Dr. Cindy Zafis, D.C.
3434 Mendocino Ave., Bldg. C, Suite B
Santa Rosa, CA 95403
707 527-7710

Welcome to the office!
In an effort to better serve you, below is a reminder check list of things to prepare before your first visit:

Before your Office Visit:

- **Fill out the complete history form before your appointment, so that we may have the entire office visit with you.**
- **Please come 5 minutes before each appointment in an effort to keep your and other appointments on time.**
- **Eat before the office visit as you may not be able to eat for 2 hours after the office visit.**

Fragrance-Free Office:

- **Do not wear fragrances, lotions, colognes, or any substance with a fragrance as people may be reactive to the fragrance.**

Payments:

- **Payments in the form of Visa, Discover, MasterCard, check and cash are collected at the time services are rendered.**

Cancellation notice:

- **New patients will be charged 50% of their initial visit fee if we are given less than a 24 hour cancelation notice from their scheduled appointment date.**
- **For returning patients the cancellation notice is 24 hour notice for changes and cancelations of 50% of fee for the appointment if the appointment time is not filled.**

Again, welcome to the office and we look forward to working with you!

Sincerely,
Dr. Cindy Zafis, D.C.

CONFIDENTIAL PATIENT INFORMATION

How did you hear about the office? ___________________________________

PATIENT DATA

Name: _________________________________ Date:______________________

Address:___________________ City:_____________ Zip:________________

Birth Date:____________ Age:___ Sex:___ Height: _____ Weight: ________

Home phone: ____________________ Work phone:_____________________

Employer:_______________________ Occupation:______________________

Marital Status:_______ E-mail Address:__________________________________

BREIFLY EXPLAIN PROBLEM THAT IS BOTHERING YOU___________

____

TREATMENT GOALS

REASONS YOU HAVE COME INTO THE OFFICE:

_____ **Eliminate pain**

_____ **Eliminate a specific reaction to a food/pollen/substance**

_____ **Work with a specific symptom or set of symptoms**

_____ **Work with a food or drug addiction/craving/sensitivity**

_____ **Be able to function from day to day**

_____ **Maintain a high level of stamina and energy on a daily basis**

_____ **Decrease or eliminate dependency for this medication**_________

_____ **Other – please explain** ________________________________

List health goals you would like to achieve in the future and by when do you want to achieve them. ____

____

____

____

History for Musculoskeletal Complaints

Important: Patients on Disability or Medicare must fill out every answer before reimbursement may occur for the next page and a half. Please put N/A if no answer is needed.

Chief complaint?

____

____

Onset? ____

Frequency/Duration?

____

What makes the symptom better? _______________________________

____

What makes the symptom worse? _______________________________

____

Does the pain refer to other areas of the body?

____

____

Are there other symptoms related to the chief complaint?

____

____

Have there been previous occurrences?

____

____

Are there secondary complaints to the chief complaint?

____

____

Other conditions?

____

____

Medications/Vitamins? Please list what the medications are treating.

____

____

____

Spinal Injuries? ____

____

Surgeries? ____

Hospitalizations? ____

____

Last Examination? ____

Previous Chiropractic? ____

Other History? ____
____

Family History? ____
____
____

Exercise? ____

Occupation? ____

SECONDARY COMPLAINT? ______________________________________
____

Onset? ____

Frequency/Duration? ____

Better/Worse? ____
____

Referral pain? ____

Previous occurance? ____

Previous treatments? ____

Patients on Disability or Medicare: All answers must be completed for previous questions in order for billing and reimbursement to occur.

GENERAL HISTORY

Unusual childhood diseases:________________________________

List previous allergy testing

Scratch test _________ Blood test________ Salvia test__________

Other____________

List know allergies to foods, medication, pollens, or chemicals.
____
____

Check when you experience allergy symptoms

Summer_______ Fall_____ Winter_____ Spring_____

Morning_______ Day-time_____ Night_____

Other____

Diet

Are you vegan/vegetarian? _______ What foods are you consistently avoiding?
____

What foods are you trying to avoid recently? ____________________________

List all foods & beverages consumed more than 3 times a week

____

____

____

List cravings to these items

Salt_____ Sugars_____ Coffee/Caffeine_____ Fats_____ Candy____

Carbohydrates_____ Drug/Alcohol____ Luncheon Meats_____

For Detoxification Treatments:

Are you a wearer of a pacemaker or any other battery operator electrical implant? Yes No

Are you taking heart regulating medication? Yes No

Are you an organ transplant recipient? Yes No

Are you taking medications that in its absence would be mentally or physically incapacitating, such as psychotic episodes, seizures, etc.? Yes No

Are you pregnant or a breast feeding mother? Yes No

Health Symptoms

Mark the intensity of symptoms from 1 to 10. 0 is no symptoms and 10 is very symptomatic.

