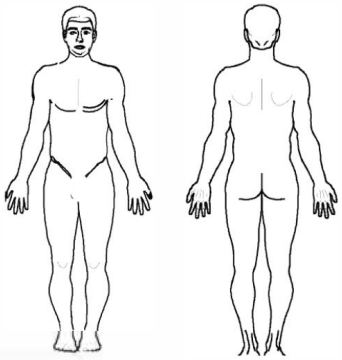
Valley Chiropractic ~ Dr. Helle Leap, D.C.
21740 Devonshire Street, Chatsworth CA 91311
Ph: 818-998-1527 www.DrLeap.com

Please Print this form at home and bring it with you on your first visit.

VALLEY CHIROPRACTIC

Patient Name_____ Birthdate_____ Sex: M ☐ / F ☐
Address_____ City_____
State_____ Zip_____ Phone (___)_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Social Security Number: _____ Dr License:_____

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?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

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)_____
☐ 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_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____
☐ 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**_____

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Name: _____ Birth Date: _____ ☐ Male

Address: _____ Home Phone: _____ ☐ Female

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

Country: _____ SSN: _____

Occupation: _____ Employer: _____

Email: _____ Referred By: _____

Please read this form. It is important..

Insurance coverage can often be a tangled web and difficult to navigate.
We ask that all our patients who plan to have their insurance billed and their treatment covered through insurance, that YOU call your insurance company so you know exactly what your benefits are, how much of your deductible has been met and if there are any "limits" to your policy.

Your insurance might neglect to tell you that your benefits are "managed" through a third -party or certain medical groups. This can make your coverage limited or non-existent, when it comes to chiropractic care. In many cases we don't know this either until we submit claims on your behalf.

If insurance information is provided to the front office, we will bill your insurance company. You will be responsible for any co-payments, deductibles and non-covered services. Be advised that once your insurance company has been billed, we are not able to offer you the "prompt payment" discounted price.

Many of our patients nowadays have high deductibles and sometimes no or limited out-of network benefits and are actually better off not even using their insurance but simply paying for their treatment receiving the "prompt-pay" / discount rate, however we can't make this decision for you.

Medicare does not cover for the Initial Exam, X-rays and maintenance (chronic) care.

Please be advised that all massage therapy is on a "Cash / Prompt Payment" basis and payable at the time of service. Massage Therapy will NOT be billed to your insurance company.

I understand that all responsibility for payment of services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) will be added to my account. I agree to pay all attorneys and collection fees if this account is turned over for collection.

Print Name: _____ Date: _____

Signature: _____ Date: _____

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Informed Consent to Receive Chiropractic Treatment
Acknowledgement of Receipt on Notice of Privacy Practices

Patient: Please discuss any questions or concerns with the Doctor before signing this consent.
I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff 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.
I have had the opportunity to discuss with the doctor and/or with the other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.
I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I understand that I could be receiving the following treatment: Chiropractic care, massage therapy and / or physical therapy.

I have read, 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Name: d _____ **Date:** _____

Signature: _____ **Date:** _____

Acknowledgement of Receipt on Notice of Privacy Practices

☐ Declined to receive Valley Chiropractic's Notice of Privacy Practices **or**

☐ Received a copy of Valley Chiropractic's Notice of Privacy Practices by printing them myself from Dr. Leaps website. http://drleap.com/clients/16464/documents/HIPPA.pdf or have been given a copy from the front office.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

PLEASE PRINT THESE DOCUMENTS AND BRING THEM TO YOUR APPOINTMENT.

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