NEW PATIENT APPLICATION

Patient Name: _____ Gender_____ Date of Birth: _____
Address: _____City: _____ Zip: _____
Email: _____
Home Phone: _____ Cell: _____ Work: _____
Occupation: _____ Employer: _____

Referred By? _____

Purpose of this appointment or primary concern:_____
_____

MEDICAL HISTORY: Please print clearly and fill in as completely as possible.

Have you used any medications or treatments for this problem(s)? _____

Patient's Primary Physician:_____

Current drugs or medications: _____

PLEASE ANSWER CAREFULLY THE LIST BELOW AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CHIROPRACTIC CARE **(circle those that apply if you have experienced in the last 6 months).**

Pneumonia	Mumps	Influenza	INTAKE
Rheumatic Fever	Small Pox	Pleurisy	Coffee
Polio	Chicken Pox	Arthritis	Tea
Tuberculosis	Diabetes	Epilepsy	Alcohol
Whooping	Cancer	Mental Disorders	Cigarettes
Cough Anemia	Heart Disease	Lumbago	White Sugar
Measles	Thyroid	Eczema	Vitamins

HAVE YOU TESTED HIV POSITIVE? _____

Height: _____ Weight: _____ Are you happy with your current weight? _____
Do you feel refreshed after waking up? _____ How old is your mattress? _____
Which position(s) do you sleep? _____ Do you exercise regularly? _____
How many hours do you spend on an electronic device? _____ Have you ever had surgery? _____
Have you ever been in an auto accident? _____ Were you evaluated and treated after each? _____
Have you had any non-vehicle accidents or falls? _____ Were you evaluated and treated after? _____

As a patient or legal guardian of minor patient I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to paid directly to OC Integrative Health. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

I have read and agree to comply with the office policy stated in the patient information sheet.

SIGNED_____

OC Integrative Health

"You deserve to have a doctor who treats you as a whole person and gets life changing results"

Check any symptoms you may have experienced in the last 6 months

Musculo-Skeletal Code
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Lower back Pain
- ☐ Arm Pain
- ☐ Joint Pain
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ General Stiffness

Nervous System
- ☐ Nervousness
- ☐ Numbness
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Convulsions
- ☐ Paralysis
- ☐ Cold/Tingling Extremities

General Code
- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Headaches
- ☐ Fever
- ☐ Allergies

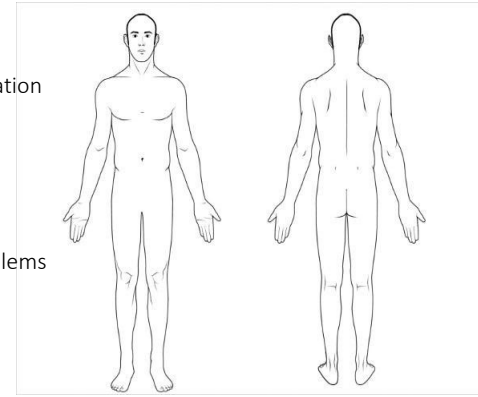
Gastro-Intestinal Code
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Weight Trouble
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver/Gallbladder Problem
- ☐ Abdominal Cramps
- ☐ Gas/Bloating
- ☐ Heartburn
- ☐ Black/Bloody Stool

Genito-Urinary Code
- ☐ Bladder Trouble
- ☐ Pain/Excessive Urination
- ☐ Discolored Urine

C-V-R Code
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Lung Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT Code
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Earaches
- ☐ Stuffy Nose
- ☐ Hearing Difficulty

Male/Female Code
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____



Please outline on the diagram the area of discomfort.

Pain Rating 1-10: (10 being the worst you feel today) _____

How many days per week can you commit to in order for you to get better? _____

What days are you available for treatment?

