berlin
wellness group

REGISTRATION FORM

FOR OFFICE USE ONLY

☐ Scan
☐ Ezn
☐ Source
☐ Provider_____

1 PATIENT INFORMATION

Date _____

Patient Name _____

Nickname _____

Address _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F

☐ Married ☐Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐Partnered

Birthdate _____ Age _____

Employer/School _____

Whom may we thank for referring you? _____

_____

Spouse's Information

Name _____

Birthday _____

Employer _____

2 INSURANCE INFORMATION

Would you like a superbill to submit to your insurance carrier for possible reimbursement?

If so, which insurance company will you be submitting to?

_____

3 CONTACT INFORMATION

Home Phone _____

Work Phone _____

Cell Phone _____

Do you prefer reminder: Call or Texts

If text, who is your cell phone carrier? _____

Email _____

IN CASE OF EMERGENCY CONTACT

Name _____

Relationship _____ Cell Phone _____

Home Phone _____

Work 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**

4 ACCIDENT INFORMATION

Is the 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 ☐Worker Comp. ☐Other

Attorney Name and contact information

_____

FOR OFFICE USE ONLY

#: _____

EDD: _____

Provider: _____

Backup: _____

Hospital: _____

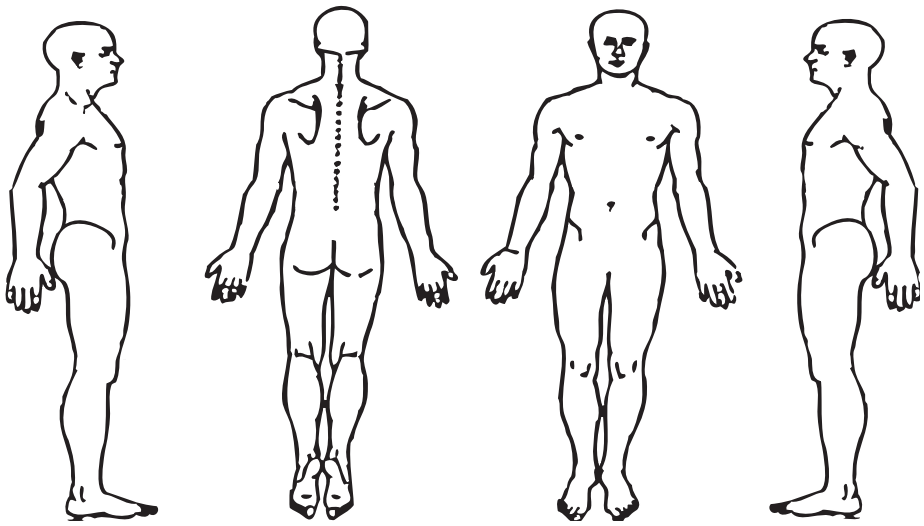
Complications: _____

Ref: _____

5 MEDICAL INFORMATION

1: What is the primary reason for your visit?

_____
_____
_____
_____
_____
_____



2: Please indicate on the adjacent drawings 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
- ☐ Dull
- ☐ Diffuse
- ☐ Achy
- ☐ Burning
- ☐ Shooting
- ☐ Stiff
- ☐ Numb
- ☐ Tingly
- ☐ Sharp with motion
- ☐ Shooting with motion
- ☐ Stabbing with motion
- ☐ Electric like with motion
- ☐ Other:_____

5. How are your symptoms changing with 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 (Please circle)

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
- ☐ ER Doctor
- ☐ Massage Therapist
- ☐ Neurologist
- ☐ Orthopedist
- ☐ Physical Therapist
- ☐ Primary Care Physician
- ☐ Other:_____
- ☐ No one

10. How long have 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) _____

Occupation _____

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

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 Dependance
☐	☐	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			
☐	☐	Arthritis	☐	☐	Ulcer	For Females Only		
☐	☐	Rheumatoid Arthritis	☐	☐	Hepatitis	☐	☐	Birth Control Pills
☐	☐	General Fatigue	☐	☐	Gall Bladder Problems	☐	☐	Pregnancy
☐	☐	Muscular Incoordination	☐	☐	Cancer			
☐	☐	Visual Disturbances	☐	☐	Tumor			

21: Are you pregnant? ☐ No ☐ Yes Due Date _____

22.

PRESCRIPTION MEDS	OVER THE COUNTER MEDS	SUPPLEMENTS	SURGICAL PROCEDURES

23. List any allergies that you have_____

24. What activities do you do outside of work? (ex: sports, exercise, yoga)

_____

25. Have you had significant past trauma? □ No □ Yes

Injuries	Description	Date
Falls		
Injuries		
Broken Bones		
Dislocations		
Car accidents		

26. Have you ever been hospitalized? □ No □ Yes □ Previously Mentioned

If yes, why? _____

27. Have you ever seen a chiropractor before? □ No □ Yes

If yes, how long ago? _____

Was the result good, mixed or poor? _____

28. 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 for all bills submitted for services rendered to me, and that this agreement is made solely for Berlin Chiropractic Corp's additional protection and in consideration of awaiting payment.

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:

- **24 hour advance notice is required** to avoid a cancellation fee when canceling an appointment. This allows the opportunity for someone else to avail themselves of our services.

- If you do not give us 24 hours advance notice of cancellation 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.**

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

PRIVACY POLICY

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 findings, 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.

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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 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 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
As a courtesy to our patients, 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 reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and the time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment. It is our policy to send out newsletters, birthday postcards, and reminder postcards several times a year. We do not disclose our patient roster nor do we sell same to any otherorganization or other business.

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 not required to agree to the restriction that you requested.
- 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.
- 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 required 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 how you can disagree with the denial.
- You have a 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 this 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 personal 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 2/14/2014
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 Name (Print)

_____
Patient Signature Date