

# TRINITY CHIROPRACTIC KINESIOLOGY

Bruce Shin, DC DIBAK  
27349 Jefferson Ave. #211 Temecula, CA 92590  
951.296.6205 FAX 296.1205

## *Patient Evaluation Questionnaire*

1. Please rate on the scale how serious you are about getting well (circle number).  
0 1 2 3 4 5 6 7 8 9 10
2. Would you prefer: (please circle)
  - A. Temporary Symptom Relief
  - B. Correction of Cause of Health Problems
3. Are you willing to follow a treatment program designed to help you return to health for at least 8-12 visits? (treating the cause)
  - A. Yes
  - B. No
4. Are you willing to take supplements?
  - A. Yes
  - B. No
5. Are you willing to make dietary changes?
  - A. Yes
  - B. No
6. Are you willing to start a moderate exercise program?
  - A. Yes
  - B. No
7. Please rate on the scale how serious you are about staying healthy after your initial intensive care.  
0 1 2 3 4 5 6 7 8 9 10
8. Are you familiar with Applied Kinesiology?
  - A. Yes
  - B. No
9. Would you be interested in attending a health workshop, which is offered monthly?
  - A. Yes
  - B. No
10. Please rate your level of stress on the scale.  
0 1 2 3 4 5 6 7 8 9 10

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

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## **PATIENT FINANCIAL AGREEMENT**

Welcome!

Thank you for coming to TCK where we provide the ultimate in chiropractic health care.

It is our office policy to maintain your account on a current basis. Charges for treatment are **DUE** and **PAYABLE** at the time service is provided, unless other arrangements have been made. We ask that you make payments on a **PER VISIT BASIS**. If you accrue a balance, it is also understood that you are responsible for any collection costs incurred.

We appreciate your business and promise to provide the highest quality in health care.

If you have any questions, please feel free to ask at any time!

### **CANCELLATION POLICY:**

Please be kind enough to give us 24-hour notice if you must change or cancel your appointment. Our office policy requires a cancellation fee if adequate notice is not given.

I have read and agree to the above.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

## Terms Of Acceptance

When a patient seeks Chiropractic Health Care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of spinal nerve interference. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well - being not merely the absence of infirmity, or symptoms.

Vertebral Subluxation: Also known as spinal nerve interference. A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter a non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

### Consent to evaluate and adjust a Minor Child

I, \_\_\_\_\_ being the parent or legal guardian of

\_\_\_\_\_ have read and fully understand the above Terms of Acceptance and hereby grant permission for my child to receive chiropractic care.

# HIPAA Notice of Privacy Practices

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**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **1. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notification was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_