Health Connection of Tustin
Amy B. Friedman, DC
Marissa Sturges, DC
165 Yorba St
Tustin, CA 92780

New Patient Intake Form

Today's Date (MM/DD/YYY) _____

Whom may we thank for referring you? _____

Patient's First Name _____ Patient's Middle Name _____ Patients Last Name _____

Birth Date (MM/DD/YYY) _____ Social Security Number _____ Age _____

Address _____

City _____ State _____ Zip Code _____ Preferred Language _____

Cell Phone _____ Home Phone _____

Preferred Method of Contact:

O Home Phone O Cell Phone
O Work Phone O E-Mail

E-mail Address _____

Occupation _____ Employer _____ Work Phone _____

Emergency Contact _____ Emergency Contact Phone _____

Primary Care Provider _____ Insurance Carrier _____ Policy Number _____

Patient Name:_____

Date:_____ Dr's Initials:_____

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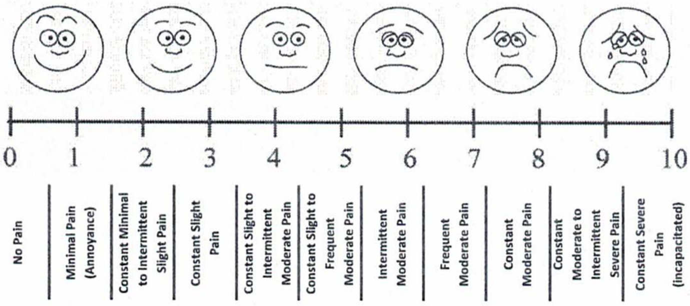
Present Health Concerns



Area of Concern #1 (circle): **Neck** **Mid Back** **Low Back** **Other:**___________________________

Pain/ Discomfort Scale : 0 1 2 3 4 5 6 7 8 9 10 (please circle)

When did it begin?: ____________ How did it begin?: ____

How often do you experience your symptoms?

- o Constantly (76-100% of the time)
- o Occasionally (26-50% of the time)
- o Frequently (51-75% of the time)
- o Intermittently (1-25% of the time)

What aggravates it?__________________________________ What alleviates?__________________________________

Limited activities?____

Area of Concern #1 (circle): **Neck** **Mid Back** **Low Back** **Other:**___________________________

Pain/ Discomfort Scale : 0 1 2 3 4 5 6 7 8 9 10 (please circle)

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Pain/ Discomfort Scale : 0 1 2 3 4 5 6 7 8 9 10 (please circle)

When did it begin?: ____________ How did it begin?: ____

How often do you experience your symptoms?

- o Constantly (76-100% of the time)
- o Occasionally (26-50% of the time)
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What aggravates it?__________________________________ What alleviates?__________________________________

Limited activities?____

Have you previously seen a Chiropractor? o Yes o No
If so, when was your last visit? ___________________________
When was the last time you had X-rays?___________ MRI?___________ Where?__________________________
Approximately when was your last medical physical?____________________
Other health care professional's you've consulted for the same issues?____________________________________
If so, when was your last visit? ___________________________

Patient Name:____
Date:______________________________ Dr's Initials:_______

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Health History

Had	Have		Had	Have		Had	Have	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Angina	O	O	Smoking/Tobacoo Use
O	O	Low Back Pain	O	O	Kidney Stones	O	O	Drug/Alcohol Dependence
O	O	Shoulder Pain	O	O	Kidney Disorders	O	O	Allergies
O	O	Elbow/Upper Arm Pain	O	O	Bladder Infection	O	O	Depression
O	O	Wrist Pain	O	O	Painful Urination	O	O	Systemic Lupus
O	O	Hand Pain	O	O	Loss of Bladder Control	O	O	Epilepsy
O	O	Hip Pain	O	O	Weight Gain/Loss	O	O	Dermatitis/Eczema
O	O	Upper Leg Pain	O	O	Loss of Appetite	O	O	HIV/AIDS
O	O	Knee Pain	O	O	Abdominal Pain	**For Females Only**		
O	O	Ankle/Foot Pain	O	O	Ulcer	O	O	PMS
O	O	Jaw Pain	O	O	Hepatitis	O	O	Birth Control Pills
O	O	Joint Pain/ Stiffness	O	O	Liver/Gall Bladder Probler	O	O	Hormonal Replacement
O	O	Arthritis	O	O	General Fatigue	O	O	Pregnancy
O	O	Rheumatoid Arthritis	O	O	Uncoordinated Movemen	If Yes, When:_____		
O	O	Cancer (Type/Date) _____	O	O	Visual Disturbances	**For Males Only**		
O	O	Tumor	O	O	Dizziness	O	O	Prostate Problems
O	O	Asthma	O	O	Glaucoma	O	O	Loss of Muscle
O	O	Chronic Sinusitis	O	O	Stroke	O	O	Erectile Dysfunction
O	O	Other:_____						

