ABOUT THE PATIENT

Back Bay Wellness, 2675 Irvine Ave. #116, Costa Mesa CA 92627

Name _____ Today's Date _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Gender ☐ M ☐ F Significant Other's Name _____ # of children _____

Your Employer _____ Type of work _____

E-mail address _____ Have you been to a chiropractor before? _____

Emergency contact _____ Phone _____

How did you hear about us? ☐ Instagram ☐ Tik Tok ☐ Yelp ☐ Other/Referred by: _____

I give consent to be videotaped/ for my child to be videotaped and for footage to be posted on social platforms:

☐ Yes ☐ No

I authorize the doctor or his/her staff to render care as deemed appropriate for me or my child.
I authorize Back Bay Wellness to release and/or request records to or from other providers as may be necessary.
I understand I am responsible for all bills incurred in this office.
I authorize assignment of my insurance benefits (if applicable) directly to the provider.
I understand that after any initial promotional services all care is rendered at usual and customary fees.

_____ _____

Patient/Parent Signature Date

REASON FOR SEEKING CARE

Present Complaints

1. _____ How long has this been an issue? _____

Is it: ☐Dull ☐Sharp ☐Ache ☐Numb/Tingle ☐Stabbing ☐Constant ☐Occasional ☐Staying the same

☐Getting worse ☐Mild ☐Moderate ☐Severe ☐Worse in morning ☐Worse in evening ☐Radiates to _____

2. _____ How long has this been an issue? _____

Is it: ☐Dull ☐Sharp ☐Ache ☐Numb/Tingle ☐Stabbing ☐Constant ☐Occasional ☐Staying the same

☐Getting worse ☐Mild ☐Moderate ☐Severe ☐Worse in morning ☐Worse in evening ☐Radiates to _____

3. _____ How long has this been an issue? _____

Is it: ☐Dull ☐Sharp ☐Ache ☐Numb/Tingle ☐Stabbing ☐Constant ☐Occasional ☐Staying the same

☐Getting worse ☐Mild ☐Moderate ☐Severe ☐Worse in morning ☐Worse in evening ☐Radiates to _____

4. _____ How long has this been an issue? _____

Is it: ☐Dull ☐Sharp ☐Ache ☐Numb/Tingle ☐Stabbing ☐Constant ☐Occasional ☐Staying the same

☐Getting worse ☐Mild ☐Moderate ☐Severe ☐Worse in morning ☐Worse in evening ☐Radiates to _____

Does your condition affect: ☐Sleep ☐Work ☐Daily Routine ☐Sitting ☐Driving ☐ _____

What makes it better? _____

What makes it worse? _____

What doctors have you seen for this? _____

Type of treatment: _____

Notes: _____

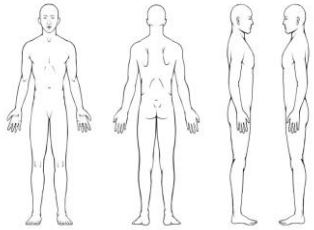
_____

_____

Are you pregnant?

☐Yes ☐No

Please mark all areas of concern



GENERAL HEALTH HISTORY

Patient Name _____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Urinary problems
☐	☐	Migraines	☐	☐	Easy bruising
☐	☐	Shortness of breath	☐	☐	Tobacco use
☐	☐	Allergies/ Asthma	☐	☐	Dental problems
☐	☐	Medication side effects	☐	☐	Fibromyalgia
☐	☐	Diabetes	☐	☐	Blood thinner use
☐	☐	Hands or feet cold	☐	☐	HIV positive
☐	☐	Muscle aches	☐	☐	Cancer
☐	☐	Trouble walking	☐	☐	Depression
☐	☐	Leg/foot numbness	☐	☐	Alcohol use
☐	☐	Fainting	☐	☐	High or low blood pressure
☐	☐	Gall bladder trouble	☐	☐	Stroke history
☐	☐	Ringing in ears	☐	☐	High cholesterol
☐	☐	Ear problems	☐	☐	TMJ
☐	☐	Sleeping problems	☐	☐	Digestive problems
☐	☐	Vision problems	☐	☐	Pain all over
☐	☐	Thyroid problems	☐	☐	Tension/ irritability
☐	☐	Liver disease	☐	☐	Chest pains
☐	☐	Kidney problems	☐	☐	Heart pacemaker
☐	☐	Light bothers eyes	☐	☐	Heart problems
☐	☐	Other _____			

1. Please list any medications you are taking: _____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any doctor or other professional advised you to "Go to a chiropractor?": ☐ No ☐ Yes, Name _____

_____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____

5. List any past work injuries: _____ Was any care received? _____

6. List any past sport, recreational, or home injuries: _____

7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries : _____

_____

FAMILY HISTORY

Father's side: ☐ Heart disease ☐ Cancer ☐ Heavy medication use ☐ Arthritis ☐ Other _____

Mother's side: ☐ Heart disease ☐ Cancer ☐ Heavy medication use ☐ Arthritis ☐ Other _____

Is there any other family history you want us to know of? _____

_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as the patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Our disturbance to the nervous system is called a vertebral subluxation. This occurs when one of the 24 vertebrae in the spinal column becomes misaligned and/or does not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If, during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

By signing below, I agree that all questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

CONSENT FOR TREATMENT OF A MINOR

I, _____ , being the parent/legal guardian of
(Name of Parent or Guardian)
_____ have read and fully understand the above informed consent
(Name of Minor)
and hereby grant permission for my child to receive chiropractic care.

