# PERSONAL INJURY QUESTIONNAIRE

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Name on Policy (If other than self) _____ Policy # _____

Responsible Party's Name _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Policy # _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

**NATURE OF ACCIDENT:**

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____

    _____

    _____

    _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:

    _____

    _____

    _____

12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

13. What are your PRESENT complaints and symptoms? _____

_____

_____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe:

_____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe:

_____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

_____

_____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

_____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

| | | | | |
|---|---|---|---|---|
| ☐ Headache | ☐ Irritablity | ☐ Numbness in Toes | ☐ Face Flushed | ☐ Feet Cold |
| ☐ Neck Pain | ☐ Chest Pain | ☐ Shortness of Breath | ☐ Buzzing in Ears | ☐ Hands Cold |
| ☐ Neck Stiff | ☐ Dizziness | ☐ Fatigue | ☐ Loss of Balance | ☐ Stomach Upset |
| ☐ Sleeping Problems | ☐ Head Seems Too Heavy | ☐ Depression | ☐ Fainting | ☐ Constipation |
| ☐ Back Pain | ☐ Pins & Needles in Arms | ☐ Lights Bother Eyes | ☐ Loss of Smell | ☐ Cold Sweats |
| ☐ Nervousness | ☐ Pins & Needles in Legs | ☐ Loss of Memory | ☐ Loss of Taste | ☐ Fever |
| ☐ Tension | ☐ Numbness in Fingers | ☐ Ears Ring | ☐ Diarrhea | ☐ _____ |

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:

_____

_____

_____

23. Other pertinent information: _____

_____

_____

_____

_____ DATE

_____ PATIENT'S SIGNATURE

# FOCUS CHIROPRACTIC CENTER

1123 Celis Street
San Fernando, Ca 91340
(818) 838-4900 Fax: (818) 838-4901

**PATIENT'S NAME:** _____ **TODAY'S DATE:** _____

## PERSONAL INJURY FORM

## YOUR MEDICAL HISTORY

Do you suffer from?

| | | | |
|---|---|---|---|
| High Blood Pressure | _____ | Diabetes | _____ |
| Arthritis | _____ | Tuberculosis | _____ |
| Ulcers | _____ | Kidney/Liver Disease | _____ |
| Epilepsy | _____ | Heart Disease | _____ |

Others _____

_____

Previous Surgeries or Hospitalizations: _____

_____

ALLERGIES (Please include all to drugs/food/etc.) _____

PREVIOUS WORK OR/AND CAR ACCIDENTS: Please, give dates, injuries, treatment & residuals, if any)

_____

_____

## YOUR HABITS

Do You: Drink Coffee _____ Drink Alcohol _____ Use Tobacco _____ Use Illicit Drugs _____

How much of each? _____ _____ _____ _____

Do You: Use any prescribed medication? ____
Names: _____

Did/Do You: Take any medication **after** this accident? ___ Names: _____

Do you Exercise Regularly? Yes / No How Often? _____

Have you stopped your exercise habits since the accident? _____

## FAMILY HEALTH PROBLEMS (please, only major medical illnesses such as diabetes, cancer, HBP, etc.)

Mother's Health History: _____

Father's Health History: _____

Other Blood Relative: _____

**YOU ARE:** MARRIED SINGLE **YOU HAVE:** CHILD(REN)

# FINANCIAL AGREEMENT
# PERSONAL INJURY

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your injury. In order to familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

***PARTY RESPONSIBLE:***
If you were involved in an auto accident in your own vehicle, we will bill the medical payments portion or Personal Injury Protection portion of your insurance policy to cover the treatment charges incurred in our office.

*MED PAY:* If you were a passenger in another vehicle, the insurance company which insures the automobile may be billed for your medical services incurred.
*PIP:* If you were a passenger in another vehicle, and you own a car which has PIP coverage, the insurance company which carries your policy will be responsible to pay your medical bills.
*3rd PARTY:* If another vehicle has caused the accident, we will first bill your automobile MedPay or PIP policy for coverage PRIOR to submitting a claim to the insurance carrier of the party at fault.

It is also to your advantage for our office to bill your own health insurance policy for your medical services, providing your policy does not state otherwise. Any amount received above and beyond your total bill in this office will be refunded to you.

