NEW PATIENT INFORMATION

Patient Name	Preferred Name		Date of Birth
Street Address	City	State	Zip
Home Phone	Cell Phone		Work Phone
Email Address	Cell Phone Carrier/Provider (for text appointment reminders)		
Emergency Contact Name	Relationship		Phone

Gender: □M □F Marital Status: □S □M □D □W Spouse's Name: _______________

Who referred you to our office: ____

May we send your PCP a report of your visit? □ Yes □ No
If yes, to whom? PCP name: _______________________ PCP phone: ____________________

Were you injured in an auto accident? □ Yes □ No Date: ____________________
Were you injured in a work accident? □ Yes □ No Date: ____________________

Attorney's name (if applicable): ____

AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize the staff of Dr. La Ruffa to perform all necessary services needed during diagnosis and treatment.
I authorize the release of any medical information necessary to process and pay this claim. I authorize payment of health benefits, "Medical Reimbursement, and/or "Government Benefits" otherwise payable to me be paid directly to:

SPORTS & SPINE INJURY CENTER
AUGUST J LARUFFA III, DC
JOHN S SCOTT, PT

I understand that I am financially responsible for all charges whether or not paid by insurance.

____

Patient/Guarantor's Signature Date

I attest that the above information is true and correct to the best of my knowledge. I understand that any charges incurred by me in this office are my sole responsibility despite any insurance plan or legal involvement.

____

Patient/Guardian Signature Date

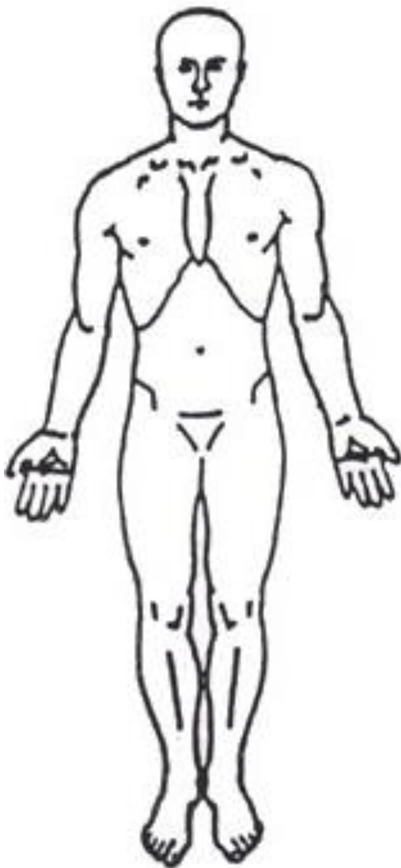
La Ruffa Chiropractic
+ Sports Rehab
Integration. Innovation. Invigoration.

MEDICAL INFORMATION

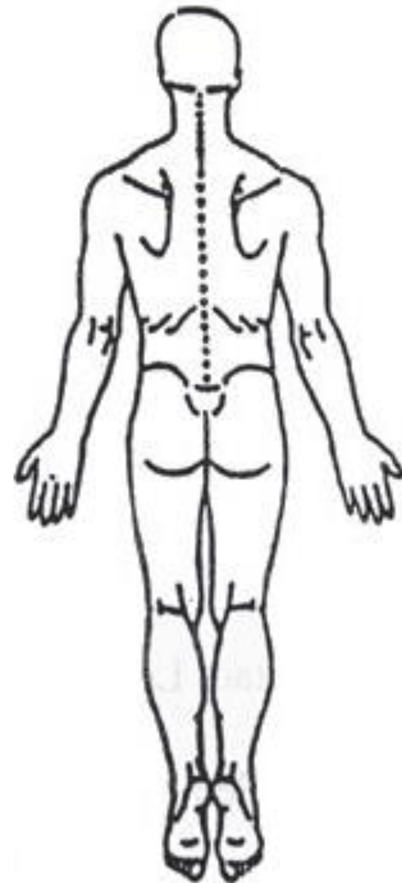
Please list current complaints, in order of severity, along with what makes them better and worse, and date (timeframe) of onset:

Problem	Onset	Frequency	Severity
1.			
2.			
3.			

Current Complaints: PLEASE MARK ON **ALL** AREAS THAT ARE IN PAIN BELOW (Along with corresponding letter)



A = Ache/Sore
T = Tension
S = Sharp
B = Burning
N = Numbness
G = Tingling
M = Spasm
O = Other



Previous Surgeries: ____

Medications/Supplements: ____

For women: Are you pregnant? ____

____

Patient/Guardian Signature **Date**

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place yourself and your family under care.

1. **If you do not have insurance**: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $200 or care may be terminated. Our payment plans make care an affordable part of your budget.

2. **If you have insurance**: All deductibles, co-payments, co-insurances, or other payments are expected at the time of service or by an authorized payment plan. You are considered a cash patient until you bring in completed insurance forms and we qualify and accept your insurance coverage.

If your insurance company has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance company has not paid a claim within 90 days of submission, you accept responsibility for payments in full for any outstanding balance.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you.

____

Patient/Guardian Signature **Date**

RECEIPT OF NOTICE OF PRIVACY POLICY

I acknowledge that I was provided the opportunity to read the Notice of Privacy Practices and that I understand this Notice. I am aware that I have the right to request a copy of this Notice at any time and that this signed form will be placed in my patient chart and maintained for six years.

____

Patient/Guardian Signature **Date**

List below the names of people to whom you authorize to access your private health information:

____

Name Relationship

____

Name Relationship

____

Name Relationship

CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me (or on the patient for whom I am legally responsible) by the doctor of chiropractic named below and/or other support staff who now or in the future treat me while working with the chiropractor named below, whether signatories to this form or not.

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

I understand that, like all health modalities, results are not guaranteed, and there is no promise of cure. I further understand that, as in the practice of medicine, the practice of chiropractic includes possible risks including fractures, disc injuries, strokes, dislocations, or 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 to perform procedures which the doctor feels are in my best interests (based upon the facts then known).

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include: over-the-counter analgesics and rest; prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand that I have the right to a second opinion if I have concerns about the nature of my symptoms and treatment options.

I have read the above consent and have had the opportunity to ask questions about its content, and by signing below I agree to chiropractic 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.

Dr. August La Ruffa III, DC

____

Patient/Guardian Signature Date

ACUPUNCTURE INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other procedures within the scope of acupuncture on me (or on the patient for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working with the acupuncturist named below, whether signatories to this form or not.

I understand that methods of treatment may include acupuncture, electrical stimulation, Chinese massage, Chinese herbal medicine, and nutritional counseling. I will immediately notify a member of the clinical staff if any unanticipated or unpleasant effects associated with treatment occur. I understand that results are not guaranteed.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects. Possible side effects include bruising, numbness or tingling near the needling sites, dizziness or fainting, and burns from the use of heat lamps. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture including lung puncture. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, vomiting, headache, diarrhea, and rashes. I understand that some herbs may be inappropriate during pregnancy and I will notify a clinical staff member if I am or become pregnant. I do not expect the clinical staff to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment to perform treatment that is in my best interest (based on facts known at the time).

I have read the above consent, have been made aware of the risks and benefits of acupuncture, and have had an opportunity to ask questions. 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.

Dr. August La Ruffa III, DC

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Patient/Guardian 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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, as to whether this agreement is unconscionable, and any procedural disputes, 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, preceptors, or 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. This agreement is intended to create an open book account unless and until revoked.

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 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 Name: ______________________________ Signature: __________________________________ Date: ________________

Parent or Guardian: __________________________ Signature: __________________________________ Date: ________________

Witness Name: _____________________________ Signature: __________________________________ Date: ________________

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