**Montellese Family Chiropractic & Pelvic Floor Rehabilitation**

NEW PATIENT INTAKE

Patient Name:_____ Today's Date:_____ Email:_____

Address_____ City_____ State_____ Zip_____

Telephone (Cell/home)_____ (work)_____ Birth Date_____ Last 4 SS#_____

Occupation_____ Employer_____ Marital Status_____

Spouse/Partner's name_____ Spouse/Partner's occupation_____

Emergency Contact_____ Phone_____ Number of children_____

Insurance Company_____ Primary insured name_____ Birth Date_____

Who can we thank for referring you to our office?_____

Please describe your main problem_____

When did it begin?_____ Is it getting better, worse, or staying the same (circle one)

**Did it start as a result of: (Circle) Auto Accident, Workers Comp, Other** _____

Describe activities that you cannot do because of the problem? _____

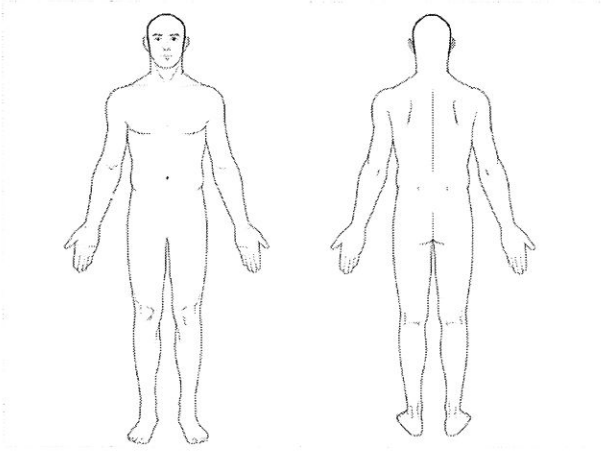
What makes it worse?_____ What relieves your problem?_____

Do your symptoms interfere with normal daily activities? Y / N Does it wake you at night? Y / N

How do you feel today (Circle): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (0 = No pain, 10 = Unbearable pain)

Circle and Label where your symptoms are located:

A=Ache, B=Burning, N=Numbness, P=Pins&Needles, S=Stabbing, O=Other



List all practitioners seen for this injury (MD, Chiropractor, Physical Therapy, etc.)_____

Have you ever experienced this condition before? Y / N When? _____

Have you had **SURGERY** for ***any*** condition in the past? Describe_____

Have you been **HOSPITALIZED** for ***any*** condition in the past? Describe_____

**Last Xray or MRI:** Of what body region _____

Have you seen: A Chiropractor for *any other* conditions? Y / N A Physical Therapist for *any other* conditions? Y / N

If yes, please explain _____

| | | | |
|---|---|---|---|
| Have you ever had:(circle) | Broken bones | Ear Aches | Numbness |
| Hospitalized_____ | Cancer _____ | Allergies | Pacemaker |
| Been in an Auto Accident | Chest pain | Shoulder Pain | Jaw pain |
| Diabetes | High blood pressure | Rib Pain | Constipation |
| Been struck unconscious | Stroke | Digestive problems | Bladder/bowel control |
| Loss of balance/Dizziness | Vertigo | Loss of taste | Pelvic / Groin pain |
| Surgeries_____ | Swelling of _____ _____ | Headaches | Incontinence (leakage) |
| Other_____ | Fever | Hernia | Diastasis Recti |

For Women:

Is there a chance that you are pregnant? Y / N If yes, do you have an OB or Midwife_____

Are you seeking care for a Pelvic Floor Dysfunction? Y / N If yes, please describe_____

**Please Read the DETAILED Laminated Forms attached with this packet. Sign and Date each line after reading.**

**Appointment and Cancellation Policy**. I, _____, have read and agree to the "No Show and Late Cancellation" policy at this office. I agree and understand this office policy that I may be charged $50.00 if I do not give 24 hours notice to cancel or reschedule. I may request a copy of this agreement to take home with me.

_____ _____

Patient Signature / Guardian Signature Date

**Financial Policy.** I, _____, have read and agree to the "Financial Policy" at this office. I agree and understand this office policy for Non-Insured, Medical Insurance, Medicare or Auto Insurance. I agree that I will be responsible for paying my bill if my insurance does not cover my treatments. I may request a copy of this agreement to take home with me.

