Welcome to Valley Wellness Health Group

(Ly Chiropractic, Inc)

Patient Information

Thank you for choosing Valley Wellness Health Group for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help!

(please print clearly)

Name: ______________________________ Social Security # : ____________

First Middle Last

Address: ______________________ City: __________ State: ______ Zip Code: ________

Sex: ❑ Female ❑ Male Birthdate: __________ Email Address: ______________________

Home Phone: (____)__________ Cell Phone: (____) __________ Work Phone: (____) __________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/School: ______________________ Occupation: ____________

Employer/School Address: ______________________ City: __________ State: ______ Zip Code: ________

Spouse or parent's name: ______________ Employer: __________ Work Phone: (____) __________

Whom may we thank for referring you to us? ______________________________

Have you ever visited our website [URL] before? ______________________________

Person to contact in case of emergency: ______________________ Phone: (____)__________

Responsible Party

Name of person responsible for this account: ______________________________

Relationship to patient: ______________________ Phone: (____)__________

Address: ______________________ City: __________ State: ______ Zip Code: ________

Name of employer: ______________________ Work Phone: (____)__________

Insurance Information

Name of insured: ______________________ Relationship to Patient: ____________

Birthdate: __________ Social Security #: __________ Date Employed: ____________

Name of employer: ______________________ Work Phone: (____)__________

Address: ______________________ City: __________ State: ______ Zip Code: ________

Insurance Co.:__________ Phone: (____)__________ Group #: ______ Employer #: ________

Insurance Co. Address: ______________________ City: __________ State: ______ Zip Code: ________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

Do you have additional insurance? ❑ Yes ❑ No If "Yes", please complete the following:

Name of insured: ______________________ Relationship to Patient: ____________

Birthdate: __________ Social Security #: __________ Date Employed: ____________

Name of employer: ______________________ Work Phone: (____)__________

Address: ______________________ City: __________ State: ______ Zip Code: ________

Insurance Co.:__________ Phone: (____)__________ Group #: ______ Employer #: ________

Insurance Co. Address: ______________________ City: __________ State: ______ Zip Code: ________

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ________

Symptoms

Reason for the visit: ______________________ When did you first notice the symptoms? ____________

Is the condition getting progressively worse? ____________ Where specifically is the problem(s) located? ____________

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain (1 = mild pain or discomfort, to 10 = severe pain) : 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ______________________

What treatment have you received for your condition? ❑ Medication ❑ Surgery ❑ Physical Therapy
❑ Other ______________________

Name and address of other doctor(s) who have treated you for your condition: ______________________

____

Health History *(check only those conditions which are applicable)*

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostrate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other ________
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	________
❑ Cancer	❑ Heart Disease	❑ Mumps	❑ Stroke	________

Dates of last exams: ______________________

List any types of surgeries which you have had and the dates which they occurred: ______________________

____

Please list all medications you are currently taking: ______________________

Allergies: ______________________

Women: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy Description: ____________

What do your daily work habits include? ______________________

What vitamins do you currently take? ____________ Nutritional supplements? ____________

Do you smoke? ❑ Yes ❑ No How much per day? ______________________

How much liquor do you consume weekly? ________ How many caffeinated beverages do you consume daily? ________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to Dr. Tam Ly all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Tam Ly may use my health care information and may disclose such information to any insurance Company(ies) i have provided him and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

______________________ ____________

Signature of Patient, Parent, Guardian or Personal Representative Date

______________________ ____________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

VALLEY WELLNESS HEALTH GROUP

4950 Hamilton Ave, Ste. 109, San Jose, CA 95130

Name: ______________________ Date of Injury: ____________ Date:____________

(1) Please describe the cause of your current symptoms:

[] Got Rear Ended [] In the Police report [] Passenger / Driver
[] Other (describe below)

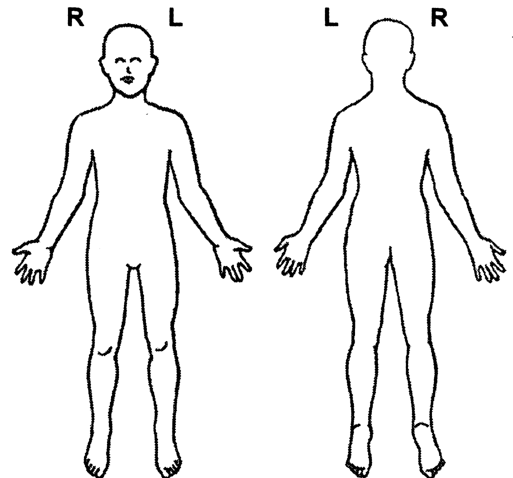
____

____

(2) Please check box or write down the area(s) of your injury/pain:

[] Neck pain
[] Upper back pain
[] Middle back pain
[] Lower back pain
[] Pain along the spine
[] (R)/(L) Shoulder pain
[] (R)/(L) Elbow pain
[] (R)/(L) Wrist/Hand pain
[] (R)/(L) Hip pain
[] (R)/(L) Knee pain
[] (R)/(L) Ankle pain
[] (R)/(L) Heel/Foot pain
[] (R)/(L) Ribs (back/front) pain
[] (R)/(L) Chest/Sternum/Waist pain
[] Headaches [] Dizziness [] Lose of sleep [] Anxiety
[] Shortness of breath [] Weakness
[] Other area(s): ________________________________

NOTES:



I declare under penalty of perjury of the State Of California that the foregoing statement is true and correct.