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

_____

List ALL surgical procedures or hospitalizations that you have had or are considering:

_____

List ALL prescription medication/ over-the-counter medications that you are currently taking:

_____

Pain Relievers O **Daily** O **Weekly** O **Occasionally** O **Never**

Physical Activity Level: O **Sedentary** O **Mildly Active** O **Moderately Active** O **Extremely Active**

Sleep Habits: O **Back** O **Side** O **Stomach** **Hours per night:**_____

Social History and Health Habits:

Alcohol	O Daily	O Weekly	O Occasionally	O Never
Energy Products	O Daily	O Weekly	O Occasionally	O Never
Soft Drinks	O Daily	O Weekly	O Occasionally	O Never
Water	O Daily	O Weekly	O Occasionally	O Never
Caffeine	O Daily	O Weekly	O Occasionally	O Never
Drugs	O Daily	O Weekly	O Occasionally	O Never
Tobacco	O Daily	O Weekly	O Occasionally	O Never

Patient Name:_____

Date:_____ Dr's Initials:_____

Name:_____ **Date:**_____

Were you the: □ Driver □ Passenger □ Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: □ Front □ Rear □ Driver Side □ Passenger Side □ Bumper □ Fender

Was your vehicle drivable? □ Yes □ No Damage Amount Estimate: □ Minor □ Major □ Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: □ Front □ Rear □ Driver Side □ Passenger Side □ Bumper □ Fender

Severity of damage to other car: □ Minor □ Major □ Totaled

Where did the accident happen? Freeway:_____ Street Names:_____ City/State _____ Time of day:_____am/pm

Was it? □ Controlled Intersection □ Uncontrolled □ Not Intersection

Was there a traffic light? □ None □ Green □ Red □ Turn Arrow □ Stop Sign

Were you: □ Slowly Moving □ Moving □ Stopped

Weather Conditions: □ Sunny □ Rainy □ Cloudy Street Surface: □ Dry □ Wet □ Icy □ Other _____

Type of Impact: □ Rear end □ Front □ Side Impact □ Roll Over

Brakes on Impact: □ Locked Tight □ Loosely Applied □ Foot not on brake

How far did your car move? □ Did not move □ Moved 1-5 ft □ Moved 6-10 ft □ Moved over 10 ft

Did your vehicle then hit another vehicle or other object? □ Yes □ No Explain:_____

Where were you seated in the vehicle: _____ Wearing Seat belt? □ Yes □ No Shoulder harness: □ Yes □ No Headrest: □ Yes □ No Headrest Position: □ Up □ Down

Is the car equipped with airbags? □ Yes □ No Did they deploy? □ Yes □ No

Did you see the impact coming? □ Yes □ No Did you brace yourself for impact? □ Yes □ No

On impact, your head was looking: □ Ahead □ Behind □ Up □ Down □ To the Right □ To the Left

On impact were you: □ Thrown forward □ Thrown backwards □ Thrown sideways □ Other _____ Did your body hit anything inside the car? □ Yes □ No Body Part: _____ What did it hit? _____ Head trauma? □ Yes □ No

Loss of Consciousness? □ Yes □ No For how long? _____ Do you remember the accident happening? □ Yes □ No

Hospital? □ Yes □ No Name of hospital: _____ How long there? _____

Taken by ambulance? □ Yes □ No X-rays taken? □ Yes □ No X-ray areas:_____ Other imaging? □ Yes □ No Explain: _____ Medication Given? □ Yes □ No

Are you being treated by another doctor for this injury? □ Yes □ No By whom?_____

Are you feeling □ Improved □ Worse □ Same

Have you lost time from work? □ Yes □ No # Days lost:_____ Do you have to modify your work? □ Yes □ No

_____

Signature

Auto Accident Flowsheet

Name_____ Date of Accident:____/____/_____ Today's Date:____/____/_____

Health Ins: _____ Ins ID#: _____

Car Ins Company: _____ Policy#: _____ Claim filed? Y / N

Claim #: _____ Adjuster Name:_____

Adjuster's Phone #:_____ Adjuster's email:_____

Do you have Medical Coverage?: Y / N Policy limit:_____ Uninsured Motorist Coverage: Y / N

Value of damage to car (repair amount): _____

Obtained law firm representation? Y / N If so, name of attorney?_____

Attorney email: _____@_____

Attorney phone number: _____ Fax number: _____

Third party at fault insurance company: _____ Adjuster Name: _____

3rd party Adjuster phone#: _____ Fax number:_____

Date saw any other doctor after accident: _____ Doctors name: _____

Doctor/facility address: _____ Phone#: _____

Doctor Fax#: _____ Were x-rays or imaging taken? Y / N

In office use:

Date verified auto MedPay coverage:_____

Auto Ins billing address: _____

3rd Party Ins billing address: _____

Date attorney lien sent:_____

Date attorney lien received:_____

Date records requested:_____

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

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. Drs. Friedman and Sturges are required to advise their 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 the doctor, including spinal manipulation, and herby give my full consent to treatment. I intend this consent to apply to all my present and future chiropractic care.

