

Patient Name _____ Birthdate _____ Sex: M / F
Address _____ City _____
State _____ Zip _____ Phone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

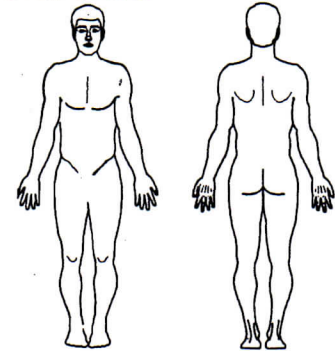
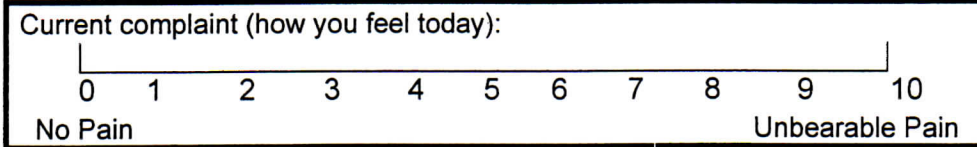
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck Pain Mid-Back Pain Low Back Pain
 Other _____

Is this? Work Related Auto Related N/A

Date Problem Began _____

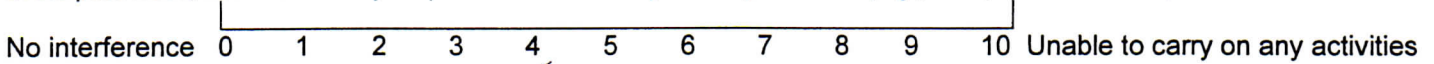
How Problem Began



How often are your symptoms present?

- (Occasional) 0 - 25% 26 - 50% 51 - 75% 76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?



HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently Pregnant, # Weeks _____ |
| <input type="checkbox"/> Stroke (Date) _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tobacco Use - Type _____ |
| <input type="checkbox"/> Epilepsy/Seizures | Frequency _____/Day |
| <input type="checkbox"/> Other Health Problems (Explain) _____ | <input type="checkbox"/> Medications _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ Date _____

MEMBER BILLING ACKNOWLEDGMENT

Chiropractic

For questions, please call ASH Plans at 800.972.4226

IMPORTANT NOTICE: In some cases, ASH Plans' contract with its providers may not account for all potential benefits available to you under your health care plan. For this reason, before completing this form you should first review your coverage options with your health care plan.

I, _____, a member being treated by Dr. _____,
(Name of Patient/Member/Subscriber) (Chiropractor Name)
do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with _____ I understand and agree to be responsible to self-pay for the following services: (Name of Health Plan)

LIST OF SERVICES TO BE PAID FOR BY MEMBER

<u>Date</u>	<u>Procedure</u>	<u>Charge</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Separately list each date of service on which non-covered services will be rendered and have the Member initial the charge. Please attach additional Member Billing Acknowledgment form(s) for additional services.

This form is only to be used if an ASH Plans Member desires to self-pay for non-covered services. Non-covered services include services that are not covered by the Member's payor. Non-covered services may also include services determined by ASH Plans to be maintenance-type services.

The ASH Plans Contracted Chiropractor may not bill the member during the course of an ASH Plans approved treatment program unless there is a copayment, deductible, coinsurance, or the Member is receiving non-covered services.

The ASH Plans Contracted Chiropractor may not bill the member for the difference between what the ASH Plans Contracted Chiropractor bills and what the ASH Plans Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH Plans Contracted Chiropractor agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill Members for any services not reimbursed by ASH Plans. Such use will render this agreement "void" and non-binding on the Member. This agreement may only be used to allow the Member to agree to "self pay" for specific services **in advance**.

I acknowledge that I have reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my chiropractor,

Dr. _____, to pay for these services myself.
(Chiropractor Name)

Dated at _____, California this _____ day of _____, 20____.
(city) (date) (month) (year)

Member Signature
(Guardian must sign for all members 17 years or younger)

Member Health Plan ID#

Provider Signature

Date

AMY B. FRIEDMAN CHIROPRACTIC CORPORATION
OFFICE POLICY

You are ultimately responsible for any usual and customary charges incurred for any evaluations, treatment, or supply provided in your care regardless of expected payment by your insurance company or any other third party. Payment for the first visit is expected to be paid in full at the time of service unless other arrangements have been made. Our fee schedule is available for your review (Please ask our staff if you have any questions regarding our fees).

If you are covered for chiropractic under your health insurance plan we will verify your coverage and notify you of your responsibility. Billing your insurance is a service we provide through our billing company, Priority One Billing. You are responsible for payment of your co-pay on each date of service provided to you. You are responsible for any outstanding co-insurance percentage owed or deductible due as stated on your Explanation of Benefits processed by your insurance company.

If this is a work-related injury and we accept your case, we will obtain authorization for your care and complete the appropriate documentation as per the Labor code.

If this is an injury caused by a third party, arrangements must be made with the doctor. If you have health insurance or med-pay we will bill for you. If you have an attorney, they must sign a lien. Itemized statements will be sent regularly to update your attorney regarding your care received. In the case of a third party (See third party agreement) you are responsible for paying any outstanding balance on your account from the proceeds paid to you directly for your case. You are ultimately responsible for paying your balance in full.

All nutritional supplements and orthopedic supplies must be paid in full at the time received regardless of insurance coverage. (Most policies do not cover these items.)

We reserve the right to charge a full visit fee for any chiropractic or massage appointment missed or cancelled with less than 24 hour notice.

All accounts inactive over 60 days are considered overdue and are subject to collections.

INFORMED CONSENT
FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to receive chiropractic adjustments, physiotherapeutic procedures and chiropractic by Dr. Amy Friedman.

I understand that there are rare but possible risks to chiropractic treatment.

These include, but are not limited to, fractures, disc injuries, dislocations, sprains/strains, burns or frostbite (physical therapy), and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications (although they would be more than happy to do so if requested). I wish to rely on the doctor's experience and expertise to exercise good judgment when choosing the most safe and effective course of care based upon my history, physical exam and x-ray findings.

I have read, or have had read to me, the above consent. I understand that I have the opportunity to ask any questions before receiving treatment. By signing below I consent to care for the entire course of treatment for my present condition and for any future conditions for which I seek consultation and treatment.

AUTHORIZATION AND ASSIGNMENT

I authorize Dr. Amy Friedman to release any information that she deems appropriate concerning my treatment and physical findings to any insurance company, attorney, doctor or insurance claims adjuster in order to process any outstanding claims for reimbursement of charges incurred or for obtaining authorization for care if necessary.

I authorize the direct payment to Dr. Amy Friedman for any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

This authorization and assignment is irrevocable and ongoing until all monies owed have been satisfied and paid in full. It will be in continual effect. A photocopy shall be as valid as the original document.

OFFICE POLICY

I acknowledge that I have read and understand the Amy B. Friedman Chiropractic Corporation Office Policy regarding my financial responsibility, insurance billing, worker's compensation or personal injury cases, massage therapy, and supplies.

Printed name of practice member

Signature of practice member or guardian

Date_____

Name of parent or legal guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Amy B. Friedman Chiropractic Corp.

As required by the Privacy Regulations, I hereby acknowledge that I have read or received a current copy of Dr. Amy B. Friedman's "NOTICE OF PRIVACY PRACTICES."

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

By way of my signature, I provide Dr. Amy B. Friedman with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient Name: Print

Patient's Signature

Date

Authorized Personnel Signature