_____ _____

Patient Signature / Guardian Signature Date

**Notice of Privacy Practices**. I, _____, have read and agree to the Privacy Notice and understand my rights contained in this notice. By my way of signature, I provide my Doctor with my authorization and consent to disclose my protected health care information for purposes of treatment, payment and healthcare operation as described in the Privacy Notice. I may request a copy of this agreement to take home with me.

_____ _____

Patient Signature / Guardian Signature Date

**MONTELLESE FAMILY CHIROPRACTIC, INC.**

**Dr. Christopher G. Montellese, D.C.**

**Dr. Kristina E. Montellese, D.C.**

**Dr. Dustin Nagai, D.C.**

## INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the Doctor of Chiropractic listed above and/or with other office or clinic personnel.

I further understand and am informed that, as in all health care, in the practice of Chiropractic, there are risks to treatment, including, but not limited to the following:

*While rare, some patients have experienced rib fractures or muscle and ligament sprain or strains following spinal adjustments;

*There have been reported cases of injury to vertebral artery following cervical spinal adjustments. Vertebral artery injury have been known to cause stroke, sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of injuries resulting from cervical spinal adjustment is extremely remote;

*There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment;

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 the procedure which the Doctor feels at the time, based upon the facts then known, and is in my best interest. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches, and other similar symptoms. Chiropractic care contributes to your overall wellbeing.

**The risk of injuries or complications from Chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.**

I acknowledge I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of Chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the Chiropractic treatment offered or recommended to me by my Chiropractor, including spinal adjustments. I intend this consent to apply to all my present and future Chiropractic care.

Date this _____ day of _____, 20___.

_____

Patient's Signature (or Parent/Guardian)

_____

Print Name

Montellese Family Chiropractic, Inc.
550 Camino El Estero, Suite 103
Monterey, CA 93940

# Electronic Health Records Intake Form

**Patient Name:**_____ **Gender:** Male / Female **Date of Birth:** _____

**Preferred method of communication** (Circle one): Email / Phone / Mail **Preferred language**: _____

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

| **Family Medical History** ***(Record one diagnosis in your family history and the affected*** | | | | |
|---|---|---|---|---|
| **Diagnosis (Write in below)** | Father | Mother | Sibling: (_____) | Offspring: (_____) |
| | | | | |
| | | | | |

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

| **Are you currently taking any medications?** *(Include regularly used over the counter medications)* | |
|---|---|
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
| | |
| | |
| | |

| **Are you currently taking any Supplements or Homeopathy?** | |
|---|---|
| Supplement Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
| | |
| | |
| | |

| **Do you have any medication allergies?** | | | |
|---|---|---|---|
| Medication Name | Reaction | Onset Date | Additional Comments |
| | | | |
| | | | |
| | | | |

☐ **Check here if you DO NOT want this form emailed to you after each visit. I choose to decline receipt of my clinical summary after every visit.**

Patient Signature: _____ Date: _____

***For office use only*** Height: _____ Weight: _____ Blood Pressure: _____ / _____

MONTELLESE FAMILY CHIROPRACTIC, INC.

**Dr. Christopher Montellese, DC ~ Dr. Kristina Montellese, DC ~ Dr. Dustin Nagai, DC**

## FINANCIAL POLICY
## INSURANCE, CASH, AND MEDICARE

### INSURANCE

It is the policy of this office that you pay for your visit in full at the time of each visit. We will verify your health insurance coverage for chiropractic care, for you. Once your eligibility and coverage is determined we will file all insurance claims for you to the extent that your policy permits.

You are responsible for paying your deductible, co-payment and non-covered supplements, supplies, and services at the time they are rendered.

### NON-INSURED

We request that you pay for all services in full at the time of each visit.

### MEDICARE

Dr. Kristina E. Montellese and Dr. Christopher G. Montellese are providers with Medicare therefore; we are required to bill Medicare for services. **Medicare does require that you pay for X-rays, examinations, supplements, supplies, physical therapy and any other non-covered services, and therefore you will be asked to pay for these services at the time you receive them.** You will also be required to pay all visits in full. Medicare will send payment directly to YOU.