***ATTORNEY LIENS:***
If you hire an attorney to represent you in a law suit, it is our policy to have your attorney sign a Doctor's Lien. This will guarantee direct payment to our office for any undid balance upon the settlement of your law suit. We retain the right to first submit all charges to your private and/or auto insurance policy for payment.Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement.

***RESPONSIBILITY FOR PAYMENT:***
As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately, you are personally responsible for payment of these charges, regardless of any insurance reimbursement or settlement you may or may not receive.

Once again, we welcome you to our office. We hope that this has answered any questions that you might have about our financial arrangements. If, at any time, you have further questions about your care, please, don't hesitate to ask.

***I have read and agree to the above***

Patient's Signature _____ Date _____

# DOCTOR'S LIEN

To: ATTORNEY/INSURANCE CARRIER

_____

_____

_____

From: DOCTOR

Lidia Alzate, D.C.
1123 Celis Street
San Fernando, CA 91340
Phone: (818) 838-4900
Fax: (818) 838-4901

**REGARDING: PATIENT RECORDS AND DOCTOR'S LIEN**

**I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, and prognosis of myself concerning my accident/illness, which occurred on _____ (please enter date of the accident).**

**I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay to said doctor such sums as may be due and owing him for services rendered to me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect the said doctor adequately.**

**I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration for his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.**

**I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).**

**A photocopy of this lien shall be considered as effective and valid as the original. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment and may declare the entire balance due and payable.**

Patient's
Name:_____

Signature_____Date_____

I undersigned, being Attorney of records or authorized representative of insurance carrier for the above patient, do hereby acknowledge receipt of the above lien, and do agree to observe all the terms of the above and honor the same to protect adequately the said above named doctor.

Attorney's
Signature_____Date_____

Please date, sign and return one copy to the doctor office. Keep one copy for your records.

# ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

**Patient Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Employer:** _____

**Claim or Group #** _____

**SS# or ID#** _____

**I hereby instruct the above named Insurance Company to pay by check made out to and mailed directly to:**

LIDIA ALZATE, D.C.

916 West Burbank Blvd Suite L, Burbank CA 91506 - Ph# (818) 842-7700 - Fax (818) 842-7001
451 South Brand Blvd Suite 203, San Fernando CA 91340 - Ph# (818) 838-4900 - Fax (818) 838-4901

**If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:**

LIDIA ALZATE, D.C.
C/0 916 W Burbank Blvd Suite L Burbank CA 91506
451 S Brand Blvd Suite 203 S Fernando CA 91340

**for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.**

**A photocopy of this Assignment shall be considered as effective and valid as the original.**

**I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.**

**Dated at** _____ **County, this** _____ **day of** _____ **20**_____

_____ _____
**Signature of Policy Holder** **Witness**

_____
**Signature of Claimant, if other than Policyholder**

# THIRD PARTY MEDICAL LIEN AND ASSIGNMENT

PATIENT: _____

CLAIM #: _____

DATE OF INJURY: _____

I hereby authorize and direct _____ Insurance Company, to pay to Dr. _____ such sums as may be due and owing him/her for medical/chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges injured for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all medical bil submitted by him/her for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his/her awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but may declare the entire balance due and payable by me.

_____ _____

Date Patient's Signature

The undersigned Insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor above and below named and make payment payable directly to said doctor.

_____ _____

Date Signature of Insurance Company Representative

_____

Print First and Last Name

_____

Insurance Company Name

Please date, sign and return one copy to the doctor's office below.

**LIDIA ALZATE, D.C.**

**916 W Burbank Blvd Suite L Burbank CA 91506 Ph 818 842-7700 Fax 818 8427001**

**1123 Celis Street San Fernando CA 91340 Ph 818 838-4900 Fax 818 838-4901**

Reorder (800) 562-3335 C107

# FOCUS CHIROPRACTIC CENTER

1123 Celis Street
San Fernando, Ca 91340
(818) 838-4900 Fax: (818) 838-4901

## YOUR INSURANCE INFORMATION (Please, fill out this form completely)

**NAME:** _____
Last Name First Name Middle

**If you are interested in receiving communication via e-mail and/or having access to our website, please give us your e-mail address (you will receive newsletters, promotional cards and celebration cards, but your e-mail will not be sold or distributed to other companies)**

