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?
○ No ○ Yes **When?** **If so, whom?**

Patient Number (office use only)

Whom may we thank for referring you?

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
○ Widowed ○ Separated

City **State/Province** **ZIP/Postal Code**

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**

CONFIDENTIAL HEALTH INFORMATION

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Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: ______________________

And are the result of (darken circle):
○ An accident or injury
○ Work ○ Auto ○ Other ______

○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other ______

Onset (When did you first notice your current symptoms?) ______

Prior interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Acupuncture
○ Over-the-counter drugs ○ Chiropractic
○ Homeopathic remedies ○ Massage
○ Physical therapy ○ Ice
○ Surgery ○ Heat
○ Other ______

Secondary Complaint
The secondary symptom that prompted me to seek care today is: ______________________

And are the result of (darken circle):
○ An accident or injury
○ Work ○ Auto ○ Other ______

○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other ______

Onset (When did you first notice your current symptoms?) ______

Prior interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Acupuncture
○ Over-the-counter drugs ○ Chiropractic
○ Homeopathic remedies ○ Massage
○ Physical therapy ○ Ice
○ Surgery ○ Heat
○ Other ______

Additional Complaint
The additional symptom that prompted me to seek care today is: ______________________

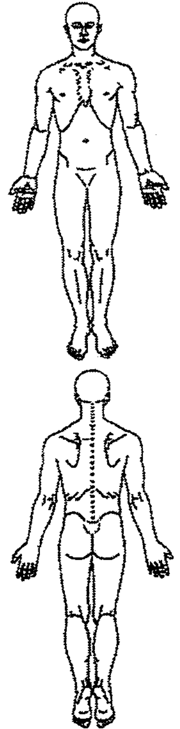
And are the result of (darken circle):
○ An accident or injury
○ Work ○ Auto ○ Other ______

○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other ______

Onset (When did you first notice your current symptoms?) ______

Prior interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Acupuncture
○ Over-the-counter drugs ○ Chiropractic
○ Homeopathic remedies ○ Massage
○ Physical therapy ○ Ice
○ Surgery ○ Heat
○ Other ______

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



1. What else should Dr. Friedman know about your current condition? ______________________

2. How does your current condition interfere with your:

Work or career: ______________________

Recreational activities: ______________________

Household responsibilities: ______________________

Personal relationships: ______________________

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders	NONE ○
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	Initials ____

b. Neurological

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness	NONE ○ Initials ____

c. Cardiovascular

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising	NONE ○ Initials ____

d. Respiratory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia	NONE ○ Initials ____

e. Digestive

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	NONE ○ Initials ____

f. Sensory

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	NONE ○ Initials ____

g. Skin

Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	Had	Have	Condition	
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	NONE ○ Initials ____

____
Patient name

____
Patient Number
(office use only)

____
Doctor's Initials

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(Continued from previous page)

h. Endocrine

Had / Have: ○ ○ Thyroid issues | ○ ○ Immune disorders | ○ ○ Hypoglycemia | ○ ○ Frequent infection | ○ ○ Swollen glands | ○ ○ Low energy — NONE ○ Initials ____

i. Genitourinary

Had / Have: ○ ○ Kidney stones | ○ ○ Infertility | ○ ○ Bedwetting | ○ ○ Prostate issues | ○ ○ Erectile dysfunction | ○ ○ PMS symptoms — NONE ○ Initials ____

j. Constitutional

Had / Have: ○ ○ Fainting | ○ ○ Low libido | ○ ○ Poor appetite | ○ ○ Fatigue | ○ ○ Sudden weight gain/loss (circle one) | ○ ○ Weakness — NONE ○ Initials ____

Patient name ____________

Patient Number (office use only) ____________

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have	Illness	Had	Have	Illness
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ________
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: ________

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ________
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ________
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ________

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	Treatment
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): ________

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

FAMILY

9. Family History

Some health issues are hereditary. Tell Dr. Friedman about the health of your immediate family members.

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother	____	○	○	________	____	○	○
Father	____	○	○	________	____	○	○
Sister 1	____	○	○	________	____	○	○
Sister 2	____	○	○	________	____	○	○
Brother 1	____	○	○	________	____	○	○
Brother 2	____	○	○	________	____	○	○
____	____	○	○	________	____	○	○

10. Are there any other hereditary health issues that you know about? ________

SOCIAL

11. Social History

Tell Dr. Friedman about your health habits and stress levels.

