

GALLA CHIROPRACTIC GROUP REGISTRATION

Date: _____

Phone: _____

Patient: _____
Last Name
First Name
Initial

Street Address: _____

City/State/Zip Code: _____

Sex: M F Age: _____ Birthdate: _____ Single Married Widowed Separated Divorced

Social Security #: _____ Email: _____

Occupation: _____ Employer Name: _____

How did you hear about us?: _____

Insured's Name: _____
Last Name
First Name
Initial

**Patient Agreement:
ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to **Galla Chiropractic Group** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

Present Complaints (Please circle the appropriate ones)

- | | | |
|---|--|--|
| Headache | Feet/Hands Cold | Unbalanced |
| Mental dullness | Depression | Fainting |
| Loss of memory | Rib pain | Blurred vision |
| Hip right/left | Shoulder right/left | Knee right/left |
| Dizzy | Nervousness | Irritability |
| Ears ringing/buzzing | Eye strain/pain | Double vision |
| Upper back pain | Shortness of breath | Loss of smell |
| Lower back pain | Fear | Chest pain |
| Midback pain | Confusion | Neck pain |
| Pins and needles in hands
right/left | Pins and needles in arms
right/left | Pins and needles in legs
right/left |

Medical Implants: _____

Medical alerts: _____

Surgical Implants: _____

Pregnancy: yes ___ no ___

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain
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Patient Name: _____

Date: _____

Medications: (please list all medications and supplements that you currently take)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (please list all medications that cause allergic reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

NO MEDICAL PROBLEMS - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other: _____ |

Cardiac / Heart and peripheral vascular disease

- | | | |
|---|---|--|
| <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> irregular heartbeat, arrhythmia |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> heart murmur, valve disorder | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> deep vein thrombosis |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> bleeding problems | |

Neurologic Disorders

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> stroke or TIA | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> cerebral palsy |
| <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> MS | <input type="checkbox"/> polio |
| <input type="checkbox"/> other: _____ | | |

Bone & Joint Disorders

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> gout | <input type="checkbox"/> osteomyelitis |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> lupus | <input type="checkbox"/> ankylosing spondylitis |
| <input type="checkbox"/> other: _____ | | |

Patient Name: _____ **Date:** _____

Gastrointestinal Disorders

- peptic ulcer or stomach ulcer
- acid reflux, GERD
- GI bleed
- other: _____
- diverticulitis
- irritable bowel
- inflammatory bowel disease
- hepatitis - Type _____
- liver disease

Genitourinary Disorders

- urinary tract infection
- bladder problems
- kidney problems
- kidney stones
- dialysis, kidney failure
- other: _____

Metabolic & Other Disorders

- Diabetes x _____ years
- thyroid problems
- sickle cell disease
- high cholesterol or lipids
- skin disorder _____
- psoriasis
- any skin ulcer
- tooth abscess, gingivitis
- depression
- anxiety
- alcohol or drug dependency
- other: _____

Cancer : any type -- please specify

Other medical problems NOT included above (explain)

Family History:

Please indicate with an "X" any significant family medical history or problems.

- asthma
- COPD or Emphysema
- heart attack, myocardial infarction
- irregular heartbeat, arrhythmia
- MS or Parkinson's
- osteoarthritis
- rheumatoid arthritis
- acid reflux, GERD
- liver disease
- kidney problems
- diabetes
- thyroid problems
- Malignant hyperthermia
- tuberculosis
- other lung : _____
- congestive heart failure
- bleeding problems
- Peripheral neuropathy
- other neuro : _____
- Lupus
- Other bone & joint: _____
- inflammatory bowel disease
- other GI : _____
- sleep apnea
- hepatitis - Type _____
- dialysis, kidney failure
- psoriasis
- sickle cell disease
- any skin ulcer
- high cholesterol or lipids

Cancer : any type -- please specify

Other medical problems NOT included above (explain)

Patient Name: _____

Date: _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> United HealthCare | <input type="checkbox"/> Auto Accident |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Major Medical | <input type="checkbox"/> Union Plan |
| <input type="checkbox"/> Anthem/BCBS | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other |

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:

Name & Address: _____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address: _____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):

Patient Name: _____ Date: _____



Galla Chiropractic Group

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and /or temporary increase in symptoms, lack of improvement of symptoms, burns and or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, stokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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Galla Chiropractic Group

Consent for Purpose of Treatment, Payment, and Healthcare Operations

I, _____ (Name of Individual) consent to Galla Chiropractic Group's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment, or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describe my rights and the practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Signature of Patient or Personal Representative: _____

Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: _____

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Galla Chiropractic Group

OFFICE POLICY AND RULES AGREEMENT

1. I agree to silence my cell phone while in the office to prevent disturbing others during treatment hours. If I need to use my cell phone, I will go outside to do so.
2. I agree to keep the office updated with my current contact and insurance information. If I am working with an attorney, I will update the office immediately with new information.
3. I agree to keep my appointments and follow the schedule set forth by the doctor/and or massage therapist. If I have to miss an appointment, I will call at least 24 hours in advance during office hours to cancel my appointment. Failure to do so will result in a service charge that will be billed to me directly and is not payable by insurance, lien, workers compensation, etc. Service charges are due and payable at time of next appointment or within one week (whichever comes first).
4. I agree to follow all recommendations made by the doctor, including the proper use of my spinal supports, doing my exercises as prescribed, etc.
5. I agree to make a personal financial agreement and promptly fill out all necessary medical, legal and insurance forms to aid in the timely payment for my care.
6. I understand that if my insurance company has not paid my claim within sixty (60) days, a copy of that unpaid claim will be given to me and I will be responsible to follow-up on the statues of payment.
7. I further acknowledge and agree that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. I also acknowledge and agree that in the event I do not pay for services Galla Chiropractic Group may place my account with a collection agency, I agree to pay reasonable collection fees, attorney fees and court cost incurred in collection of my overdue account.

Patient: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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Galla Chiropractic Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (patient's name)
acknowledge that I have received, reviewed, understand and agree to the Notice
of Privacy Practices of Galla Chiropractic Group, which describes the Practices'
policies and procedures regarding the use and disclosure of any of my Protected
Health Information created, received, or maintained by the Practice.

Date: _____

Patient Printed Name: _____

Patient Signature: _____

Witness Signature: _____

GALLA CHIROPRACTIC GROUP

MANDATED RELEASE OF MEDICAL RECORDS

I understand that information regarding myself and family members will be kept confidential, within the confines of the treatments teams, unless express written permission is given to release information. However, exceptions to maintain confidentiality are **1. Incidents of mandating reporting; 2. When a court order is issued for records; 3. In the event that an individual is dangerous to self or others, at which time the minimal amount of information necessary will be shared to ensure the safety of the individual and others to provide for community of care.**

Finally, I understand that I may withdraw this consent for services at any time.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS

I, _____, give Dr. Eric Galla and Galla Chiropractic Group staff authorization to disclose my protected health information to the following family, friends, and/or caregivers:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Name: _____ Signature: _____ Date: _____