**E-MAIL ADDRESS:** _____ **Not Interested** _____

**ATTORNEY REPRESENTATION? YES / NO**

**Attorney's Name:** _____

Attorney's Address: _____

City _____ Zip Code _____ Phone # _____

**YOUR MEDICAL COVERAGE:** _____

POLICY #: _____

INSURANCE COMPANY'S ADDRESS: _____

**YOUR AUTO INSURANCE:** _____

POLICY #: _____ COMPANY PHONE #: (_____)_____

**OTHER PARTY'S INSURANCE COMPANY INFORMATION:**

INSURANCE COMPANY: _____

INSURED'S NAME _____

INSURED'S
ADDRESS: _____

INSURED'S PHONE #: (_____)_____ (_____)_____

POLICY/CLAIM #: _____ COMPANY PHONE #: (_____)_____

_____ _____
Date Patient's Signature

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays, and physical therapy techniques, on me (or on the patient named below, for whom I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or on the future, render treatment to me, while employed by, working for, or associated with or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, Homer's 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 serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interests.

I have an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Print Name(s) of Doctor Treating This Patient


**LIDIA ALZATE, D.C.**
**1123 Celis Street, San Fernando, CA. 91340**
**Phone: (818) 838-4900 Fax (818) 838-4901**
**Phone: (818) 842-7700 Fax (818) 842-7001**


_____

_____

_____

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative Date

_____ _____
Witness to Patient's Signature Date

_____ _____
Translated by Date

# Focus Chiropractic Center

## Dr. Lidia Alzate, D.C.

# CALIFORNIA LANGUAGE ASSISTANCE INFORMATION (CA LAP)

**DO YOU REQUIRE LANGUAGE ASSISTANCE? ( ) YES or ( ) NO**

**IF YES, WHICH LANGUAGE** _____

You may be entitled to the rights and services below. These rights apply only under California law. However, these rights do not apply to all California residents. These rights do not apply to all languages.

Effective January 1, 2009, California health plans are required to implement a language assistance program to comply with Senate Bill 853. The legislation was passed to assist those with limited English language proficiency to better communicate and participate in personal health care matters.

The Department of Patient Safety is available to respond to questions related to the S.B.853 language service requirements. Please call (800) 421-2368, extension 1243, for assistance and support.

| | |
|---|---|
| _____ | _____ |
| Printed Name of Patient | Date |
| _____ | _____ |
| Signature of Patient | Date |
| _____ | _____ |
| Signature of Patient's Representative | Date |
| _____ | _____ |
| Witness to Patient's Signature | Date |
| _____ | _____ |
| Translated by | Date |

