American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

Email:____________________@____________.______

INITIAL HEALTH STATUS
Chiropractic

Patient Name________________________________ Birthdate______________ Gender: 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.

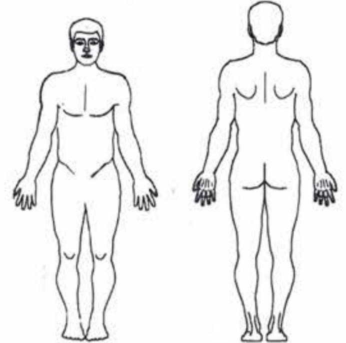
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ 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? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

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

In general would you say your overall health right now is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner 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**______________________

American Specialty Health (ASH)
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Fax: 877.248.2746

MEMBER BILLING ACKNOWLEDGMENT
For Medicare Advantage Member

For questions, please call ASH at 800.972.4226

IMPORTANT NOTICE: You may have additional coverage options for these services through your Medicare Advantage plan. If you have not received an Integrated Denial Notice from ASH or your Medicare Advantage plan, we recommend that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I,____________________, a member being treated by Dr. Amy Friedman,
(Name of Patient/Member/Subscriber) (Practitioner Name)

do hereby acknowledge that a certain portion of my care will not be covered by my Medicare Advantage 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 (1-unit by Doctor)	$ 10.00
	Massage (by therapist)	$ 40.00 - $100.00
	K-Laser/Spinal Decompression	$ 25.00 - $30.00 / $75.00 - $100.
	Ancillary therapies / Exam / Maintenance	$ 20 / $115 / $50
	Supplies / Supplements	$ Varies

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 for Medicare Advantage Member form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered services may also include services determined by ASH to be maintenance-type services.

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

The ASH Contracted Practitioner may not bill the member for the difference between what the ASH Contracted Practitioner bills and what the ASH Contracted Practitioner agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Practitioner 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. 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 received my Integrated Denial Notice explaining my denial rights, reviewed my coverage options, and 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 practitioner, Dr. Amy Friedman,
(Practitioner Name)
to pay for these services myself.

Dated at Tustin, CA this ____ day of ________, 20____.
(city) (state) (date) (month) (year)

____________________ ____________________
Member Signature — Member Health Plan ID#
(Guardian must sign for all members 17 years or younger)

____________________ ____________________
Practitioner Signature — Date

Informed Consent for Chiropractic Manipulation and Treatment

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 treatments.

The nature of chiropractic treatment: The doctor will use her hands or a mechanical device (known as an Activator instrument) 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 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 the bone, muscular strain, ligamentous sprain, dislocations of the 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 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 risk 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 significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as and extended convalescent period in a significant number of cases.

Risk 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 the doctor, 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

OFFICE POLICY FOR HEALTH CONNECTION OF TUSTIN

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 (Amy B Friedman Chiropractic Corporation) 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. 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 of the office. 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.
- Massage Therapy: All massage therapy services are provided on a fee-for-service/cash basis and require payment upon completion of that service. In order to hold a future massage appointment a credit card will be kept on file and only charged for late cancellations or missed appointments. 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 Health Connection of Tustin 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 my doctor 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 Health Connection of Tustin 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

Health Connection of Tustin

Amy B. Friedman, DC
165 Yorba St
Tustin, CA 92780

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 may request to see the notice at any time. You ascertain that by your signature, that you have review 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 call, e-mail, 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 allowed members:

____

____

This consent was signed by:____
(Print Name Please)

Signature:____ Date:__________________

Office Staff: ____ Date:__________________