### IT MUST BE UNDERSTOOD:

1. This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.
2. The clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. **This is the patient's obligation.**
3. We do file secondary insurances, other than Medicare. At the time of your visit, we will collect the copay or deductible of your primary insurance, and after your primary and secondary insurances have been processed, if there is a credit from payments, you will be reimbursed.

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

**Patient's Signature on file for acknowledgement of Financial Policy**

## Appointment and Cancellation Policy!

Individual Appointments are usually 30 - 40 minutes in duration. Because these appointments are exclusively reserved for you, it is necessary that you make any and all cancellations 24 hours before your scheduled appointment time.

All missed appointments without 24 hours-notice will be billed at a rate of $50.00 per each 30-minute increment of time that was reserved for your treatment. Appointments that are not cancelled are considered a "No Show / No Call" and will be billed in full.

Insurance will not be billed for any of these missed appointments, therefore you are responsible for payment in full, to be paid within 30 days of the missed appointment time. You may call our office Monday through Friday from 8:00am to 5:00pm to cancel and appointment.

More than 3 consecutive cancellations or 3 consecutive "No Show / No Call" appointments severely interrupts our office scheduling and your Healthcare needs and may result in termination from our practice.

**Patient's Signature on file for acknowledgement of Cancellation Policy**

# MONTELLESE FAMILY CHIROPRACTIC, INC.

**Dr. Christopher G. Montellese, D.C.**
**Dr. Kristina E. Montellese, D.C.**
**Dr. Dustin Nagai, D.C.**

# NOTICE OF PRIVACY PRACTICES

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

Dr. Kristina E. Montellese, D.C., Dr. Christopher G. Montellese, D.C., Dr. Dustin Nagai, D.C. are committed to maintaining the privacy and confidentiality of your protected health information, which includes information about your health condition and the care and treatment you receive from these Doctors. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your protected health information may be used and disclosed to third parties. This Notice also details your rights regarding 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. (example)

***"On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with this practice. It is our policy to provide a substitute healthcare provider, authorized by your Doctor, to assess and/or treat our patients without advance notice, in the even of your Doctor'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 healthcare operations. (example)

***"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Montellese Family Chiropractic, Inc. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including date of injury or condition and codes which describe the health care services rendered."***

**Worker' Compensation**

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**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 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 to a law enforcement official for the purpose of identifying or 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**

If you are an organ donor, we may disclose your health information to the entity to whom you have agreed to donate your organs and tissues.

**Research**

If we are involved in research activities, your health information may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your protected health information.

**Public Safety**

We may 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**

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

**Appointment Reminder**

As a courtesy to our patients, it is our policy to contact you to provide appointment reminders. The following appointment reminders are used by our office: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

**Sign-In Log**

We maintain a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in our office.

**Change of Ownership**

In the event that Montellese Family Chiropractic practice is sold or merged with another organization, your health information and record will become the property of the new owner.

**Authorization**

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

**Your Health Information Rights**

1. You have the right to request restrictions on certain uses and/or disclosure of your health information, as provided by law. Please be advised, however, that we are not obligated to agree to any requested restrictions.
2. 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.
3. You have the right to inspect and copy your health information.
4. You have the right to request that Montellese Family Chiropractic amend your protected health information. Please be advised, however, that we are not required to agree to this amendment. If your request to amend your health information has been denied, you will be provided with an explanation of our denial and information about how you can disagree with the denial.
5. You have the right to receive an accounting of disclosures of your protected health information.
6. You have the right to a paper copy of this Notice of Privacy Practices upon request.

**Changes of this Notice of Privacy Practices**

Montellese Family Chiropractic 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, Kristina E. Montellese, D.C., Christopher G. Montellese, D.C., Dustin Nagai, D.C. are required by law to comply with this notice.

Kristina E. Montellese, D.C., Christopher G. Montellese, D.C., Dustin Nagai, D.C. are required by law to maintain the privacy of your health information and to provide you with notice of his legal duties and privacy practices with respect to your protected health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our office by calling 831-655-3255.

**Complaints**

Complaints about your Privacy Rights, or how Kristina E. Montellese, D.C. or Christopher G. Montellese, D.C. handled your health information should be directed to our office at 831-655-3255.

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 Ave., S.W.
Room 509F HHH Building
Washington, D.C. 20201

**Copy of Patient's Signature (for acknowledgement of privacy practice) on file.