Olivieri Chiropractic inc.

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Newport Beach, CA 92660
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New Patient Information

Full Legal Name _____ Nick Name _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Driver's License # _____SSN _____
Mobile # _____Email: _____
Occupation _____ Full Time ❒ Part Time ❒
Employer _____ Address _____
Insurance Carrier _____Subscriber ID # _____
Subscriber's Name (if different from above) _____Subscriber's Date of Birth _____
Sex: M❒ F❒ Marital Status: Single ❒ Married ❒ Separated ❒ Divorced ❒ Widow ❒ Widower ❒
Spouse's Name _____ Spouse's Date of Birth _____
Children: # of Boys_____ Ages _____ # of Girls_____ Ages _____
Women- Are you pregnant? Yes❒ No❒ # of weeks: _____ Due Date: _____ Baby's Gender _____
How were you referred to our office? _____
Reason for your visit today? _____
When did this condition start? _____ Is this the first time? Yes❒ No❒
If no, when was the first time? _____
Please list all activities that you cannot do as a result of your condition: _____
_____
Is this a problem related to work or an auto accident? Yes❒ No❒ If yes, please explain: _____
_____
What other problems/complaints have you had in the past? _____
Describe all past illnesses, surgeries and/or accidents and dates: _____
_____
Have you been treated by any other doctor for this? Yes❒ No❒ If yes, who/where/why?
_____
Have you ever seen another Chiropractor? Yes❒ No ❒ If yes, why? _____
_____
Who/Where was your previous Chiropractor? _____
When was your last adjustment? _____Were you satisfied with him/her? Yes❒ No❒ If no, why? _____
Has anyone in your family died from anything other than old age? Yes❒ No❒
If yes, give name, age, condition & relationship _____
What illnesses and what physical and/or mental impairments do any of your relatives suffer from? Please give name, age, illness/impairment and relationship: _____
_____
List the vitamins/medications you are taking: _____
Covid Vaccine? (optional): Yes❒ No❒ Type: _____ Date(s): _____
Do you smoke? Yes❒ No❒ If yes, how long? _____Describe your exercise habits _____
Water intake _____Typical Diet _____Height_____ Weight_____
Hours of sleep per night _____ Quality of sleep _____

I agree that I am responsible for all fees charged by this office. I authorize release of this information to my insurance carrier. I authorize payment directly to this doctor's office. I authorize a copy of this authorization to be used in place of an original.

Today's Date: _____ Signature: _____

Privacy Confidentiality Statement

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.

Disclosure of Information
We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with Worker's Compensation and Public Health Laws as well as Judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

Appointment Reminder
It is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a message on your voice mail or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternate contact number, please inform us the number you would prefer.

Facility Set Up
While our examination rooms are private, our office utilizes an open adjustment/therapy/exercise/rehabilitation setting. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed, please request to have such discussions in a private room.

Your Rights

- Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or hospitals.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances, they may be prohibited by law.
- Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.
- Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment of health care operations, or the law otherwise restricts the accounting.
- You have the right to inspect and have a copy of your health information. There is no cost for the first copy and any copy thereafter is $25.
- You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement you will be provided with information about our denial of your amendment and how you may appeal the denial amendment.
- You have the right to a copy of the notice upon request.

Complaints
Complaints about your privacy rights or how your privacy is handled at this office can be directed to J.R. Privacy by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201

I have read this Privacy Notice and understand my rights contained in this notice.
By signing this form, I provide authorization and consent to use and disclose my protected information as noted above.

Patient Signature (or legal guardian) _____

Print Patient Name_____ Date_____

Informed Consent to Chiropractic Care

Tara Olivieri D.C.
250 Newport Center Drive, Suite 102
Newport Beach, CA 92660

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 above and/or other licensed doctors of chiropractic 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 above, including those working at the clinic or office listed above.

I will have the opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.

I understand 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, sprains, and burns. 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 on the facts then known, is in my best interest.

I have read, or had it read to me the above consent. I have also had the 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 Signature (or legal guardian) _____

Print Patient Name_____ Date_____

To be completed by Doctor or Staff:

Witness to Patient's Signature_____ Date_____