X__________________________________ ____________________

Patient Signature Date

OFFICE POLICY

LY CHIROPRACTIC, INC (DBA: VALLEY WELLNESS HEALTH GROUP)

Thank you for choosing Dr. Ly and his staff as your health care providers. We are committed to providing you with caring, comprehensive, quality health care. The following is a summary of our office policies. We believe a clear definition will allow us both to concentrate on the most important issue: ***regaining and maintaining your health***.

Payment Policy:

We feel the patient's health needs are paramount; therefore we have maintained a pricing structure that allows care for all budgets. We accept most Insurance Plans, including Auto Accident and Worker's Compensation.

Payment is expected in full at the time of each visit. We take Visa, MasterCard, Care Credit, Cash and Check. In the event a check is returned for non-sufficient funds, you will be responsible to cover the fees incurred by Valley Wellness Health Group.

Patients who opt to pay for services as a treatment package will receive a discount on usual and customary rates. Patient has the right to discontinue/cancel treatment package purchased by providing 10 days notice. Patient will lose any discounted rate and accumulated visits will be based on the usual and customary fee. Any remaining visits, balance due or balance owed will be refunded or billed to the patient and due at time of cancellation.

Insurance Policy:

Today most insurance policies cover Chiropractic/Massage. As a courtesy to our patients we will check your benefits for you and provide you with a comprehensive summary of benefits but it is ultimately your responsibility to know your coverage levels.

Remember, your insurance is an agreement between you and your insurance company, not between your insurance company and our office. Benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you our office will file any necessary forms at no additional charge. It is to be understood and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or co-pays.

If your insurance company sends payment for services rendered to you, please notify and forward payment(s) to Valley Wellness Health Group, so that your account may be credited accordingly.

Chiropractic Appointment Cancellations:

In order to better serve our patients we ask you call ***24 hours in advance to CANCEL or CHANGE*** your appointment. Your appointment time is reserved specially for YOU. If you fail to notify the office, it leaves an open appointment that could be used to help someone else like yourself.

ALL "no show" appointments and appointments cancelled same-day will be subject to a ***$25 cancellation fee*** due on your next visit. ***All Pre-paid packages will lose that chiropractic visit***.

Prepayment packages/visits/copays, etc:

Any prepayments to include but not limited to packages, visits, copays, etc expire 1 year from the date of payment unless otherwise stated or directed by the doctor. That is any prepayment package, visit, etc must be used within 1 year and upon expiration amount paid is forfeited with no carry over.

I have read and understand the office policy of Valley Wellness Health Group. I have indicated my understanding and agree to abide by these policies by my signature below.

Name: ____

Signature: ____ Date: ___________________________________

HIPPA

PATIENT RIGHTS TO PRIVACY RULES:

In accordance to federal law, we are required to disclose this form to you to inform you of your rights to privacy.

During certain circumstances, we may have to release your health information to an outside party.

- We may have to disclose your health care information to another provider if it is decided it is necessary for referral, testing, or treatment
- We may have to disclose your health care and billing information to a third party if they are responsible for payments to your accounts
- We may have to disclose your health care information within our practice for operational purposes and quality control

Your Right To Limit Or Restrict The Uses Of Your Health Care Information

You do have the right to request for limitations to be put on who we disclose your health care information to; such as specific individuals, companies, or organizations. Should you like to request any restrictions on the use or disclosure of your health care information, please inform us in a written statement. We are not required to agree to any restrictions, however the restriction is binding should we agree to it.

We are required to house and provide you with a copy of the HIPAA Compliance Manuel upon request for a fee, and you have a right to file a complaint to the office designated Compliance Officer.

As always, you have a right to get answers to all of your questions and concerns to the best of our knowledge.

By your signature below you certify that you are a current or prospective patient at Ly Chiropractic, Inc / Valley Wellness Health Group and that you have read and understand your privacy rights as outlined above.

Print Name: ______________________________________

Signature: ___________________________________ Date: _________________________

INFORMED CONSENT

PATIENT NAME: ___________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of Chiropractic Adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy and will use this procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints, which may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. This may cause you to feel a sense of movement.

Analysis, Examination, and Treatment:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy, vital signs, range of motion testing, Chiropractic testing, Orthopedic testing, Neurological testing, radiographic studies.
- Physical therapy modalities such as: Ultrasound, Electrical Stimulation, Paraffin, Intersegmental therapy, Massage, Heat or Cold therapy

The Material Risks Inherent in Chiropractic Adjustment:

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fracture, 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, leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me.

The Possibility of the Risks Occurring:

Fractures are rare occurrences and generally result from underlying weakness of the bone which I will check for during the taking of your history, examination, and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare, estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

I have read an explanation of the chiropractic adjustment and related treatments. I have disclosed with Valley Wellness Health Group / Ly Chiropractic, Inc and have had my questions answered to my satisfaction in that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I am giving my consent to treatment.

Patients Name: _________________________ Signature: _________________________ Date: __________

Parent/Guardian (if a minor): _________________________ Signature: _________________________ Date: __________

Doctor's Name: Tam Ly, D.C. Signature: _________________________ Date: __________