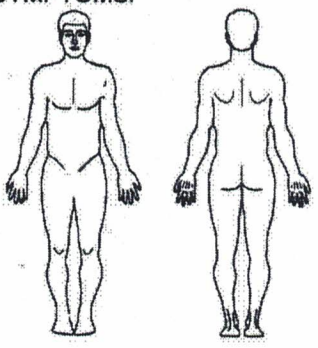
American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002

INITIAL HEALTH STATUS

Chiropractic Fax: 877.427.4777

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_____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

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?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

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:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

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**_____

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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, _____ (Name of Patient/Member/Subscriber), a member being treated by Dr. _____ (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 _____ (Name of Health Plan). I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER

Date	Procedure	Charge
	Massage	$
	K-Laser	$
	Spinal Decompression	$
	Supplements	$
	Supplies	$
		$

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

Dated at _____ (city), California this _____ (date) day of _____ (month), 20_____ (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 coinsurance 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 can 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 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 Patient

_____ Date _____

Signature of Patient or guardian

_____

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

Amy B. Friedman, D.C.
Health Connection of Tustin

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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