



Dr. Sean Milam
13372 Newport Ave. Suite I ~ Tustin, CA 92780
(714) 731-9355 ~ Fax (714) 731-9350

Date: _____

Staff Name: _____

Patient Application Form

Patients Name: _____ Chief Complaint: _____
Address: _____ Home Phone: _____
Social Security #: _____ Email: _____
Date of Birth: _____ Age: _____ Marital Status: M S W D
Occupation: _____ Employer: _____
Referred By: _____ Ins. Company: _____
ID#: _____ Group#: _____ Ins. Phone: _____
Name of Insured: _____ Date of Birth: _____

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury someone else might be responsible for? Yes No

Family Physician: _____ Name of Facility: _____

Person to contact in case of emergency (Name and Phone): _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

What medications or drugs are you taking? (check those that apply): Pain Killers Insulin Cholesterol Meds Blood Pressure Meds Muscle Relaxers Birth Control Other:

What is your goal in our office? _____

Have you been to a Chiropractor before? Was your experience positive?

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Milam Chiropractic Health & Wellness all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date



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Health Conditions

Did You Know???

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass the vertebrae. These misalignments are called **Subluxations (sub-lux-a-shun)**. It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted **POSTURE**. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Please check any health conditions you may be experiencing.

Cervical Spine (Neck):

Postural distortions from **suxluxations**, (causing **Forward Head Syndrome**), in your neck will weaken the nerves into your arms, hands and head, and affect these parts of your body. Do you experience....?

- | | |
|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pain into your shoulders/arms/hands |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Hearing Disturbances |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Visual Distractions |
| <input type="checkbox"/> Coldness in hands/feet | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Explain: _____ |
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Recurrent Colds/Flus |
| <input type="checkbox"/> Fatigue | |

Thoracic Spine (Upper Back):

Postural distortions from **suxluxations**, (resulting from **Forward Head Syndrome**), in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience....?

- | | |
|---|---|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Recurrent lung infections/bronchitis |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Asthma/wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Pain on deep inspiration/expiration |

Thoracic Spine (Mid Back):

Postural distortions from **subluxations**, (resulting from **Forward Head Syndrome**), in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of the body. Do you experience....?

- | | |
|--|---|
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pain into your ribs/chest | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Tired/irritable after eating or when you haven't eaten for a while |

Lumbar Spine (Low Back):

Postural distortions from **subluxations** in the low back, (resulting in **Forward Head Syndrome**), will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience....?

- | | |
|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Recurrent bladder infections |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping |
| <input type="checkbox"/> Weakness/injury in your hips/knees/ankles | <input type="checkbox"/> Sexual dysfunction |

Please list any health conditions not mentioned. _____

Please list any medications/surgeries. _____

I certify that the above information is accurate to the best of my knowledge.

Date: _____ Patient Signature: _____

Date: _____ Guardian Signature: _____



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Protecting Your Health Information

New Regulation Passed

The new regulations are part of the Health Insurance Portability and Accountability Act or HIPPA does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage; although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes a very attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment, and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request, or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will be given general about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Also upon becoming a patient, we will be entering your name into our database and you will receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.



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Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any question please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Milam Chiropractic Health & Wellness, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I am / am NOT pregnant and (give my permission / don't give permission) to x-ray me for diagnostic interpretation. (Circle one above)

Missed Appointments:

There will be a \$20 fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to who may we do so?

Spouse: _____

Children: _____

Others: _____

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes [] No []

I, _____, have read and fully understand the above statements.

Acknowledgement

I have received the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____ Date: _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal 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 also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. 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. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures 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. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

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 provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

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. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL 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 SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

CHIROPRACTIC INFORMED CONSENT TO TREAT

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, whether signatories to this form or not.

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

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE