

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M / F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver Lic. #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Health Plan: \_\_\_\_\_  
Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Spouse Name: \_\_\_\_\_  
Spouse Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Primary Care Physician Name: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

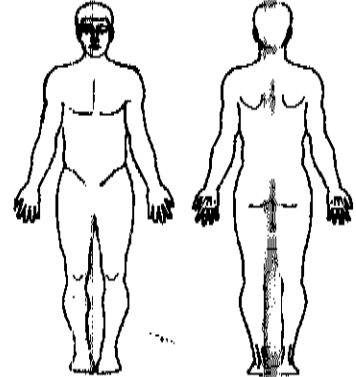
**DATE PROBLEM BEGAN:** \_\_\_\_\_

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain

Unbearable Pain



How often are your symptoms present?  0 - 25%  26 - 50%  51 - 75%  76 - 100%  
Can you perform your daily activities?  Yes  No (Describe) \_\_\_\_\_

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN?**  No  Yes Date(s) taken: \_\_\_\_\_

**WHAT AREAS WERE TAKEN?**

Please check all of the following that apply to you:  None Apply

- | No                       | Yes                      | Condition                   |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use          |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma               |

- | No                       | Yes                      | Condition   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____  |
|                          |                          | _____   |
|                          |                          | _____   |

Family History:  Cancer  Diabetes  High Blood Pressure  Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*e-mail:* \_\_\_\_\_

Salanger/Spiegelman Chiropractic Office  
8304 Clairemont Mesa Boulevard, Suite 114  
San Diego, CA 92111  
(858) 565-8645

## PATIENT COPY

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

In the course of your care as a patient at SALANGER CHIROPRACTIC we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an Insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are under required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to the Office manager.

If you would like further information about our privacy policies and practices please contact the Office manager.

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any matter whatsoever.

This notice is effective as of \_\_\_\_\_. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

## NOTICE OF PATIENT RIGHTS & PRIVACY PRACTICES

Chiropractic Office of  
Dr. Charles Salanger, D.C. & Dr. Carol Spiegelman, D.C.  
8304 Clairemont Mesa Blvd #114 San Diego, CA 92111  
Phone: (858)565-8645 fax: (858)565-4207

I, \_\_\_\_\_ have read and understand the  
previous page(s) regarding the Privacy Practices and your rights as a patient in  
this office.

\_\_\_\_\_  
Name (printed please)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are a minor, or if you are being represented by another party

\_\_\_\_\_  
Personal representative Printed

\_\_\_\_\_  
Personal representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of the authority to act on behalf of the patient

## 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 diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of chiropractic named below 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 below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but no limited to, fractures, disc injuries, strokes, dislocations and sprains. 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, is in my best interests.

I have read, or have had 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.

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To be completed by patient:

\_\_\_\_\_

Print patient name

\_\_\_\_\_

Signature of patient

\_\_\_\_\_

Date signed

To be completed by patient's  
Representative if patient is a  
minor or physically or legally  
incapacitated:

\_\_\_\_\_

Print name of patient

\_\_\_\_\_

Print name of patients representative

\_\_\_\_\_

Signature of Rep. and date signed

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**CHARLES P. SALANGER  
CAROL L. SPIEGELMAN  
8304 CLAIREMONT MESA DRIVE SUITE 114  
SAN DIEGO, CA. 92111**

**Patient Authorization for appointment reminders and scheduling  
related matters**

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointments related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information your decision will have no adverse effect on your care from Dr. Salanger, Dr. Spiegelman or on your relationship with the staff.

Your signature indicates your authorization of this activity.

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization.

Please allow a reasonable processing time for the change in our system to be completed.

Thank you

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR  
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

I hereby instruct and direct \_\_\_\_\_  
Name of Insurance Company

To pay by check made out and mailed directly to:

**CHARLES P. SALANGER, D.C.  
8304 CLAIREMONT MESA BLVD #114  
SAN DIEGO, CA 92111**

**OR**

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

\_\_\_\_\_  
Your name and address

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_\_.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of claimant, if different than Policyholder