FOR OFFICE USE ONLY

Scan	
EZN	
EHR	
Provider	

REGISTRATION FORM

1. PATIENT INFORMATION

Date:			
Patient Name:		Nickname:	
Address:			
City:	State:	Zip:	

Sex: ☐ M ☐ F | ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Birthdate:		Age:		Occupation:	

Employer/School:		Whom may we thank for referring you?	

Are you pregnant? ☐ No ☐ Yes | Due Date:

Spouse's Information

Name:		Birthday:	
Employer:			

2. INSURANCE INFORMATION

I understand my provider is Out of Network with my insurance provider and I may request a superbill for potential reimbursements

I agree that I am not a medicare beneficiary

Signature:	

3. CONTACT INFORMATION

Home Phone:		Cell Phone:	
Email:			

IN CASE OF EMERGENCY CONTACT

Name:		Relationship:	
Home Phone:		Cell Phone:	

Check 'yes' if you would like to receive important updates for growing families including money saving offers on products and services, product reviews and recalls, and local events and activities ☐ YES ☐ NO

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#:		Backup:		Position:	
EDD:		Complications:		Persistant:	
Provider:		Ref:		Fluid:	
Hospital:				Placenta:	

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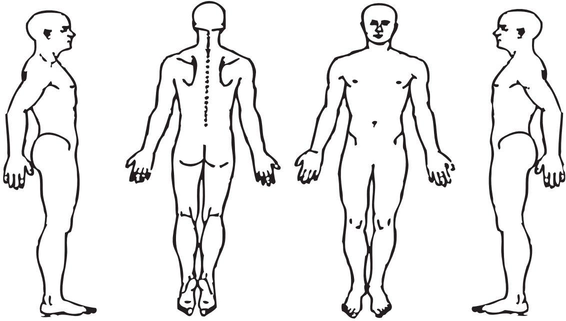
4. ACCIDENT INFORMATION

Is this condition due to an accident?	☐ Yes ☐ No	Date:	
Type of Accident:	☐ Auto ☐ Work ☐ Home ☐ Other		
To whom have you made a report of the accident?	☐ Auto Insurance ☐ Employer ☐ Workers Comp ☐ Other		
Attorney Name and Contact Information:			

4. MEDICAL INFORMATION

1. What is the primary reason for your visit?

2. Please indicate on the adjacent drawing where you have pain/symptoms:



3. How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)

☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

☐ Sharp ☐ Numb ☐ Dull ☐ Tingly

☐ Diffuse ☐ Sharp with motion ☐ Achy ☐ Shooting with motion

☐ Burning ☐ Stabbing with motion ☐ Shooting ☐ Electric like with motion

☐ Stiff ☐ Other: ______________________________

5. How are your symptoms changing over time

☐ Getting worse ☐ Not changing ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

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7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician

☐ ER Doctor ☐ Orthopedist ☐ Other: ______________________

☐ Massage Therapist ☐ Physical Therapist ☐ No-one

10. How long had you had this problem?	
11. How do you think your problem began?	
12. Do you consider this problem to be severe?	☐ Yes ☐ Yes, at times ☐ No
13. What aggravates your problem> (ex: bending, driving, sitting, stress)	
14. What alleviates your problem? (Ex: heat, ice, massage, Tylenol, adjustments)	

15. What concerns you the most about your problem; what does it prevent you from doing?

16. What is your:	Height:		Current Weight (even if pregnant)	

17. How would you rate your overall health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
18. What type of exercise do you do?	☐ Strenuous ☐ Moderate ☐ Light ☐ None

19. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus

☐ Heart Problems ☐ Cancer ☐ ALS

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REGISTRATION FORM

20. For each of the conditions listed below, place a check in the 'past' column if you have had the condition in the past. If you presently have a condition listed below, place a check in the 'present' column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Dizziness	☐	☐	Asthma
☐	☐	Neck Pain	☐	☐	High Blood Pressure	☐	☐	Chronic Sinusitis
☐	☐	Upper Back Pain	☐	☐	Heart Attack	☐	☐	Diabetes
☐	☐	Mid Back Pain	☐	☐	Chest Pains	☐	☐	Excessive Thirst
☐	☐	Low Back Pain	☐	☐	Stroke	☐	☐	Frequent Urination
☐	☐	Shoulder Pain	☐	☐	Angina	☐	☐	Tobacco Use
☐	☐	Arm Pain	☐	☐	Kidney Stones	☐	☐	Drug/Alcohol Dependence
☐	☐	Wrist Pain	☐	☐	Kidney Disorders	☐	☐	Allergies
☐	☐	Hand Pain	☐	☐	Bladder Infection	☐	☐	Depression
☐	☐	Upper Leg Pain	☐	☐	Painful Urination	☐	☐	SLE (Lupus)
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Epilepsy
☐	☐	Knee Pain	☐	☐	Prostate Problems	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Change	☐	☐	HIV/AIDS
☐	☐	Jaw Pain	☐	☐	Loss of Appetite	☐	☐	Hormonal Replacement
☐	☐	Joint Swelling	☐	☐	Abdominal Pain			**For Females Only**
☐	☐	Arthritis	☐	☐	Ulcer	☐	☐	Birth Control Pills
☐	☐	Rheumatoid Arthritis	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	General Fatigue	☐	☐	Gall Bladder Problems			
☐	☐	Muscular Incoordination	☐	☐	Cancer			
☐	☐	Visual Disturbances	☐	☐	Tumor			