# Focus Chiropractic Center

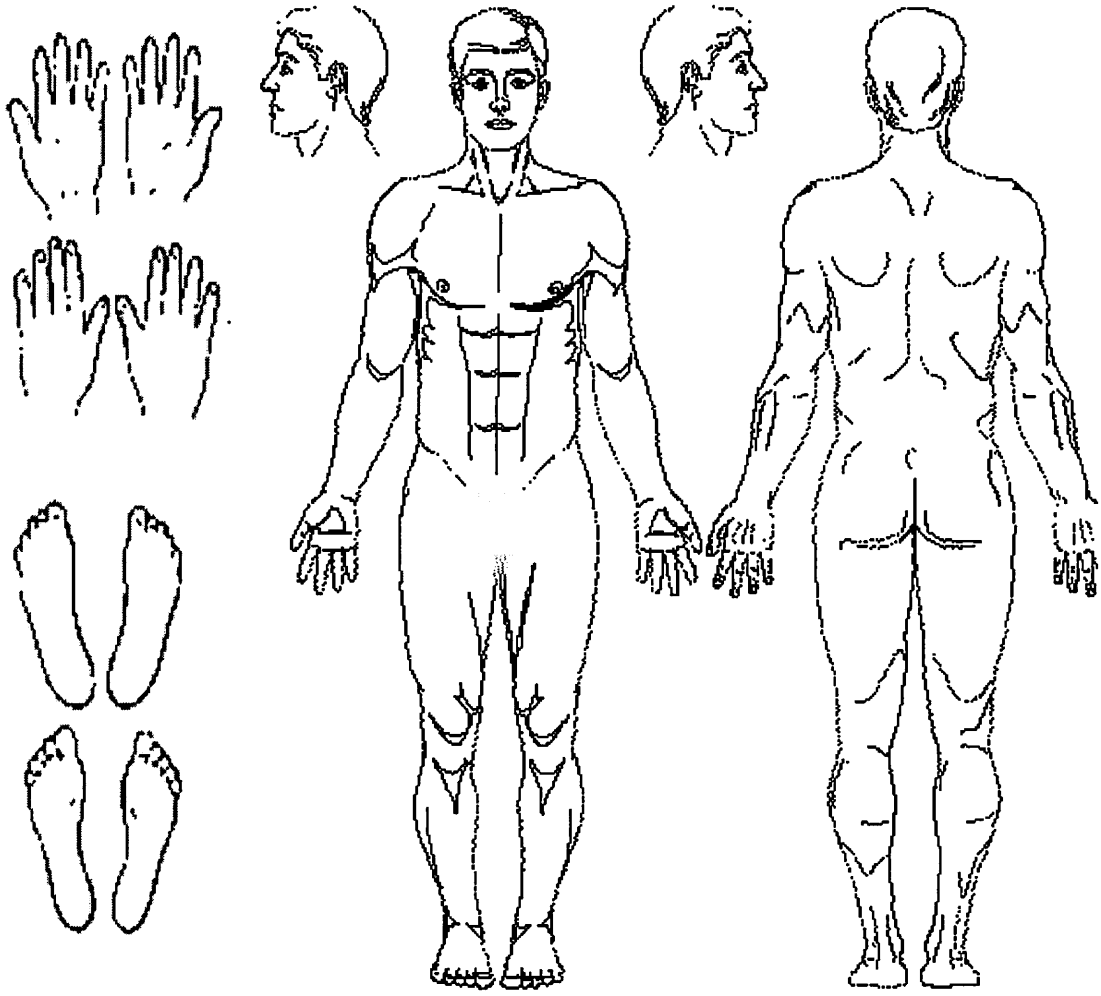
1123 Celis Street - San Fernando, CA. 91340
Phone (818) 838-4900 - Fax (818) 838-4901

## SUBJECTIVE COMPLAINTS

Date: _____

PATIENT'S NAME _____ AGE _____

**PLEASE, MARK YOUR AREAS OF PAIN AND RATE EACH AREA:**
**Scale from 1 to 10 (1 for very mild pain to 10 for unbearable pain).**



**REQUESTER: Dr. LIDIA ALZATE, D.C.**
1123 Celis Street – San Fernando, California 91340
Phone # (818) 818-838-4900 - Fax # (818) 838-4901
*Medical Records can be emailed to: Dralzate@focuschiropracticcenter.com

## AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

**FACILITY PROVIDING RECORDS**

_____
_____
_____
_____

**Date of Request:** _____

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider named above.

Patient's Full Name: _____

Patient's Address: _____

Patient's Date of Birth: _____/_____/_____ Patient's SS# _____

Patient's Signature: _____ Date:_____
Indicate relationship if signed by other than patient.

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.
REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.
REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

## SPECIFIC RECORDS TO BE RELEASED AND/OR DISCLOSED (circle one):

1) General Medical Information from _____ to _____.

2) Information pertaining specific injury or treatment from _____ to _____.

3) X-rays: films and/or reports (circle one or both)

4) Other: Specify_____ _____.

Patient's Signature:_____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purpose only: management of injuries sustained on _____.
A copy of this Authorization is valid as an original. I have the right to receive a copy of this authorization.

# FOCUS CHIROPRACTIC CENTER – DR. LIDIA ALZATE, D.C.
# NOTICE OF PRIVACY PRACTICES

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.

**Focus Chiropractic Center (Dr. Lidia Alzate, D.C.)** is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

## Disclosure of Your Health Care Information

### Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

*"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Focus Chiropractic Center (Dr. Lidia Alzate, D.C.)."*

*"It is our policy to provide a substitute health care provider, authorized by Focus Chiropractic Center (Dr. Lidia Alzate, D.C.)to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

### Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

*"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

### Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

### Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

### Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

### Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

### Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

### Deceased Persons.

We may disclose your health information to coroners or medical examiners.

### Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

### Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

### Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

### Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

**Marketing.**

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

*"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Focus Chiropractic Center (Dr. Lidia Alzate, D.C.)sponsored fund-raising events."*

**Change of Ownership.**

In the event that Focus Chiropractic Center (Dr. Lidia Alzate, D.C).is sold or merged with another organization, your health information/record 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. Please be advised, however, that Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) is not required to agree to the restriction 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 of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) amend your protected health information. Please be advised, however, that Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Focus Chiropractic Center (Dr. Lidia Alzate, D.C.)
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this Notice of Privacy Practices**

Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) is required by law to comply with this Notice.

Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Dr. Lidia Alzate, chiropractor by calling this office at (818) 842-7700. If Dr. Alzate is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints**

Complaints about your Privacy rights, or how Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) has handled your health information should be directed to Dr. Lidia Alzate, D.C. by calling this office at (818) 842-7700 If Dr. Lidia Alzate, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

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

By way of my signature, I provide Focus Chiropractic Center (Dr. Lidia Alzate, D.C.) with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____

Patient's Name (print)

_____ _____

Patient's Signature Date

_____ _____

Authorized Facility Signature Date

# WELCOME TO *Focus Chiropractic Center- Dr. Lidia Alzate, D.C.*

If you would like to receive Newsletters and updates, please provide us with your e-mail address.

YOUR E-MAIL ADDRESS HERE:_____

## You can look us up at www.focuschiropracticcenter.com, YELP and Facebook.

**We would like to share with you some of our company policies which we believe will improve the quality of our services:**

**1. If you have any questions or concerns regarding your treatment course, required documentation and/or medical recommendations, please, feel free to contact our the doctor or our office staff.**
**2. Make sure you follow the doctor's prescription for treatment and management of your condition. Following the doctor's recommendations is the most important step towards benefiting from the treatment prescribed.**
**3. If you were recommended x-rays and/or any other diagnostic studies, our office staff will assist you with the appointments and/or referrals. Make sure you follow the instructions for the studies and have them done as soon as possible. If you are unable to have the studies performed or choose not to have them done, please, notify our office immediately.**
**4. If you were recommended specialized consultations, we will try to assist you with the appointments for these consultations as well. Please, be aware that if you are referred to another facility or another physician for consultation and/or care, you will need to provide that facility and/or that other physician with all your information. Even though you might have authorized us to disclose your records to them, that other facility will request information directly from you. All the documentation signed to our office and/or to a specific physician does not apply to all other physicians or facilities you might be referred to.**
**5. We do not allow pets in our offices.**
**6. No food or drink allowed in any area of our facility, including the waiting area and treatment area.**
**7. Turn off your cell phone in any area of our office. For your and other patients' comfort and relaxation, we do not allow the use of cellular phones in the offices. If you have urgent matters to address via cell phone, please step outside.**
**8. We do not allow children unattended in our offices. We do not provide child care service. Children must remain in the front area assisted by a responsible adult at all times. If the child is in the office to see the doctor and/or to undergo treatment, she/he must be accompanied by a parent/guardian at all times and in all areas of the office. We do not allow children unaccompanied in the restrooms.**
**9. Please, avoid arriving late to your appointment. We do take appointments for our treatment sessions in order to avoid prolonged waiting. By arriving late, you will be compromising your and other patients' treatment courses. We do accept and welcome walk-ins, but, please, understand that there might be a wait for the walk-in patients.**
**10. If you are unable to come in for your treatment visit, please, advise us in advance. We like to plan our and the doctor's schedules. The no-show will disturb our regular day schedule and will compromise your treatment course.**
**11. Come in for treatment as comfortable as possible. Avoid use of alcohol, drugs or tobacco immediately before your treatment or office visit. Avoid use of strong perfumes and/or lotions. We may use heat as part of your treatment. Please, do not bring valuables or large bags into the treatment rooms.**
**12. We are not responsible for personal lost items.**
**13. We do try to keep a relaxing atmosphere in our offices. Therefore, we try to keep the noise volume down. If you must maintain loud conversations with others, please, do it outside the office.**
**14. We strive to avoid prolonged waiting. We do know when you come in and will be with you within minutes.**
**15. We do follow the doctor's prescription for your treatment. This might include physiotherapy. The physiotherapy will include several modalities and procedures. If you are not familiar with a modality or procedure, do not feel comfortable or notice increasing pain or discomfort while undergoing any of them, please, let us know immediately.**

**We hope that we can help and assist you. We feel honored you have chosen our office for your care.**

**I received copy of the Welcome letter.** _____

**Patient's Signature & Date**