Welcome to Miller Chiropractic

It is our pleasure to welcome you to Miller Chiropractic.

The examination and treatments available at Miller Chiropractic are based on functional neurology, a discipline that builds on clinical neuroscience and uses various strategies to help improve or re-establish optimal neurological processes. For many individuals who have dealt with neurological or cognitive impairments, the Board Certified Functional Neurologist can provide carefully determined, cautious and safe care that holds the prospect of potentially improving neurological function.

These interventions can include various sources of input through visual, physical, and other neurologic channels. Therapeutic goals are determined by a thorough examination, assessment, review of records and consultation with the patient and additional specialists as required. Our doctors training includes an additional 4 years of clinical education after the Doctor of Chiropractic Degree.

Many of our patients have been through years of other types of care and recovery, and have struggled to live within the limits imposed on them by their injuries. It is our hope that we can help you improve on those limitations; however, we must stress that we cannot make any promise of cure or improvement. After a careful intake process and examination, our Doctors will discuss treatment options with you and, if there is a reasonable expectation of some degree of clinical improvement, offer you the option of continuing under care. That care may or may not result in some degree of improvement. Any improvement may or may not be continuous, intermittent, or permanent.

The human body is a wonderful, marvelous creation; it is capable of being self-organizing, self-developing, and self-healing. There are often constraints on what our bodies are capable of doing, however, and it is impossible to predict how responsive individuals may be to functional neurological applications. Every person is unique. That uniqueness is an important attribute of our individuality, but it also means that no two people respond to care in exactly the same manner.

We take pride in our ability to offer innovative, science-based approaches in the attempt to address what, for many, are profound limitations in their function and quality of life. We look forward to partnering with you and your support community to explore what your individual responses may bring to your life and your future.

Miller Chiropractic
2441 Professional Pkwy Santa Maria, CA 93455
(805)934-5703 (805)934-1590 FAX

Gyrostim
New Patient Instructions

We welcome your interest in functional neurology and the services available at Miller Chiropractic. This packet contains the basic information we need from you to get started. It is most helpful if you have these filled out prior to your first visit.

Prior to your first visit, we need the following forms and information filled out from this packet:

- **A copy of your medical records or a signed medical release form.** It is most important that we have as complete an understanding as is possible of your history, prior and concurrent care. If you have any questions about this, please call our office.
- **The New Patient Intake Form** with you personal information and history.
- **Signed releases/forms for the following:**
    - **Records from prior care** in the event we need to request these from other sources.
    - **A Medical Release** that acknowledges your understanding about the basis for the care provided.
    - **Informed Consent for Chiropractic care.** It is important you understand the recommendations for care and your responsibilities. If you have any questions about this, please ask!
    - **Consent for video recording.** We do use video as part of the patient care records in many cases, but not all. We treat these records as we do all others, respecting the confidentiality of those we care for.
    - **Financial Policies.** Miller Chiropractic does not accept insurance. We do accept cash, check and credit cards, and in unusual circumstances we can consider short-term payment arrangements for those who need them.

The **Professional Services Form** will be filled out upon your arrival if you are paying by credit card. You do not need to fill this out before your first visit.

If you are coming from out of town, you can stay at a local hotel that is listed on our website, millerchiropracticholisticwellness.com. Please review the FAQ page on the site for more information.

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Miller Chiropractic
What to Expect

At Miller Chiropractic, the experience of being a Chiropractic patient may be new to you. We want to let you know some of the things that you can expect when you are evaluated at the office, and what to expect if you are accepted as a patient and receive care.

Chiropractic is a way of looking at the human body from the perspective that structure and function are inextricably connected. The health of the nervous system is of paramount importance to our ability to live effectively. Functional neurology is a way of looking especially closely at the human nervous system to ensure that it is able to function at its own optimal level.

When you come to the office, you will be interviewed and given a very thorough examination. Your doctor will put you through a battery of tests to analyze the health and effective function of your nervous system and body. All prior records of concerns and treatment will be reviewed. More tests, laboratory work, or imaging may be required. Once all the information is gathered together and reviewed, your doctor will meet with you to present their diagnostic impressions to you. If they believe that they have identified something that functional neurology can potentially offer some beneficial impact or improvement, the options for treatment will be presented to you and discussed.

