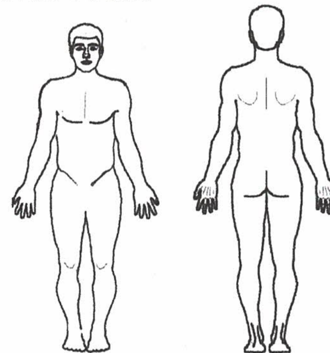
American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_______________ Birthdate_______________ Gender: M / F
Address_______________ City_______________
State_______ Zip_______ Phone (____)_______________ Patient Primary Language_______________
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_______________

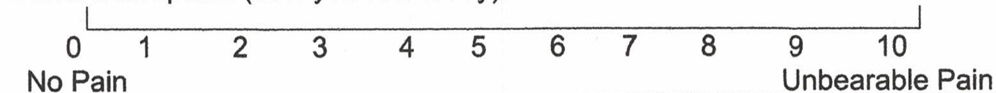
MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_______________

Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began_______________
How Problem Began

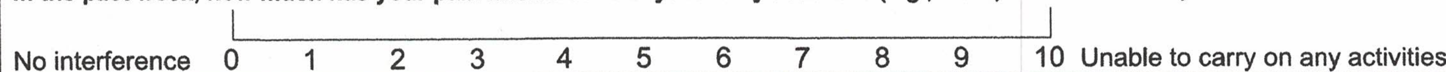
Current complaint (how you feel today):



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%

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?



No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken_______________ **What areas were taken?**_______________
Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_______________
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_______________
____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_______________

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_______________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_______________
____
☐ Tobacco Use - Type_______________
Frequency_______________/Day
☐ Medications_______________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, 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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_______________ **Date**_______________

 Email_______________

NAME____ DATE___________

THINGS YOUR THERAPIST NEEDS TO KNOW...

Have you ever had a professional massage?

Is your visit due to a recent accident or injury?

What areas do you have pain?

Do you have any medical conditions we should be aware of?

- ❖ High blood pressure?
- ❖ Cancer?

  If YES:

  - ❖ What type?
  - ❖ When
  - ❖ What type of treatment did you receive?
  - ❖ When was your last treatment?
  - ❖ Are you still receiving treatment?
- ❖ Allergies?
- ❖ Are you pregnant?
- ❖ Do you have varicose veins?
- ❖ Have you had any surgeries within the past year?
- ❖ Are you a good water drinker?

***No Alcohol consumption 24 hours before or after your massage. Consuming Alcohol before or after your massage will **increase dehydration** and **risk of stroke.**

Please sign Massage Therapy Agreement on back Rev 2/2022

MASSAGE THREAPY AGREEMENT

To ALL massage patients:

Due to the overwhelming demand for massage therapy in our office, the following policies have been implemented to best serve all of our patients.

MISSED APPOINTMENT: Patients who miss appointments OR cancel with less than 24 hours notice WILL be charged $25.00. Insurance plans do not cover such charges. PATIENTS are responsible for payment to our office.

SCHEDULING: We have limited massage appointments available. Appointments will only be made up to 30 days in advance. It will be patients responsibility to remember their appointments, as we are not always able to make confirmation calls.

THERAPIST AVAILABILITY: Patients should recognize that Massage Therapist schedules may change from time to time. Patients agree to be seen by the therapist on duty.

We will do our best to accommodate your schedule and inform you of any scheduling changes.

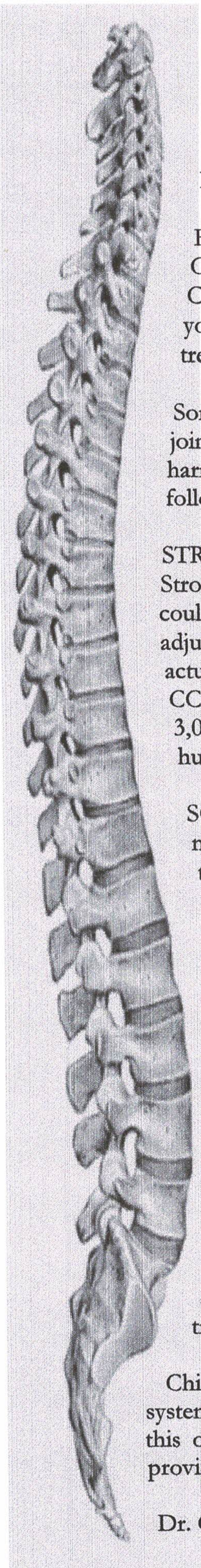
I have read and agree to the above.