Habit	Daily	Weekly	How much?
Alcohol use	○	○	________
Coffee use	○	○	________
Tobacco use	○	○	________
Exercising	○	○	________
Pain relievers	○	○	________
Soft drinks	○	○	________
Water intake	○	○	________

Question	Yes	No
Prayer or meditation?	○	○
Job pressure/stress?	○	○
Financial peace?	○	○
Vaccinated?	○	○
Mercury fillings?	○	○
Recreational drugs?	○	○

Hobbies: ________

Doctor's Initials ____________

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12. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? ____________

14. How much sleep do you average per night? ______ **Hours**

15. What is the type and approximate age of your mattress and pillow? ______

16. What is your preferred sleeping position? ______

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? ____________

19. In addition to the main reason for your visit today, what additional health goals do you have? ____________

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ___ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ___ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ___ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** ____________

Initials ___ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ___ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ___ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

____________ Patient (or Guardian's) signature

____________ Date (MM/DD/YYYY)

Patient name

Patient Number
(office use only)

Consultation Notes

Doctor's Initials

Health Connection of Tustin
Amy B. Friedman, DC

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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

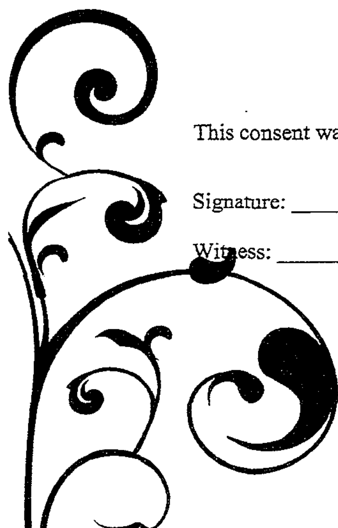
May we leave a message on your answering machine at home or on your cell phone? YES NO

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: ______________

165 YORBA ST.
TUSTIN, CA 92780

(714) 832-8747
(866) 572-2498 FAX
WWW.HEALTHCONNECTIONTUSTIN.COM

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:

1. Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back
2. My pain began: ( ) gradually ( ) suddenly
3. I have pain: ( ) sometimes ( ) all of the time
4. My pain goes into my: ( ) right leg ( ) left leg ( ) both
5. I have tingling and/or numbness in my: ( ) right leg ( ) left leg ( ) both
6. 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
7. My back is worse with sexual activity ( ) Yes ( ) No
8. My pain wakes me up during the night ( ) Yes ( ) No
9. Changes in the weather affect my pain ( ) Yes ( ) No

NECK PAIN:

1. My neck pain began:	( ) gradually	( ) suddenly	
2. I have pain:	( ) sometimes	( ) all of the time	
3. My pain goes into my:	( ) right arm	( ) left arm	( ) both
4. I have tingling and/or numbness in my:	( ) right arm	( ) left arm	( ) both
5. My pain is worse when I:			
cough or sneeze	( ) Yes	( ) No	
bend forward	( ) Yes	( ) No	
lift	( ) Yes	( ) No	
push	( ) Yes	( ) No	
pull	( ) Yes	( ) No	
turn my head	( ) Yes	( ) No	
6. My pain wakes me up during the night	( ) Yes	( ) No	
7. Changes in the weather affect my pain	( ) Yes	( ) No	
8. I have neck stiffness	( ) Yes	( ) No	
9. I have headaches	( ) Yes	( ) No	
10. If I do get headaches, they occur:	( ) sometimes	( ) all of the time	

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

____

____

____

____

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING		FIRM GRASPING		FINE MANIPULATING	
Right hand	( ) Yes	( ) No	( ) Yes	( ) No	( ) Yes	( ) No
Left hand	( ) Yes	( ) No	( ) Yes	( ) No	( ) Yes	( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No

Describe: ______________________________

____

____

8. Are you required to be around moving machinery? ( ) Yes ( ) No

Describe: ______________________________

____

____

9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No

Describe: ______________________________

____

____

10. Are you required to drive automotive equipment? ( ) Yes ( ) No

Describe: ______________________________

____

____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No

Describe: ______________________________

____

____

12. Please list any additional comments: ______________________________

____

____

Signature: ______________________________ Date: ______________

Reorder H.J. Ross Co. (800) 562-3335

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 co-insurance 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 have the opportunity to 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 in order 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.

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Printed name of practice member

_________________________________ Date__________
Signature of practice member or guardian

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Name of parent or legal guardian