Signature _____ Printed Name _____ Date _____

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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:_____

NOTICE OF DOCTOR LIEN ON PERSONAL INJURY PROCEEDS

I hereby authorize **Dr. Amy Friedman** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of me regarding the accident on or about _____, for which you have been retained.

I understand that all bills incurred by me at **Dr. Amy Friedman's** office are my responsibility to pay and I will either pay them in full at the time of service or make payment arrangements with **Dr. Amy Friedman**. I also understand that, unlike my attorney, **Dr. Amy Friedman** does not work on a contingency fee and I must pay for her services at the time of her rendering of them and that this lien is only to protect her interests in case there is a balance owing when my case is resolved.

I irrevocably instruct my attorney to withhold from my settlement or judgement any amount that, at that time, is owed to **Dr. Amy Friedman** for my health care in connection with this accident and pay it directly and promptly to **Dr. Amy Friedman** at:

Amy B Friedman, D. C.
165 S. Yorba St.
Tustin, CA 92780

I am granting **Dr. Amy Friedman** an irrevocable lien on the proceeds of my legal case and it is my intent that this lien shall be binding on my present attorney and/or any subsequent attorney which either I might hire or to whom my present attorney may assign this case. In the event I have no attorney, I hereby instruct any insurance company from which I may receive a settlement regarding this accident to add **Amy B. Friedman, D.C.** as a payee on the settlement draft.

_____ _____
Print Patient's Name Patient's Signature

_____ _____
Date of Signature Date of Accident

I, the attorney of record for the above-named signatory regarding the accident in question, hereby agree to abide by the terms of this lien.

_____ _____ _____
Print Name of Attorney Attorney's Signature Date

Financial Agreement for Personal Injury Cases

Our office would like to take a moment to thank you for the opportunity and trust in utilizing our care for your injuries. Our doctors assure that you will receive the very best care available or they will appropriately refer you to outside physicians or facilities as necessary. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills for your injuries will be handled. **Amy B Friedman Chiropractic Corporation, Doctors Amy B Friedman and Marissa Sturges, do not accept third party cases without a prior financial agreement.**

PARTY RESPONSIBILITY:
If you were involved in an accident in your own vehicle, we will bill the medical payment (MedPay) portion of your automobile insurance policy to cover the treatment charges incurred in our office. This portion of your policy is not fault determinant. If you were a passenger in another vehicle, the insurance company which insures that automobile may be billed. If another vehicle has caused the accident, we will first bill *your* automobile Medpay PRIOR to submitting a claim to the insurance carrier of the party at fault *unless* you have arranged a financial arrangement prior to care which may include means of private pay (payment in full or partial visit payment upon each date of service). Private health insurance should NOT be billed if the accident is the fault of a third party. At the end of your care, a complete itemized statement will be provided to submit to the third-party claim's representative along with your medical records and report, if required, to obtain a settlement. The third-party insurance will settle directly with YOU for the entire claim and you will be responsible to pay Health Connection of Tustin the balance due within 3 days of that settlement. Any failure to pay your balance in full may result in immediate legal action.

ATTORNEY LIENS:
If an attorney has been retained to handle your auto injury case, upon approval from your doctor, an attorney lien must be signed by your attorney. This will guarantee direct payment to our office for any unpaid balance upon the settlement of your case. We retain the right to first submit all charges to your auto or private insurance policy for payment. Further, this office does not discount or reduce the amount of your balance based upon the outcome of your settlement. If the total balance of your care is not completely covered by the settlement of your case you are responsible for the difference. At the end of treatment for your auto injuries, the full itemized statement for your care in addition to fees for medical reports, as requested by your attorney, will be provided along with your records for your attorney to settle your case.

RESPONSIBILITY FOR PAYMENT:
As a courtesy to you, we will gladly submit your charges to your insurance company(ies) and/or your attorney; however, all services rendered by this office are charged directly to you, and ultimately you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive. In the case of a 3rd party responsibility claim I agree to pay $_____ per visit until the completion of treatment for this case.

VOLUNTARY TERMINATION OF CARE:
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office.

We hope this answers any questions you might have concerning the financial policy of injury cases in this office. We will be glad to answer any further questions that you might have.

I have read, understand, and agree to the terms of this agreement.

_____ _____
Patient signature Date

_____
Printed name of patient