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to her attention, it is your responsibility to inform her.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone, something for which the doctor will be checking for during your medical history, your examination, and the examination of your x-rays. Stroke has been the subject of tremendous disagreement. The most recent research shows that there is no relationship between a chiropractic adjustment of the neck and stroke occurrence. The incidences of stroke from a chiropractic adjustment are exceedingly rare and are estimated to occur between one in one million (same as the chance of Aspirin or Tylenol causing death) and one in ten million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you chose to use one or more of the above noted other treatment options, you should be aware that there are risks and benefits of such options and you should discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE BOX AND SIGN BELOW

☐I have read the above explanation of the chiropractic adjustment and related treatment risks.

By signing below, I am stating that I have weighed the risks involved in chiropractic treatment and have decided that it is in my best interest to undergo the treatment as recommended. I hereby give my consent to that treatment:

Print /Sign / Date:_____

Parent or Guardian Signature (If Minor) / Date: _____

Chiropractic Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: *An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.*

Health: *A state of optimal physical, mental and social well-being, not merely the absence of disease or symptoms.*

Vertebral Subluxation: *A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.*

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider who specializes in that area.

Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I have read and understand the above statements and accept chiropractic care on this basis.

Signature: _____ Date: _____

Office Fee Schedule and Financial Policy

Service	Fees
Initial Exam	$85 - $300
Periodic Dynamic Exam	$50 - $200
Spinal Adjustments	$65 - $85
Extremity Adjustment	$25 - $45
Therapeutic/Rehabilitative Services	$15 - $90

Financial Policy and Chiropractic Active Life Plans
We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless previous arrangements have been made. We offer different options designed to be the most cost effective way to keep you and your family as healthy as possible. They include Corrective Care, Relief Care or Health Incentive Care Plans. You may also prepay for visits to save money. Details of these plans will be discussed with you during your chiropractic report. Please choose one of the following documentation options:

- **Insurance:** If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed quickly. This includes your diagnosis, prognosis and copies of your records or reports. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send your receipts with a copy of your claim form to your insurance company, and they will communicate with you about your reimbursement. Remember your agreement with your insurance company is between you and them. Please note that insurance may not be used for Health Care Plans or prepaid visits.

- **No Insurance:** If you do not have health insurance, choose not to use your health insurance or are participating in a Health Care Plan, you will be given a receipt for tax purposes or a health savings account indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident, you will be charged our fee's until the claim is settled. We will help you get reimbursed as quickly as possible on these claims.

I, _____ have read and I understand the above policies. I have initialed the receipt option, (above) that applies to me.

Signature:_____Date:_____

Cancellation & Reschedule Policy

You are required to give a minimum of 24 hour notice to cancel or reschedule your appointment.

If notification is not received in a timely manner or you simply fail to show, you are then responsible for the full cost for your scheduled visit.
(Example: adjustment $75 + DMT $55 = $130)

Note: Cancellation/Reschedule fees cannot be deducted from a prepaid package or plan.

I have read and understand the above policy and agree to the terms.

Signature: _____Date_____

Thank you for your consideration!

Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

**********For Office Use Only**********

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices however, acknowledgement could not be obtained due to the following:

- ❏ Individual's refusal to sign
- ❏ Communication barriers prohibited obtaining acknowledgement
- ❏ Other (Specify)

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PATIENT COPY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this Notice about our privacy practices, and our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect 4/13/03.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed in this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for care, payment and healthcare operations. For example:

Health Care

We may use or disclose your health information to a physician or other healthcare provider providing care to you.

Payment

We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations

We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

In addition to our use of your health information for your care, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends

We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care

We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written authorization.

Required by Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we can reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address in this Notice. If you request copies, we will charge you $0.50 cents for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means, or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the Privacy Officer or with the Office for Civil Rights.

Privacy Officer: James Sampair
Telephone: (408) 371-0068 Fax: (408) 871-0733
Address: 1925 WINCHESTER BLVD. STE. 101, CAMPBELL, CA 95008

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

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Office Hours

Monday:	9:00 - 1:00	3:00 - 6:30
Tuesday:	9:00 - 1:00	3:00 - 6:30
Wednesday:	9:00 - 1:00	3:00 - 6:30
Thursday:	9:00 - 1:00	3:00 - 6:30
Friday:	9:00 - 1:00	
Saturday:	9:00 - 1:00 (1st & 3rd of the Month)	
Sunday:	Closed	

Call to schedule appointments during business hours or leave message.
If you have medical emergency, please call 911.

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