	Degree of Symptoms(0-10)	**Length of symptoms in years**
Allergy Symptoms		
Asthma	_____	_____
Bronchitis	_____	_____
Hay Fever	_____	_____
Colds & Flu	_____	_____
Cough	_____	_____
Mucous Production	_____	_____
Post-Nasal Drip	_____	_____
Shortness of Breath	_____	_____
Sore throat	____	_____
Skin Disorders		
Acne	_____	_____
Hives	_____	_____
Itching	____	_____
Psoriasis	_____	_____
Eczema	_____	_____
Rashes	_____	_____
Addictive Disorders		
Alcoholism	_____	_____

Drug dependency	______	______
Eating disorders	______	______
Smoking	______	______
Mental/Emotional Disturbances		
Depression	______	______
Anxiety	______	______
Irritability	______	______
Mood swings	______	______
Obsessive Behavior	______	______
Mental Confusion or Disorientation	______	______
Vascular Disorders		
Heart Irregularities	______	______
Hemorrhoids	______	______
High Blood Pressure	______	______
Digestive Disorders		
Colitis	______	______
Constipation	______	______
Diarrhea	______	______
Diverticulitis	______	______
Heartburn	______	______
Gas	______	______
Gallstones	______	______
Gastric distress	______	______
Indigestion	______	______
Female disorders		
Breast swelling	______	______
Menstrual disorders	______	______
Mood swings	______	______
PMS	______	______
Heavy Menstrual Flow	______	______
Sugar & Carb Cravings	______	______
Other disorders		
Edema	______	______
Fainting spells	______	______
Fatigue	______	______
Fever	______	______
Forgetfulness	______	______
Hair loss	______	______

Mark the intensity of symptoms from 1 to 10. 0 is no symptoms and 10 is very symptomatic.

	Degree of Symptoms(0-10)	**Length of symptoms in years**
Insomnia	_____	_____
Migraine Headache	_____	_____
Premature Graying	_____	_____
Ringing in ears	_____	_____
Seizures	_____	_____
Urinary Tract Disorders	_____	_____

Our Office Policy

1. We do not bill most insurance companies. Patients that are self-billing or are paying cash are expected to take care of their fees as services are rendered. We do not claim responsibility of collecting your insurance claim or for negotiating a settlement of a disputed claim.
2. Assignment of Benefits. If the office is billing insurance, I hereby assign all medical benefits to which I am entitled. Including Major Medical, private insurance or any other health plans to Dr. Cindy Zafis, D.C.. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.
3. Letters to insurance companies will be bill at $25 a page.
4. I understand that I am financially responsible for all charges, whether or not paid by said insurance.
5. If you need to cancel your appointment, please inform us 24 hours prior to your appointment to avoid a 50% charge for the appointment if the appointment time is not filled.
6. There is a service charge of $25.00 for every returned check from the bank.
7. If you are under 18 years of age, please have your parent or legal guardian sign below.
8. Patient record files are $10 for administration fees + $.025 per page.
9. This office is required by law, to maintain the privacy and confidentiality of your protected health information. The policy is available for you to read in our waiting room or you can also request a written copy. Please ask the receptionist for more information.
10. Nutritional supplements may be returned if not opened or if returned within 2 weeks.

I have read and agree to the terms of the preceding paragraphs. All the information is true to the best of my knowledge.

______________________________ ________________________

Signature Date

CONSENT TO TREAT A MINOR CHILD

I authorize Dr. Cindy Zafis, D.C. to treat______________________________(Name)

who is my ___________________________(Relationship).

Adult's Signature______________________________Date_______________________

EMAIL CONSENT FROM PATIENT

I realize that the e-mail is not a secure system. I authorize Dr. Zafis to e-mail me despite the lack of security in the e-mail system.

_____________________________ ___________________________

Signature Date

We do not bill most insurance companies. However if we have discussed that the clinic will be billing insurance, please fill out this information.