____

Patient Signature Date

____

Staff Signature Date



DR. WILLIAM T. CUDMORE, JR.
PROGRESSIVE CHIROPRACTIC

ABOUT INFORMED CONSENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes Chiropractic care. We want you to be informed about potential problems associated with Chiropractic before consenting to treatment. This is called informed consent. We must also let you know that we may use trained staff personnel to assist the doctor with portions of your treatment.

Some risks are associated with chiropractic adjustments, the therapeutic moving of bones and joints with the doctor's hands or with the use of a tool. These movements often result in a harmless "pop" or "click" sound and/or sensation in the area being adjusted. Risks include the following:

STROKE: Stroke is the most serious potential problem associated with Chiropractic adjustments. Strokes occur when a portion of the brain does not receive oxygen for a period of time. The result could be a temporary or permanent dysfunction of the brain, or even death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery. This artery is actually found inside the neck vertebrae. The most recent studies, published in the Journal of the CCA. Vol. 37 No. 2 June, 1993, estimate that the incident of this type, stroke, is 1 per every 3,000,000 neck adjustments (the average Chiropractor would have to be in the practice for hundreds of years to reach that statistic!).

SOFT TISSUE INJURY: Soft tissue primarily refers to muscles, ligaments and discs. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment, massage therapy, and/or therapeutic exercise may cause a minor injury to soft tissue. The result could be a temporary increase in pain.

RIB FRACTURES: The ribs are anchored to the thoracic spine or middle back. Rarely, a chiropractic adjustment may crack or fracture a rib bone. This may occurs only in patients who have weakened bones from such things as osteoporosis. All risks and precautions are taken into account by your doctor before any treatment is performed.

SORENESS: It is common for Chiropractic adjustments, traction, massage therapy, and/or therapeutic exercise to result in an increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous and may vary according to your general health.

OTHER PROBLEMS: There may be other problems or complications that can arise from Chiropractic care other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance prior to treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and when necessary, refer you to the proper provider for your needs.

Dr. Cudmore will be happy to discuss any questions you may have regarding the above.

PATIENT NAME ______________________________ DATE ______________

INFORMED CONSENT

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 the patient named below, for whom I am legally responsible) by Dr. Cudmore or any of his appropriately trained staff.

I have had the opportunity to discuss with Dr. Cudmore and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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 not 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 upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an 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.

Patient Signature: ______________________________ Date: ______________

Legal Guardian Signature: ________________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

HIPAA Notice of Privacy Practices

Progressive Chiropractic
Dr. William T. Cudmore
7200 South Land Park Drive, Suite 200
Sacramento, CA 95831
(916) 424-0828

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. Another example would be our office giving your PHI to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose your PHI information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI to contact you to remind you of your appointment.

We may use or disclose you PHI in the following situations without your authorization. These situations include: as Required By Lay, Public Health Issues as Required By Law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be

disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agrees to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to our office or the Secretary of Health and Human Services if you believe your privacy rights have been violated by our office. You may file a complaint with our office by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

If you have any questions or comments regarding this notice or authorization, please contact the HIPAA Officer in our office at the phone number listed above.

Signature is acknowledgement that I have received this Notice of our Privacy Practices.

Print Name________________________________ Signature____ Date____________________

Health Care Authorization

I give permission to Progressive Chiropractic for the following:

☐ To use my PHI to contact me with birthday/holiday cards, newsletters or other health related information.

☐ To treat me in an open area where other patients may over hear my PHI during care. I understand that a private room will be provided as needed for private consultations with the doctor.

I understand that I have the right to revoke this authorization, in writing, at any time.

Signature____ Date___________________________