HMO

New Patient Health History Form

Patient Data

First Name _____ Last Name _____ Email _____

*Your email will NOT be shared with any 3rd parties, and is used only for occasional office announcements and promotions

Mailing Address

Address _____ City _____ State ____ Zip _____ Birth Date _____

Age ___ Male ___ Female ___ Cell Phone _____ Home Phone _____

SS# _____ Occupation _____ Employer _____

Number of children ____ Marital Status _____ Spouse's Name _____ Referred By _____

Emergency Contact _____ Relationship: _____ Phone _____

Current Complaints

Nature of Injury: ___ Auto ___ Work ___ Other. Please describe your symptoms: _____

_____

Is it possible that your injury could have been caused by an auto accident within the last 1-2 years? __ YES __ NO

Have you retained an attorney? __ YES __ NO

Date of Injury _____ Date symptoms appeared _____ Have you had the condition before? __ YES __ NO

If yes, when did you have the condition? _____ Have you ever been under chiropractic care? Y/N

List other practitioners seen for this injury/condition _____

Insurance Information

Name of party responsible for payment _____ Phone _____

Do you have health insurance? ___ YES ___ NO Name of company _____

Subscriber's Name _____ DOB _____ Policy ID# _____ Employer _____

Do you have a secondary health insurance? __ YES __ NO If yes - Insurance company name _____

Subscriber Name _____ DOB _____ Policy ID# _____ Employer _____

Signatures

I (_____) understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

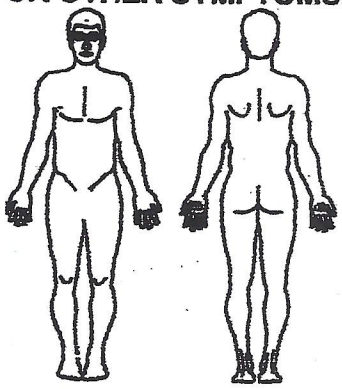
American Specialty Health Plans (ASHP)
P.O. Box 509002, San Diego, CA 92150-9002

INITIAL HEALTH STATUS

(Chiropractic) Fax: 877/427-4777

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____
_____
_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE 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%
Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____
WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date) _____
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	History of Low/Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Surgeries/Medications: _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that 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 provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____

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

MEMBER BILLING ACKNOWLEDGMENT

Chiropractic

For questions, please call ASH at 800.972.4226

IMPORTANT NOTICE: You may have additional coverage options for these services through your medical insurance benefits. ASH recommends that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I, _____ (Name of Patient/Member/Subscriber), a member being treated by Dr. _____ (Chiropractor Name),

do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit 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
		$
	cold laser therapy	$ 25.
	mechanical traction	$ 25.
	therapeutic exercise	$ 38.
	electrical stimulation	$ 20.
		$

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 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 Chiropractor 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 Chiropractor may not bill the member for the difference between what the ASH Contracted Chiropractor bills and what the ASH Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Chiropractor 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 reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, including non-covered services as described above, and agree to make financial arrangements with my chiropractor,
Dr. Anthony Becerra, DC (Chiropractor Name), to pay for these services myself.

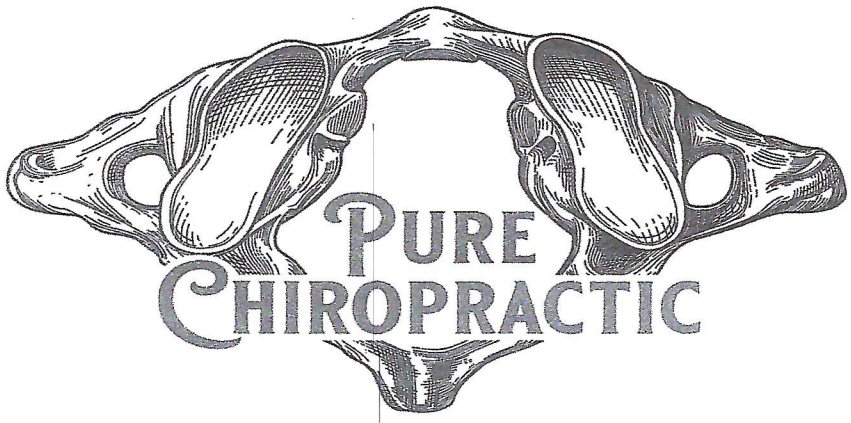
Dated at _____ (city), _____ (state) this _____ (date) day of _____ (month), 20_____ (year).