DOCTOR-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to arbitrate: It is understood that nay dispute as to professional malpractice, that is as to whether any professional services rendered this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law, and not by a lawsuit or resort to court process except as California Law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All claims must be Arbitrated: It is the intention of the parties, that this agreement binds all parties whose claims may arise out of or relate to treatment or services provided by the doctor including any spouse or heirs of the patient. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the doctor, and/or the doctor's association, corporation, partnership, employees, agents and estate, must be arbitrated including without limitation, claims for loss of consortium, wrongful deaths, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. Following the assertion of any claim against the doctor, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Proceedings and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that the provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this Arbitration Agreement including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2) and the right to have judgement for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration rules of the American Arbitration Association shall govern any arbitration conducted pursuant to the Arbitration Agreement.

Article 4: Revocation: This agreement may be revoked by written notice delivered to the doctor within 30 days of signature and if not revoked will govern all professional services received by the patient.

Article 5: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial below:

Effective as of the date of first professional services.

_____

Patient's Initials

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THE CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF PROFESSIONAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. (See article 1 of this contract).

Patient's Signature: _____ Date: _____

Patient's Guardian: _____ Date: _____

Doctor's Signature: _____ Date: _____

BACK BAY WELLNESS
2675 Irvine Ave. #116
Costa Mesa, CA 92627
(949)631-0200

HIPAA NOTICE OF PRIVACY PRACTICES

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 Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment- In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.
(b) Payment- In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
(c) Health Care Operations- In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-Identified Information- Information that does not identify you and, even without your name, cannot be used to identify you.
(b) Business Associate- To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.
(c) Personal Representative- To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
(d) Emergency Situations-
    (i) For the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

    (ii) To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers- If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.
(f) Public Health Activities- Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.
(g) Abuse, Neglect or Domestic Violence- To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities- Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.
(i) Judicial and Administrative Proceeding- For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
(j) Law Enforcement Purposes- In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.
(k) Coroner or Medical Examiner- The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
(l) Organ, Eye, or Tissue Donation- If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
(m) Research- If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
(n) Avert a Threat to Health or Safety- The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
(o) Workers' Compensation- If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.

- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Sign-in Log

This Practice maintains a sign-in log for individuals seeking care and treatment in the office. This sign-in is located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family/Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death. However, in both cases, the following conditions will apply:

- If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.
- If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions
You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

You Have a Right to
Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as paper or electronic copy).

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice.

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, (202)619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS

The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Signature: _____ Date: _____

BACK BAY WELLNESS

(Financial Policy)

In order to reduce confusion and misunderstanding between our patients and the Practice,
we have adopted the following financial policy.
We are dedicated to providing the best possible care and service to you.
We thank you for your understanding of your financial responsibilities.

- Your Insurance policy is a contract between you and your Insurance Company.
- As a courtesy, we will file your insurance claims for you. If your Insurance Company does not pay the Practice within a reasonable amount of time, your assistance in retrieving payment will be needed.
- In the event the Insurance Company does not pay the incurred charges, you will be responsible to pay your account balance.
- All Health Plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- You are responsible for paying for your co-payments and/or deductible at the time of service (No exceptions).
- If for any reason you receive an Insurance check in the mail for services provided by Back Bay Wellness, you will be responsible to bring in the check or forward it with the attached explanation of benefits immediately, or you will be responsible to pay the office.
- For all services rendered to minor patients, we will look to the adult, guardian, or parent accompanying the patient for payment.
- All cash patients are to pay at the time of service, or have a financial plan. Payments are to be made with cash, credit card, or check. A $20 service fee will be billed to the patient for all returned checks, non-sufficient funds, and/or stopped payments.
- There is a cancellation fee on missed massage appointments. These times are reserved especially for you. Any person who cancels a massage without 24 hour notice will be charged $20 for any half hour missed massage, and $40 for any hour long massage missed. Payable before another massage appointment is scheduled.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____

Print Name of Patient

_____

Signature of Patient or Guardian

_____

Date

BACK BAY WELLNESS
2675 Irvine Ave. #116
Costa Mesa, CA 92627
(949)631-0200

Consent to Bring In Insurance Payment For Chiropractic Services

Dear Patient:

Please be advised that your healthcare provider (Belling Chiropractic Inc., Rick Belling DC, Victoria Vodon DC, Alex VanDerschelden DC or Rodiel Kirby Baloy RPT), may not be "in network" with your insurance (i.e. the healthcare provider is considered an "out of network" provider). Your insurance may send the check for our services payable directly to you.

Please understand that *the check is to pay for the chiropractic services that you received* in our office provided by or on behalf of Belling Chiropractic Inc., Rick Belling DC, Victoria Vodon DC, Alex VanDerschelden DC or Rodiel Kirby Baloy RPT and *not in any way a payment or reimbursement to you*.

Please read and sign the statement below. We sincerely appreciate your cooperation and understanding.

Thank you,

Belling Chiropractic, Inc.
Rick Belling DC
Victoria Vodon DC
Alex VanDerschelden DC
Rodiel Kirby Baloy RPT

I understand that I may receive a check from my insurance company for services rendered by or on behalf of Belling Chiropractic, Inc. (Rick Belling DC, Victoria Vodon DC, Alex VanDerschelden DC or Rodiel Kirby Baloy RPT) that may be payable to my name instead of the proper payee-due to my specific insurance company regulations.

If I do receive such a check from my insurance company, I will notify the office immediately and either mail or bring a personal check or a cashier's check in the same amount payable to Belling Chiropractic, Inc. to the office **within 5 calendar days of having received it**.

I will also provide a copy of the explanation of benefits (EOB) that usually accompanies the payment.

Alternatively, I may also pay the balance with a credit card, money order or cash with the same time frame. My failure to do so in a timely manner may cause further collection attempts from the service provider and may result in additional collection charges to me.

I have read and understood the above consent and promise to comply with the above.

Signature: _____

Name: _____

Date: _____