Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Complaints**

Nature of injury: ☐ Automobile ☐ Work ☐ Other

Have you ever had same condition: ☐ Yes ☐ No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been under chiropractic care? ☐ Yes ☐ No

Date of injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other practitioners seen for this injury/condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Name of party responsible for payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree that health insurances policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Have you been treated for any conditions in the last year? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities aggravate your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are you taking and for what conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What vitamins, minerals or herbs do you currently take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant? ☐ Yes ☐ No Have you had x-rays? ☐ Yes ☐ No

**Please check any recent or chronic medical conditions:**

☐ Alcoholism ☐ Cramps ☐ HIV ☐ Pacemaker

☐ Allergies ☐ Depression ☐ Hot flashes ☐ Polio

☐ Anemia ☐ Diabetes ☐ Irregular heart beat ☐ Poor posture

☐ Arteriosclerosis ☐ Digestion problems ☐ Irregular cycle ☐ Sleep problems/insomnia

☐ Arthritis ☐ Dizziness ☐ Kidney infection ☐ Spinal curvatures

☐ Asthma ☐ Ears ringing ☐ Kidney stones ☐ Stroke

☐ Back pain ☐ Excessive menstruation ☐ Loss of memory ☐ Swelling of ankles

☐ Breast lump ☐ Eye pain/difficulties ☐ Loss of balance ☐ Swollen joints

☐ Bruise easily ☐ Fatigue ☐ Loss of smell ☐ Thyroid condition

☐ Cancer ☐ Frequent urination ☐ Loss of taste ☐ Vertigo

☐ Chest pain/conditions ☐ Headaches ☐ Neck pain/stiffness ☐ Ulcers

☐ Cold extremities ☐ Hepatitis C ☐ Nervousness ☐ Other:

☐ Constipation ☐ High blood pressure ☐ Nosebleeds

**Have you ever:** Yes No Briefly explain

Broken bones? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Been hospitalized? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Been in an auto accident? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had sprains and/or strains? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Been struck unconscious? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had surgery? ☐ ☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History Continued**

 Yes No

Do you experience pain every day? ☐ ☐

Do your symptoms interfere with daily life? ☐ ☐

Does pain wake you up at night? ☐ ☐

Are your symptoms worse during certain times of the day? ☐ ☐

Do changes in weather affect your symptoms? ☐ ☐

Do you wear orthotics? ☐ ☐

**Habits**

 None Light Moderate Heavy

Alcohol ☐ ☐ ☐ ☐

Coffee ☐ ☐ ☐ ☐

Tobacco ☐ ☐ ☐ ☐

Drugs ☐ ☐ ☐ ☐

Exercise ☐ ☐ ☐ ☐

Sleep ☐ ☐ ☐ ☐

Appetite ☐ ☐ ☐ ☐

Soft Drinks ☐ ☐ ☐ ☐

Water ☐ ☐ ☐ ☐

Salty Foods ☐ ☐ ☐ ☐

Sugary Foods ☐ ☐ ☐ ☐

**Family history**

Please list present & past health conditions. (Examples: heart disease, cancer, diabetes, arthritis, etc)

Condition: Relationship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent**

I hereby consent to the performance of examination and treatment by the licensed doctors of chiropractic, medical doctors, physician’s assistants, physical therapists, Pilates instructors, acupuncturists and/or licensed therapists who may be employed by or engaged in practice in this clinic.

Additionally, as is the case with most health care interventions, there is a certain inherent risk of complication associated with physical examination, physiotherapeutic, spinal manipulation procedures, home and in office exercises, use of medical equipment (in office and home use) and medications. These complications include but are not limited to muscle strains, dislocations, skin irritation, costovertebral sprains, electrical shock, fractures, disc trauma, minor burns, stroke and nerve injury. I understand my doctor will not be able to anticipate all potential complications, but elect to rely on his/her clinical expertise and judgment to determine reasonable courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time. I also hold LIV Integrative Health and its staff harmless for injuries caused by the use of durable medical equipment due to improper use or manufacture defects. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment based upon facts known that is in my best interests.

I have read and understand the preceding statements and hereby consent to voluntarily participate in treatment at LIV Integrative Health deemed appropriate by my doctor. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Information Practices**

Protecting the privacy of your personal health information is important to us. By signing below you understand how information about you may be used and disclosed and how you can get access to this information.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. The provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Responsibility**

As a courtesy to you, LIV Integrative Health will call your insurance company to verify your benefits. We assume no liability for errors made by your insurance company in this quote. We will review the coverage with you. It is then your responsibility to pay any balance remaining after your insurance carrier has paid its portion of the bill.

If you have a deductible that is not yet met, we will collect payment from you directly. You will need to pay for your service out of pocket until your deductible is met. Once your deductible has been met, we will collect your co-pay or co-insuranceat the time of services.

If any of your checks are returned unpaid, we will assign a fee of $25. If you refuse to pay your bill, we may initiate collections proceedings.

**There is a chance that the covered benefit checks will be sent from your insurance carrier directly to you, the patient, rather than to us, the provider. The amount of these checks is due to us in addition to any co-pay or co-insurance. Please ensure that this amount is promptly paid to us for services rendered.**

By signing below, I acknowledge that I understand and agree to the terms of the Financial Responsibility.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Insurance Benefits / Authorization of Information**

I instruct and direct my insurance company to pay LIV Integrative Health the professional and medical expense benefits allowable under my current insurance policy for services rendered. This is a direct assignment of my rights and benefits under this policy. I understand and agree that I am ultimately responsible for the balance on my account for any services rendered.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation Policy**

In order to serve all of our patients and provide the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. We realize circumstances occur and you may need to change an appointment. We ask that you notify us at least **24 hours** in advance formassage therapy, acupuncture and Pilates appointments. If at least a 24-hour notification is not given for these appointments, no-shows and cancellations will be charged **$30**. The more notice you provide, the better we can serve all patients. If you reach our voicemail, please leave a message and we will call you back to reschedule. Thank you in advance for your cooperation!

By signing below, I acknowledge that I understand and agree to the terms of the Cancellation Policy.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Record Release Authorization**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Records requested from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize and request the release of my medical records to:

**LIV Integrative Health**

20301 SW Acacia Street Ste 250

Newport Beach, CA 92660

Phone #: 949-274-7104

Fax #: 949-274-7644

Info@LIVIH.com

Records requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_