If we believe that we cannot offer some potential for relief or improvement, we will let you know. If we do believe that the potential for some degree of relief, improvement or change is possible, you and your doctor will discuss the type of treatment, frequency, after-care and follow-up required.

Among the options are that care can begin immediately; care can be deferred, or care can be referred back to other providers you may have already consulted or treated with. The frequency of care can vary widely. Some people require a very intense course of treatment; others require a spacing of the treatment applications, and others require some combination of those two options.

We want you to be very comfortable with us and how we work. If you have any questions, please do not hesitate to ask! Any questions you have and do not voice or bring up can become a potential barrier to health and optimum performance. And that doesn't serve anyone well!

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Miller Chiropractic
Location, Lodging, Transportation

Miller Chiropractic is located at 2441 Professional Pkwy, Santa Maria, CA 93455. A Google map graphic of the office looks like this:

We have a special arrangement with the Historic Santa Maria Inn for our patients and guests to stay. The Historic Santa Maria Inn is a charming Inn located in the heart of Santa Maria. A full-service property, the Inn features an on-site restaurant, Starbuck's Coffee, English Pub and Wine Cellar. It also boasts a heated pool and spa, fitness facility and massage therapist. With modern convenience and access to shopping and restaurants, the Inn is the ideal destination. Mention "Miller Chiropractic" and receive reduced rates during your stay of $119.00 in the Executive Tower and $199.00 in our Grand Suites. Each rate includes our full American Breakfast Buffet for up to (2) per day. More information is available on our website, millerchiropracticholisticwellness.com, under FAQ and "Where Do I Stay?"

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Miller Chiropractic
New Patient Intake Form

We, the clinic Doctors and staff, are committed to serve our community in a professional clinical environment and to empower patients to actively participate in their healthcare. Miller Chiropractic recognizes and respects the self-aware, self-directed, self-maintaining, self-healing, and self-improving nature of life and living beings.

SECTION 1

Personal Data

Patient Name: First _____ Last _____ M.I. _____

Prefers to be called _____ Birth Date ___/___/____ ___ M ___ F

Parent of Guardian's Name if the Patient is a Minor: _____

Are you currently pregnant? ___ Yes ___ No ___ Maybe
Have you ever been pregnant? ___ Yes ___ No

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____ Mobile _____

Email: _____

Current Employer: _____ Contact Phone: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Job Description: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Spouse/Partner Name: _____ Spouse's Employer: _____

Number of Children: _____ Ages: _____

Emergency Contact Person: _____ Phone: _____

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REQUEST FOR PROTECTED HEALTH INFORMATION (PHI)

Requested of:

Office: _____

Address: _____ City/State/Zip _____

Phone: _____ Fax: _____

Information Requested:

☐ Films (Please List): _____ ☐ All Available Films _____

☐ Records: _____ ☐ Lab Work: _____

☐ Radiology Reports: _____ ☐ Other: _____

Patient Information:

Full Name: _____

DOB: _____ File Number: _____

Release:

I, the undersigned, hereby authorize the above listed organization to release requested PHI to Miller Chiropractic.

I understand that:

1. This authorization to disclose PHI is voluntary.
2. My treatment, payment or eligibility for benefits will not be affected if I do not sign this authorization.
3. I understand I have the right to revoke this authorization by submitting a written revocation to Miller Chiropractic: If I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requestor or receiver is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

Purpose of Disclosure:

☐ Request of Individual ☐ Attorney Access ☐ Disability

☐ Continuity of Care ☐ Other: _____

Expiration:

Unless otherwise revoked in writing, this authorization expires upon:

☐ Completion of this request (one time disclosure) ☐ Expires as specified: _____

Signature:

Patient/Patient Representative Signature: _____

Relationship to Patient: _____ Date: _____

FOR INTERNAL USE ONLY:

Faculty Clinician Signature: _____ Date: _____

Fax Number: _____ Faxed by: _____

Miller Chiropractic
Medical Release

_____ has been accepted as a patient to be seen at Miller Chiropractic.

The patient and/or his/her guardian(s) or legally responsible person(s) desire to be examined by the Miller Chiropractic clinical staff and understand and agree that all examination and therapeutic procedures will not include drugs or surgery and give permission/consent to any and all clinically appropriate examination and therapeutic procedures involved.