Member Signature
(Guardian must sign for all members 17 years or younger)

Member Health Plan ID#

Practitioner Signature

Date



INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of Chiropractic, medical doctors, osteopathic physicians and physical therapists who use manual therapy techniques such as manipulation of the spine and or extremities are required to advise patients that, although extremely rare, there may be some risks associated with such treatment.

In particular on rare occasions, patients have experienced rib fractures, muscular strains, or ligamentous sprains following spinal adjustments. Some type of spinal adjustments of the neck leading to or contributing to complications including stroke. This has been the subject of tremendous disagreement within and out of the profession, with one prominent authority stating that at most there is a one in one million chance of a stroke occurring as a result of a chiropractic adjustment of the neck. We employ tests in our examination which are designed to identify such susceptibility to that kind of injury. There have also been rare reported cases of disc injuries in the time following manipulation of the spine, although no scientific study has ever demonstrated with certainty that disc injuries have been specifically resulted by such treatment.

Chiropractic treatment including manipulation has been the subject of governmental reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches, nerve pain, and many other conditions. Chiropractic care contributes to your overall well being. The risks of injury or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same conditions.

PLEASE READ BEFORE SIGNING

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time based on the facts then known, is in my best interests. I understand that the results are not guaranteed. I acknowledge that I have discussed or have had the opportunity to discuss with my chiropractor the nature and purpose of the chiropractic treatment which I am about to receive (including chiropractic manipulation) as well as the contents of this consent form. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including chiropractic manipulation.

Name _____ Date _____

Signature (Patient/Guardian) _____

Witness Signature _____

Dr. Anthony Becerra, D.C.
25186 Hancock Avenue, Suite 100, Murrieta, CA 92562
(951) 461-4617

ASSIGNMENT OF PROCEEDS

(Agreement)

I understand that I remain personally responsible for the total amounts due to **Pure Chiropractic** for their services. This agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Pure Chiropractic** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **Pure Chiropractic** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

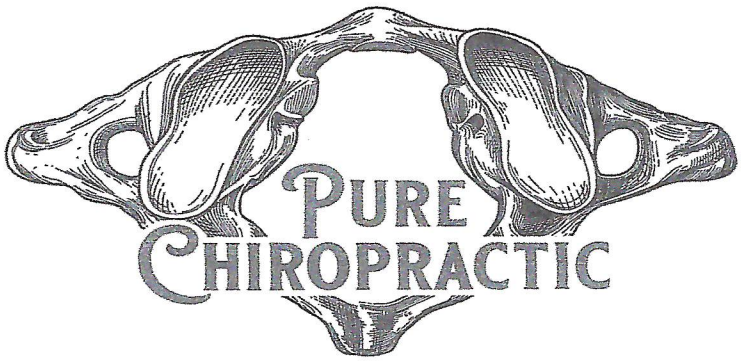
Name (print) _____ Date _____

Patient Signature _____

Name of Custodial Parent or Legal Guardian (print) _____

Parent/Guardian's Signature _____ Date _____

Dr. Anthony Becerra, D.C.
25186 Hancock Avenue, Suite 100, Murrieta, CA 92562
(951) 461-4617



TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specified adjustments of the spine.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interferes with the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. If during the course of a chiropractic spinal examination, however, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. We may use other procedures, however, to help your body hold the adjustments.

I, _____, have read and fully understand the above statements.

I therefore accept chiropractic care on this basis.