Primary Insurance:

Insurance Co. Name: ____________________ Insurance Co. Phone: ____________

Address: _______________ City: ______________ State: ________ Zip: ________

Policy/Claim#: ____________________ Policy Holder: ________________________

Insured's Employer: ____

Primary or referring physician: ______________________ Phone: _______________

Date of injury ____

Secondary Insurance:

Insurance Co. Name: ____________________ Insurance Co. Phone: ____________

Address: _______________ City: ______________ State: ________ Zip: ________

Policy/Claim#: ____________________ Policy Holder: ________________________

Insured's Employer: ____

Primary or referring physician: ______________________ Phone: _______________

PATIENTS CONSENT ACKNOWLEDGEMENT AND REQUEST FOR SESSIONS

We appreciate the opportunity to join forces with you in working to improve your health.

It is understood and acknowledged that the requested sessions, work and/or techniques employed by and with Cindy Zafis, D.C. are considered non-medical and non-traditional and are an alternative health care practice or approach toward managing and/or working with patients with allergic conditions. I understand that this form and approach is a part of chiropractic/acupressure adjustment or treatment.

Additionally, I understand that no medications will be administered for this scope of my work with Dr. Zafis. Further, while there may be recommendations to diet, food(s), food groups and/or meals(s) as a part of my work with Dr. Zafis, and I accept full responsibility for the success of implementation of any recommendations and/or adjustments to my diet and/or meals.

I understand that while Dr. Zafis clients have received and reported astounding positive results while working with Dr. Zafis, each person is unique and no representations to certainty or guarantee have been made nor is any certainty or guarantee of effectiveness of such work, approach, treatments, sessions and/or techniques expected or interpreted by me and accordingly, I take full responsibility for applying, receiving and use of any recommendations of Dr. Zafis and hold her harmless and indemnify her from any and all bodily reactions or any actions, claims, suits or any matter whatsoever as a result of my endeavor toward optimal health and any work with Dr. Zafis.

Further, Dr. Zafis has advised me that she is not a medical doctor nor a doctor of allergic medicine and that I should always consult with a medical doctor for the medical and traditional treatment of allergies and/or allergic conditions. If I am interested in weight loss, then any work in that regard with Dr. Zafis will be done in accordance and within her normal practice of chiropractic separate from this work and further I understand and know that I should always consult with my doctor before beginning any weight loss program.

Mediation and Arbitration

Any controversy between the parties involved in the construction or application of any terms, covenants or conditions of this agreement shall, first be submitted to neutral mediation and each party shall enter into said mediation in good faith and with the intention of resolving any dispute through such mediation. If good faith attempts at mediation are unsuccessful at resolving any such dispute, on written request of one party served on the other, be submitted to arbitration, and such arbitration shall comply with and be governed by the provisions of the California Arbitration Act, Section 1280-1294.2 of the California Code of Civil Procedure.

I the undersigned, acknowledge that I have read and understand all of the above and affirm that the work, approach, form, sessions, techniques and/or recommendations to be employed by and with me with the assistance of Dr. Zafis, have been fully explained to me and that I have consulted with my doctor as recommended, required or requested or hereby of my own choice have not consulted with my doctor and further affirm, declare and attest that I am fully responsible for my own health and well being.

_______________________________________ Date:____________________

(Patients signature)

_______________________________________ Date:____________________

(Patients name printed)

Directions to the Office:

Health Resolutions Treatment Center

Dr. Cindy Zafis, D.C.

3434 Mendocino Avenue

Building C

Suite B

(707) 527-7710

www. healthresolutions.net

Going North on 101: Take the Bicentennial Way exit, take the Bicentennial East Ramp. Continue straight on Bicentennial and make a left onto Mendocino Avenue. Pass the radio station KZST on the right. The complex will be on the right.

Going South on 101: Take Hopper Avenue Exit, turn left onto Cleveland Avenue, turn left onto the Mendocino over pass. Turn right on Mendocino Avenue. The complex will be on the left.

Directions in the Complex

Our office is located in the office complex called the **Fountain Grove Office Park**. The sign will say entrance for **3400-3460.** There are two driveways into the complex. The northern driveway is the entrance. Building C will be on the bottom level of the office park.

Entrance to office with no stairs: When entering the office park go up the steep hill and take the first left. Park close to the entrance of the parking lot. There is a long side walk going south leading to **Building C-Suite B**

Entrance to the office with stairs: When entering the office park take the first right on the bottom level of the office park. **Building C** will be on the left. You may park on the bottom level of the office park and take the stairs to **Building C.**