

CONFIDENTIAL HEALTH INFORMATION

Health Connection of Tustin

Amy B. Friedman, DC

165 Yorba St.

Tustin, CA 92780

P (714) 832-8747

F (866) 572-2498

www.HealthConnectionTustin.com

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

Whom may we thank for referring you?

No Yes

When?

If so, whom?

Age

Gender

Male Female

Race

American Indian Alaskan Native Asian Black or African American
 Native Hawaiian Other Pacific Islander Other White
 Decline to answer

Ethnicity

Hispanic or Latino
 Not Hispanic or Latino
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

Never A Smoker Former Smoker
 Current Every Day Smoker Current Some Day Smoker
 Heavy Smoker Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status Married

Single Divorced

City

State/Province

ZIP/Postal Code

Widowed Separated

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self Spouse Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

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PAGE
1/4

Health History:

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Weight Gain/Loss	For Females Only	
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> PMS
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder	For Males	
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Prostate
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular In coordination	<input type="checkbox"/>	<input type="checkbox"/> loss of muscle
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> loss of libido
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> lack of motivation
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

Family Health History: (Cancer, Arthritis, Diabetes, Heart Disease, Kidney Disease, Etc.)

List ALL surgical procedures you have had SINCE CHILDHOOD or are considering:

List all prescription medications/ the over-the-counter medications you are CURRENTLY taking:

Social History & Life Choices:

Alcohol:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Diet Foods:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Energy Products:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Fresh/Homemade Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Soft Drinks:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Water:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Caffeine:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Drugs:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Tobacco:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
Exercise:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never

WORK / COMP HISTORY

Patient _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Name of Compensation Carrier: _____ Phone () _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone () _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Date Injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? () Yes () No

3. Previous Workers' Compensation Injury? () Yes () No

4. Accident reported to employer? () Yes () No Name of person reported accident to _____

5. Injured at: _____ City _____ State _____ Zip _____

6. Length of time worked there prior to accident: _____

7. Type of work being done at time of injury: _____

8. In your own words, please describe accident: _____

9. Have you been treated by another doctor for this accident? () Yes () No

If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

10. Are you: () improved () unchanged () getting worse

11. What types of medicines are you taking? _____

Do these medicines help? () Yes () No () Don't know

12. Have you had physical therapy? () Yes () No If yes, how often?

() Daily () Every other day () Several times a week () Weekly () Every other week

() Monthly () Other _____

Does the physical therapy help? () Yes () No () Don't know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

() Yes () No () Don't know

If yes, describe: _____

Were these similar complaints the results of a previous accident(s)? () Yes () No

Please provide details of accident(s): _____

14. Have you had any other serious accidents which required medical care? () Yes () No

Describe: _____

15. Have you had any serious illnesses that required hospitalization? () Yes () No

Describe: _____

16. Have you had any surgeries? () Yes () No

If yes, list type of surgery and date: _____

17. Have you had any nervous or mental illnesses? () Yes () No

Have you had psychiatric care? () Yes () No

18. Have you received a medical discharge from the Armed Forces? () Yes () No

19. Have you returned to work since this accident? () Yes () No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

- Currently, I have pain in my: () low back () mid back () upper back
- My pain began: () gradually () suddenly
- I have pain: () sometimes () all of the time
- My pain goes into my: () right leg () left leg () both
- I have tingling and/or numbness in my: () right leg () left leg () both
- My pain is worse when I:
 - cough or sneeze () Yes () No
 - sit () Yes () No
 - bend () Yes () No
 - walk () Yes () No
 - lift () Yes () No
 - push () Yes () No
 - pull () Yes () No
- My back is worse with sexual activity () Yes () No
- My pain wakes me up during the night () Yes () No
- Changes in the weather affect my pain () Yes () No

OFFICE POLICY FOR AMY B FRIEDMAN CHIROPRACTIC CORPORATION (ABFCC)

Financial Responsibility: You are ultimately responsible for charges incurred as a result of any chiropractic evaluation, treatment or supplies provided for your care regardless of expected payment by your insurance company or third party. If you have chiropractic benefits through your private health insurance, we will verify your coverage and based upon that information notify you of your responsibility, which is never a guarantee until your insurance is billed and an EOB (explanation of benefits) is received. Insurance billing is provided for ABFCC through Priority One Billing who often utilizes online statements and payment portals sent through our practice management software, Kareo. If you have a flat co-pay, you are responsible for payment each day you receive care. Co-insurance and deductible fees that are applied by PPO insurances will be balance billed and due within thirty days of upon receipt of your email or if preferred paper/mailed statement.

