

New Patient Intake Form

Today's Date (MM/DD/YYYY)

Whom may we thank for referring you?

Patient's First Name

Patient's Middle Name

Patient's Last Name

Birth Date (MM/DD/YYYY)

Social Security Number

Age

Address

City

State

Zip Code

Preferred Language

Cell Phone

Home Phone

Preferred Method of Contact:

Home Phone

Cell Phone

Work Phone

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: _____

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: _____		
3 rd 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: _____

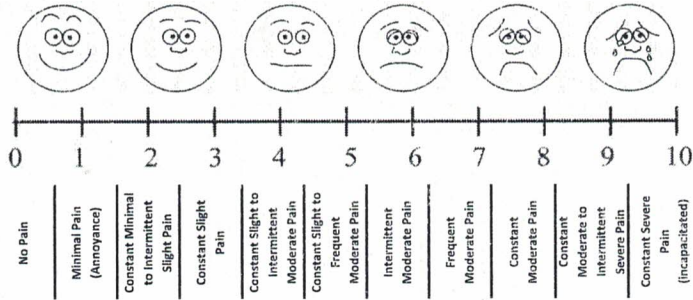
3rd Party Ins billing address: _____

Date attorney lien sent: _____

Date attorney lien received: _____

Date records requested: _____

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?

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

What aggravates it? _____ What alleviates? _____

Limited activities? _____

Area of Concern #2 (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?

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

What aggravates it? _____ What alleviates? _____

Limited activities? _____

Area of Concern #3 (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?

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

What aggravates it? _____ What alleviates? _____

Limited activities? _____

Have you previously seen a Chiropractor? Yes 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: _____

Health History

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

Family Health History: (Cancer, Arthritis, 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 Daily Weekly Occasionally Never

Physical Activity Level: Sedentary Mildly Active Moderately Active Extremely Active

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

Social History and Health Habits:

<u>Alcohol</u>	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
<u>Energy Products</u>	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
<u>Soft Drinks</u>	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
<u>Water</u>	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
<u>Caffeine</u>	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
<u>Drugs</u>	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> Never
<u>Tobacco</u>	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasionally	<input type="radio"/> 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

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 doctor assures that you will receive the very best care available or she 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 does 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 the doctor 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

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. 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, table drop pieces, 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 due to the arteries of the neck or more rarely blood clots being dislodged if you are predisposed to them. 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. I understand that significant high blood pressure and A-Fib already predispose me 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, irreversible anatomical changes, 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

TO BE SIGNED WHEN IN EXAM ROOM WITH DR. FRIEMDAN

I have spoken with Dr. Friedman and she has verbally gone over any individual risks involved. All of my questions have been answered and I consent to treatment.

Patient Signature

Printed Name

Date

Doctor 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 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