M ☐ W ☐ F ☐

Family History

The following members have a same or similar problem as I do:
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

Females Only:

When was your last period?_____

Are you pregnant? _____

Why Functional Neurology Medicine? People come to us for a variety of reasons. Some for symptomatic relief (Relief Care), other are interested in finding the cause (Corrective Care). We will consider your needs and desires when recommending your treatment program. Circle the one(s) you desire most: Relief Care/Corrective Care/Doctors Recommendation

Do not write below this line_____

Patient Accepted? Yes NO Dr. Signature_____ Date:_____

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Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3

Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome? **Yes** **No**

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3

Have you had your gallbladder removed? **Yes** **No**

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

SMGEMAF(122215)Version 3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes			No
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

OC Integrative Health

Name:_____ Date:_____

Please answer these questions so we can help you get better faster. **(Please circle all that apply)**

1. How have you taken care of your health in the past?
   - ☐ Medications
   - ☐ Emergency room
   - ☐ Routine medical
   - ☐ Exercise
   - ☐ Nutrition/Diet
   - ☐ Holistic care
   - ☐ Vitamins
   - ☐ Chiropractic
   - ☐ Other (please specify) _____

2. How did the previous method(s) work out for you?
   - ☐ Bad results
   - ☐ Some results
   - ☐ Great results
   - ☐ Nothing changed
   - ☐ Did not get better
   - ☐ Did not get worse
   - ☐ Did not work very long
   - ☐ Still trying

3. How have others been affected by your health condition?
   - ☐ No one is affected
   - ☐ Have not noticed any problem
   - ☐ They tell me to do something
   - ☐ People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - ☐ Job
   - ☐ Kids
   - ☐ Future ability
   - ☐ Marriage
   - ☐ Self-esteem
   - ☐ Sleep
   - ☐ Time
   - ☐ Finances
   - ☐ Freedom

5. Are there Health Conditions you are afraid this might turn in to?
   - ☐ Family health problems
   - ☐ Heart disease
   - ☐ Cancer
   - ☐ Diabetes
   - ☐ Arthritis
   - ☐ Fibromyalgia
   - ☐ Depression
   - ☐ Chronic fatigue
   - ☐ Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____

_____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples

_____

_____

What are you most concerned with regarding your problem? _____

_____

_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific. _____

_____

What would be different/better without this problem? Please be specific. _____

_____

What do you desire most to get from working with us? _____

_____

What is that worth to you? _____

_____

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OC Integrative Health
Office Policies

We are committed to providing you with the best possible care. Please ask if you have any questions about our fees or policies.

For your best results from care, you agree to follow the recommendations by the doctor, including following the treatment schedule and the use of supports, supplements, diet, exercise, etc. _____

Before you start care, it is necessary to make a financial agreement and promptly fill out all necessary forms for your care.
_____

Recommendations for future care will be made only after an examination and/or x-rays. _____

PAYMENT IS DUE, IN FULL, AT THE TIME OF SERVICE.

If you have health insurance, remember that this is a contract between you and your insurance company (BENEFITS ARE NOT GUARANTEED and is subject to what they agree to pay). If your insurance company does not cover any part or all of your services, you are responsible for the charges; professional services are rendered and charged to you, the patient, and your insurance may or may not pay them (even if benefits are verified). In most cases, we are not a party to this contract.
_____

If there is a dispute between you and your insurance company regarding deductibles, covered charges, co-payments, etc., our commitment is to provide factual information as necessary. Any information requests requiring Dr. Olsen's time will be billed to you at the rate of $300/hour. ____

If you must miss an appointment, please provide us with at least 48 hour notice. Less than a 48 hour notice results in a cancellation charge EQUAL to the cost of your missed appointment. This is your responsibility, it is not covered by insurance or other payment arrangements. _____

Our office does not provide billing of accounts. We require a credit card on file to cover any future balance and/or charges. In the event payment is due, the following terms will apply (please initial):

_____ 1. You will only be charged for services or products at the office of OC Integrative Health, if you have a balance on your account.
_____ 2. You will not be charged for services not performed or products not received.
_____ 3. Your authorized card on file will be charged at the time services are provided.