- **Personal Injury Claims:** are taken upon approval and arrangements will be made on an individual basis by Dr. Friedman. If you have MedPay (Medical coverage) on **your** auto policy it is customary for our office to bill that policy during the course of your care regardless if the injury is the fault of a third party. Third party cases without an attorney require the patient to pay a portion of their total bill as they receive care (see third party agreement) and the balance upon settlement of the case. If you have an attorney representing your case, a lien may be signed upon approval by Dr. Friedman. You are ultimately responsible for paying your balance in full immediately upon settlement from a third party.
- **Work Related Injury Cases:** are taken upon approval and require pre-authorization to see Dr. Friedman.
- **Massage Therapy:** All massage therapy services are provided on a fee-for-service/cash basis and require payment upon completion of that service. Missed or cancelled massages less than 24-hour notice are subject to fees as determined by our massage policy, \$35 for ½ hour and \$65 for one hour.
- **Supplements and Supplies:** Any supplements or supplies must be paid upon receipt.
- All accounts over 60 days are considered overdue and subject to collections.

Informed Consent: By signing below, I acknowledge I have read and received the informed consent for chiropractic care and have all my questions answered regarding the safety and purpose of chiropractic manipulative treatment. I wish to rely on the doctor's experience and expertise to exercise good judgement when choosing the most safe and effective course of care based upon my history, physical exam and any radiological imaging obtained. I consent for care for the entire course of treatment for my present and future conditions.

Authorization and Assignment: I authorize ABFCC to release any information and records required and appropriate for appropriate insurance authorization, billing or appeals, attorney, or referred physician. I authorize direct payment from my insurance company or attorney to ABFCC for charges made for treatment rendered. This authorization and assignment are irrevocable and ongoing until all monies owed have been satisfied and paid in full. It will remain in continual effect. A photocopy shall be as valid as the original document.

I acknowledge that I have read and understand the ABFCC office policy regarding my financial responsibility, informed consent and assignment of payment for services rendered.

Printed Name

Signature of patient if >18 yrs or parent

Date

Name of parent or legal guardian

Informed Consent for Chiropractic Manipulation and Treatment by Amy B Friedman, DC

As with any healthcare procedure there are certain complications which may arise during the course of chiropractic manipulation and ancillary therapy such as hot or cold packs, electric muscle stimulation, laser therapy, micro-stimulation, traction, therapeutic ultrasound and non-surgical spinal decompression. Dr. Friedman is required to advise her patients that there are risks associated with such treatment

The nature of chiropractic treatment: The doctor will use her hands or a mechanical device (known as and Activator instrument) in order to move your joints, known as chiropractic manipulation. With manual adjustments you may feel a "click" or "pop", such as the noise when a knuckle is "cracked". You may or may not feel movement of the joint. Some patients may experience some soreness/tenderness/stiffness following the first few days of treatment which are more common when beginning care vs. ongoing treatment.

Possible Risks: Complications may include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. An exceptionally rare cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck or more rarely dislodged if you are predisposed to blood clots. Ancillary therapeutic procedures could produce skin irritation, bruising, burns or minor abrasions.

Probability of risks occurring: The risks of complications due to chiropractic treatment (manipulation and ancillary procedures) have been described as "rare". The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The doctor will make every appropriate effort to screen for contraindications to care; however, I know it is my responsibility to inform the doctor of any conditions that are not obvious from my intake forms or physical findings upon my examination. Significant high blood pressure and A-Fib already predispose patients to stroke, regardless of manipulation. Underlying diseases such as cancer or osteoporosis could lead to more risk of fractures.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I understand that the doctor will verbally acknowledge any unusual risks I may pose to manipulation.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I consent to undergo the recommended treatment as recommended by Dr. Friedman, including spinal manipulation, and hereby give my full consent to treatment. I intend this consent to apply to all my present and future chiropractic care.

Signature

Printed Name

Date

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

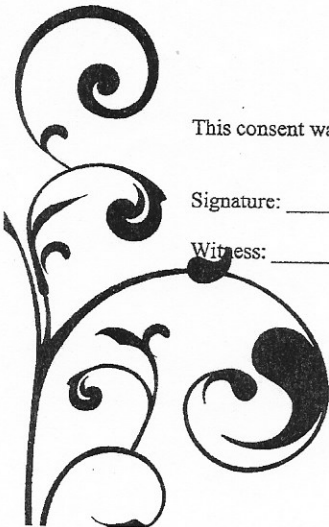
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

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

Signature: _____ Date: _____

Witness: _____ Date: _____



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