Patient Signature _____ Date _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I, _____ am not pregnant and Pure Chiropractic have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. **Date of last menstrual period** _____

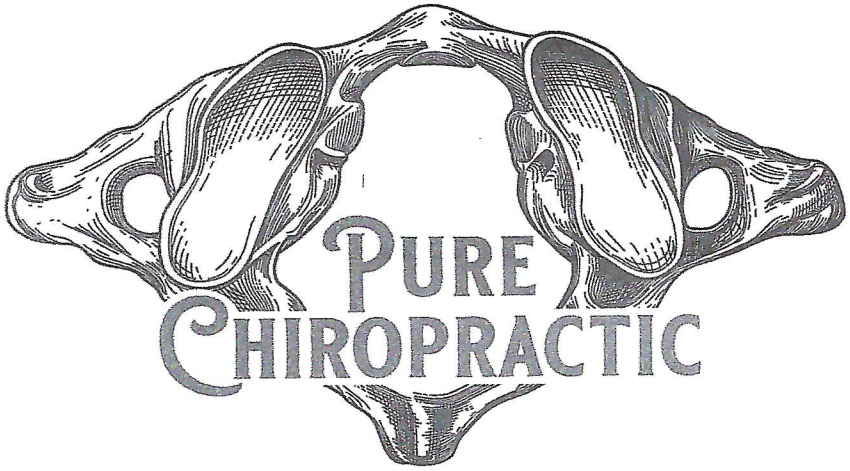
Patient Signature _____ Date _____

CONSENT TO EVALUATE AND ADJUST A MINOR

I, _____ **(print name)**, being the parent or legal guardian of _____ **(print child's name)**, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Patient/Guardian Signature _____ Date _____

Dr. Anthony Becerra, D.C.
25186 Hancock Avenue, Suite 100, Murrieta, CA 92562
(951) 461-4617



APPOINTMENT CANCELLATION & NO SHOW POLICY

APPOINTMENTS

At Pure Chiropractic there is nothing more important than our commitment to your health. We take this responsibility very seriously. Please arrive on time for your appointments. Our doctors do their best to stay on schedule and we all respect your time. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and, when it is missed, that time cannot be used to treat another patient.

CANCELLATION / NO SHOW POLICY

If you need to cancel or reschedule your appointment we kindly ask that you give us a 24-hour notice. This policy allows other patients access to care when needed and to avoid the expense to our office due to late cancellations and no shows. We take your time very seriously and are committed to providing you with the highest level of care.

If you call with less than 24-hour notice or if you do not call at all, we reserve the right to bill you for the time we reserved especially for you. The Cancellation / No Show Fee is $25 for chiropractic treatment visits and $50 for chiropractic review of findings and new patient visits. We understand there are unpredictable situations that cannot be helped so please contact us to share your unique situation.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation / No Show Policy of Pure Chiropractic and I agree to be bound by its terms.

Patient's Signature Date

Dr. Anthony Becerra, D.C.
25186 Hancock Avenue, Suite 100, Murrieta, CA 92562
(951) 461-4617

NOTICE OF PRIVACY (HIPAA)

I, _____ acknowledge being informed of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I am fully aware and fully understand that there is a copy located in the patient waiting room for my convenience. I fully understand that HIPAA is a notice describing:

- Pure Chiropractic's commitment to my privacy
- How Pure Chiropractic may use and disclose my identifiable health information
- My rights regarding my individually identifiable health information

I furthermore understand that the terms of the HIPAA notice apply to all records containing my individually identifiable health information that is created or retained by Anthony Becerra, D.C. at Pure Chiropractic. Pure Chiropractic reserves the right to revise or amend the Notice of Privacy Practices (HIPAA). Any revision or amendments to the HIPAA notice will be effective for all my records that Anthony Becerra, D.C. or Pure Chiropractic may create or maintain in the future. Pure Chiropractic will post a copy of their most current HIPAA notice in a visible location in the patient waiting room at all times. I am also fully aware that I may request a copy of Pure Chiropractic's most current HIPAA notice at any time.

_____

Print Patient's Full Name Patient Signature

_____

Date

Dr. Anthony Becerra, D.C.
25186 Hancock Avenue, Suite 100, Murrieta, CA 92562
(951) 461-4617