If your account becomes past due, interest will be charged for any balance over 30 days at 1.5% per month and a $5 statement fee will be added per statement sent. Any costs associated with collecting your account will be your responsibility and added to your account balance.

By signing this, you have agreed that you have read, understood, and agreed to the above policies and procedures and received a copy.

Name: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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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 California 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 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 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment 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 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 of 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:	Date
(Or Patient Representative)	(Indicate relationship if signing for patient)

OFFICE SIGNATURE:	Date

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INFORMED CONSENT FOR TREATMENT

Clinic Name: OC Integrative Health

I hereby request and consent to treatments which may include chiropractic adjustments, pulsed electromagnetic field therapy, low level laser therapy and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during treatment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

Printed name of Patient

x_____ _____

Signature of Patient Date

x_____ _____

Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____

Witness to Patient's Signature Date

NOTICE OF PRIVACY PRACTICES
OC Integrative Health

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.

OC Integrative Health, is required by law to maintain the privacy and confidentiality of your protected health information and to provide you with notice or our legal duties and privacy practices with regard to your protected health information.

Disclosure of your health information

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare procedures. This may be for the purpose of consultation regarding your condition with other healthcare providers for assessment and/or treatment.

Payment: We may disclose your healthcare information to your insurance provider or Worker's Compensation for the purpose of treatment, payment or healthcare procedures. This includes the billing statement which contains information such as date of injury, dates of treatment, diagnosis, and procedure codes.

Emergencies: to assist in notify a family member, or another responsible person for your care in an emergency.

Public health: for the purpose of preventing or controlling disease, injury or disability, reporting child abuse or neglect, domestic violence or disease or infection exposure.

Judicial and Administrative Proceedings: in the course of these proceedings.

Law Enforcement: for the purpose of identifying and locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons: to coroner's or medical examiners.

Organ Donation: to organization involved with organ donation.

Research: for research that has been approved by an institutional Research Board.

Public Safety: to prevent or lessen a serious or imminent threat to the health and safety to a person or the general public.

Special Government Agencies: for military, national security, prisoner and governmental benefits purposes.

Marketing: without the use of any health information, we may contact you for general marketing purposes for charitable events or healthcare events and awareness through a letter, postcard, phone call, email or text.

No personal health information will be disclosed with any phone call from Dr. Greg Olsen's office to you.

Change of ownership: In the event that Dr. Greg Olsen, D.C. should sell his practice or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method or communication or delivery.
- You have the right to inspect and copy your health information.
- You have the right to request an amendment to your protected health information. We are required to amend this information, but will provide an explanation. You can have your own amendment added.
- You have the right to receive an accounting of disclosures of your health information.
- You have a right to a paper copy of this notice upon request.

Changes to this Notice of Privacy Practices: OC Integrative Health reserves the right to amend this notice at any time and will make the new provisions effective for all information that it maintains or contains.

Our office is required by law to maintain the privacy of your health information and to provide you with this notice of its legal duties and privacy practices.

If you have any questions, or if you want more information about your privacy rights, or you have a complaint about your privacy rights, please contact OC Integrative Health by calling 949-859-5192. If you are not satisfied with the manner in which this office handles your complaint, you may contact:

DHHS, Office of Civil Rights, 200 Independence Ave., SW, Room 509F HHH Building, Washington DC, 2021

This notice is effective as of January 1, _____.

I have read the Privacy Notice and understand my rights contained in this notice.

_____ _____

Print Your Name | Sign your Name | Date

Notice and Acknowledgement

Acknowledgment: I acknowledge that I have received the Notice of Privacy Practices

_____ _____ _____

Print your Name | Sign your Name | Date

22691 Lambert Street, Suite 503 Lake Forest, CA 92630 | askdrolsen@gmail.com | www.askdrolsen.com | **Phone:** (949) 859-5192 | **Fax:** (949) 583-2961