The patient and/or his/her guardian(s) or legally responsible person(s) understand and agree that providers of many disciplines may be in attendance or participate in this clinical evaluation and care process and will potentially observe all examination and treatment procedures.

The patient and/or his/her guardian(s) or legally responsible person(s) understand and agree that the physical examination and treatment will be video taped subject to the terms of a signed Video Release form and HIPAA requirements.

The patient and/or his/her guardian(s) or legally responsible person(s) understand and agree that the contents of related medical records, without any personally identifying information, specific to each case may be a part of subsequent clinical teaching rounds.

The patient and/or his/her guardian(s) or legally responsible person(s) understand and agree that all costs specific to transportation and lodging/travel expenses are to be borne by the patient and/or his/her guardian(s) or legally responsible person(s).

The patient and/or his/her guardian(s) or legally responsible person(s) understand and agree that there are risks associated with diagnostic and therapeutic procedures and that no promise of a cure has been given.

The patient and/or his/her guardian(s) or legally responsible person(s) understand and agree that neither the patient nor any assigns will hold Miller Chiropractic or its staff liable for any actions, non actions or outcomes associated with the diagnosis, treatment and recommendations presented.

_____ _____
Patient Name Date

_____ _____
Guardian's Name, if patient is a minor Relationship to patient

_____ _____
Witness Date

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Miller Chiropractic

Consent for Video Records

I, _____, give permission to Miller Chiropractic to record (a) video clip(s) and/or photograph(s) of my person during the course of my examination and treatment as a patient.

I give authorization to Miller Chiropractic to disclose the information in the video clip(s) and/or photograph(s) of my person within the constraints of my HIPAA authorization.

I understand that the video clip(s) and/or photograph(s) may be submitted for publication in a peer reviewed medical journal.

I understand that the video clip(s) and/or photograph(s) may eventually be used by the readers of a peer-reviewed medical journal for educational purposes.

I understand that the video clip(s) and/or photograph(s) may eventually be used by students and clinicians for educational purposes.

I agree that there will be no expiration date relating to my consent or the purpose of the use or disclosure.

I understand that I have the right to revoke my consent in writing at any time.

I understand that the information in the video clip(s) and/or photograph(s) of my person, once disclosed, may be subject to further disclosure by the recipient journal or publication, in which case confidentiality would no longer be assured.

I understand, additionally, that in some cases the video might be re-presented elsewhere because the journal has policies that allow permissions and/or use copyrighted materials with other educational organizations.

I understand that in such a case the signed author's consent form may be shared with a third party and the consenting party consents to this sharing of information for educational purposes.

Signed _____ **Date** _____

Witness _____ **Date** _____

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Miller Chiropractic
Financial Policies

Miller Chiropractic operates on a fee for service basis. We do not submit our services for billing to third party payers such as insurance companies. We will provide you with a copy of your bill that you may seek to submit on your own if you so choose.

The fees for services at Miller Chiropractic are as follows:

Comprehensive New Patient Intake Examination, Assessment, Review of Records and Consultation:	**$1,000**
Treatment Regimen of up to five days of care:	**$5,000**

Treatment regimens of care may be provided closely together or spaced over a period of time, depending on your clinical needs and other circumstances you and your doctor discuss.

The clinic accepts cash, checks, and credit cards.

I acknowledge that I have been provided with this information and accept the financial terms of care at Miller Chiropractic.

Signed _____ **Date** _____

_____
Please print name

If signing on behalf of a minor, please indicate that person's name and your relationship to them.

_____ _____
Minor's Name **Relationship**

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