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PRESCRIPTION MEDS	OVER THE COUNTER MEDS	SUPPLEMENTS	SURGICAL PROCEDURES

22. List any allergies that you have	
23. What activities do you do outside of work? (Ex: sports, exercise, yoga)	
24. Have you had significant past trauma?	☐ No ☐ Yes

Injuries	Description	Date
Falls		
Injuries		
Broken bones		
Dislocations		
Car accidents		

25. Have you ever been hospitalized?	☐ No ☐ Yes ☐ Previously Mentioned
26. Have you ever seen a chiropractor before?	☐ No ☐ Yes
If yes, how long ago?	
Was the result good, mixed or poor?	
27. Anything else that you think I should know?	

Patient Signature:		Date:	

FINANCIAL CANCELLATION & LATE POLICY

Financial Responsibility Statement

‘I fully understand that I am directly and fully responsible to Berlin Chiropractic Corp and any independent providers for all services rendered to me, and that this agreement is made solely for Berlin Chiropractic Corp and independent practitioners additional protection.

Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. Business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our patient’s and out of consideration for our practitioners’ time, we have adopted the following policies:

- I understand that 24 hour advanced notice, to the hour of my appointment, is required to avoid a cancellation fee when canceling and/or rescheduling an appointment. This allows the opportunity for someone else to avail themselves of our services.

- Failure to receive appointment courtesy reminders does not negate this policy as these reminders are a courtesy and are subject to carrier technological disruptions.

- If you do not give us 24 hours advance notice of cancellation/rescheduling by phone, and you are unable to come for your session or fill the spot with friend or family member, you will be charged the full fee for the session that was missed.

- I ____ authorize the use of the following credit card information or any card I leave 'on file' in the future, for all cancellation fees. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Cardholder Name:			
Card Number:		Expiration Date:	
CVV:		Zipcode:	

Late Arrival Policy

We try very hard to minimize your waiting time, and in order to do so we need to start and finish appointments on time. Depending upon how late you arrive, your practitioner will determine if there is enough time remaining to start a treatment and regardless of the length of the treatment actually given, you will be responsible for the "full" session.

Out of respect and consideration to your practitioner and other patients, please plan accordingly and be on time.

WE LOOK FORWARD TO SERVING YOU

Patient’s Printed Name:			
Patient’s Signature:		Date:	

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Berlin Chiropractic Corp. Notice of Privacy Practices 6221 Wilshire Blvd. Suite 518, Los Angeles, CA 90048

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.

Berlin Chiropractic Corp. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to 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 or with whom we are collaborating for the purpose of treatment, payment or healthcare operations.

Payment: In order to help you get reimbursement from your insurance company, we may disclose your health information to your insurance provider upon their request. This may include billing, history, and exam finding, treatment notes and other clinical information.

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

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

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 child abuse or neglect, reporting domestic violence, reporting to the Food or Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as 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: We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety: It may be necessary to 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.

Communication: Our office sends out courtesy text reminders to all patients to the cell phone number provided. No personal health information will be disclosed during this message. Patients can request to not receive these messages at any time. Standard messaging rates may apply. Our office has a separate dedicated text line that we may use to communicate with patients regarding appointment information, payment information, and additional communications relating to booking and/or appointment status and payment. It is our policy to send out email newsletters several times a year. We do not disclose our patient roster nor do we sell the same to any other organization or other business.

Video Surveillance: Our office is equipped with multiple 24 hour surveillance cameras for the safety and security of our staff and patients. Security cameras are visible – not concealed – and are only in the "public" or common areas (such as the waiting room, reception, and hallways). Cameras are not in view of exam rooms, bathrooms, or other areas where people have a reasonable expectation of privacy

Change of Ownership: In the event that Berlin Chiropractic Corp. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Berlin Chiropractic Corp. is to required to agree to the restriction that you requested

- You have the right to have you health information received or communicated though an alternate method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information

- You have a right to request that Berlin Chiropractic Corp. amend your protected health information. Please be advised, however, that Berlin Chiropractic Corp. is not requires to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about ow you can disagree with the denial.

- You have the right to receive an accounting of disclosures of your protected health information made by Berlin Chiropractic Corp.

- You have a right to a paper copy of the Notice of Privacy Practices at any time upon request

Changes to this Notice of Privacy Practices: Berlin Chiropractic Corp. 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, Berlin Chiropractic Corp. is required by law to comply with this Notice.

Berlin Chiropractic Corp. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Elliot Berlin by writing to info@DoctorBerlin.com or calling (323) 549-0070. If Dr. Elliot Berlin is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints: Complaints about your Privacy rights, or how Berlin Chiropractic Corp. has handled your health information should be directed to Dr. Elliot Berlin, writing to info@DoctorBerlin.com or by calling this office (323) 549-0070. If Dr. Elliot Berlin is not available, you may make an appointment for a person conference in person or by telephone within 2 working days.

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 Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 6/1/2022

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Berlin Chiropractic Corp. with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operation as described in the privacy notice

Patient’s Printed Name:			
Patient’s Signature:		Date:	

PRINT SAVE SUBMIT