INITIAL HEALTH STATUS
Chiropractic

PATIENT INFORMATION

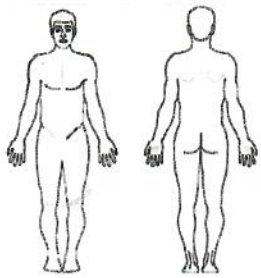
Patient Name _____ Birthdate ____/____/____ Sex: M / F
Address _____ City _____ State _____
Zip _____ Home Phone (____)_____ Cell Phone (____)_____
Occupation _____ Employer _____ Work Phone (____)_____
Address _____ City _____ Zip _____
E-mail Address _____ Subscribe to Office Newsletter ☐ Yes ☐ No

INSURANCE INFORMATION

Subscriber Name _____ Health Plan _____
Subscriber ID # _____ Group # _____
Spouse Name _____ Spouse Employer _____
Address _____ City _____ Zip _____

Primary Care Physician Name _____ PCP Phone (____)_____

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



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other _____
Is this ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began ____/____/____
How Problem Began _____

Current complaint (how you feel today):

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

How often are your symptoms present?

(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% **(Constant)**

In the past week, how much has your pain interfered with your daily activities (i.e., work, house chores, social activity)?

No interference 0 1 2 3 4 5 6 7 8 9 10 **Unable to carryon any activities**

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- ☐ Alcohol/Drug Dependence
- ☐ Tobacco Use – Type _____ Frequency _____/Day
- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (Date) _____
- ☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
- ☐ Dizziness/Fainting
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Numbness in Groin/Buttocks
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Urinary Problems
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Currently Pregnant, # Weeks _____
- ☐ Taking Birth Control Pills
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Visual Disturbances
- ☐ Surgeries _____
- ☐ Cancer/Tumor (Explain) _____
- ☐ Other Health Problems (Explain) _____
- ☐ Medications (List) _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this 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. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ Date _____

NON WORK-RELATED ACCIDENT

If your condition is due to a non-work related accident, please answer the following:

Date _____ Time_____ AM / PM of accident. Police report made? ☐ Yes ☐ No

Place/location of accident_____

Do you have an attorney that has advised you in this case? ☐ No ☐ Yes

If yes, list the name & address_____

WORK-RELATED ACCIDENT

If your condition is due to a work related accident, please answer the following:

Have you notified your employer? ☐ No ☐ Yes If yes, who or what department? _____

Date _____ Time_____ AM / PM Date last worked_____

Injured at_____

Please describe the accident _____

_____

Please list ALL serious illness or operations you have had.

Illness or Operation	Doctor	Hospital	Date From	Date To

Please list ALL accidents or injuries you've had (automobile, sprains, fractures, dislocations, etc.)

Accident or Injury	Doctor	Hospital	Date

Do you presently use

Coffee ☐ No ☐ Yes How much _____

Tea ☐ No ☐ Yes How much _____

Alcohol ☐ No ☐ Yes How much _____

Tobacco ☐ No ☐ Yes How much _____

Please list the sports and physical activities you participate in: _____

_____

How often? ☐ Weekly ☐ Once a month or less ☐ More than once a week

When was the last time you felt really good?

If you have insurance coverage, we will process your claim, but you must collect from your insurance company. Give this information to the receptionist.

I understand that all treatments, X-rays, and laboratory examinations are to be paid for as they are received or definite financial arrangements made in advance.

Signature _____ Date _____

Informed Consent Form Chiropractic

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common [1, 2]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [3, 4]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy burns due to some therapies
- Disc herniations
- Cauda Equina Syndrome [(2)] (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have every felt[(3)]

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concern with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery[5].
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition[6]

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improve your chances of recovery.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine.* Oct 1 2007;32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther.* Jul-Aug 2007;30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008;33(4 Suppl):S176-183.
4. Boyle E, Cote P, Grier AR, Cassidy JD. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008;33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders. *Spine.* Feb 15 2008;33(4 Suppl):S75-82.

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	DOCTOR'S COMMENTS
GENERAL		
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	
BONE WEAKNESS		
Have you been diagnosed with osteoporosis?	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	
Have you been diagnosed with a compression fracture(s) of the spine?	☐	
Have you ever been diagnosed with cancer?	☐	
Do you have any metal implants?	☐	
VASCULAR WEAKNESS		
Do you take aspirin or other pain medication on a regular basis?	☐	
If yes, about how much do you take daily? _____		
Do you take warfarin (coumadin), heparin, or other similar "blood thinners"?	☐	
Have you ever been diagnosed with any of the following disorders/diseases?		
• Rheumatoid arthritis	☐	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	☐	
• Giant cell arteritis (temporal arteritis)	☐	
• Osteogenesis imperfecta	☐	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	☐	
• Medial cystic necrosis (cystic mucoid degeneration)	☐	
• Bechet's disease	☐	
• Fibromuscular dysplasia	☐	
Have you ever become dizzy or lost consciousness when turning your head?	☐	
SPINAL COMPROMISE OR INSTABILITY		
Have you had spinal surgery?	☐	
If yes, when? _____		
Have you been diagnosed with spinal stenosis?	☐	
Have you been diagnosed with spondyliolithesis?	☐	
Have you had any of the following problems?		
• Sudden weakness in the arms or legs?	☐	
• Numbness in the genital area?	☐	
• Recent inability to urinate or lack of control when urinating?	☐	

I have read the previous information regarding risks of chiropractic care and I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

PATIENT [or PARENT/GUARDIAN] SIGNATURE _____ **DATE** _____

Franklin S.S. Kam, D.C.
230 M. Maryland Ave., Suite 108
Glendale, CA 91206
(818)500-9440

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD, AMERICAN EXPRESS, AND DISCOVER.

Regarding Insurance
We may accept assignment of insurance benefits after your second visit. However we do require the bill to be paid the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill you insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extent payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your credit card or the extended payment plan. Please be award that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. ***Regarding Insurance Plans where we are a participating provider:*** All the co-pays and deductible are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the paragraph above.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Patient Responsibility
Adult patients are responsible for full payment at time of service. For minor patients, the adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, and Discover Card, or payment by cash or check at time of service has been verified.

Missed Appointments
Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

I have read the Financial Policy. I understand that I am responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection and attorney fees.

Signature of Patient or Responsible Party _____ Date _____

Signature of Co- Responsible Party _____ Date _____

ELIGIBILITY GUARANTEE/ ASSIGNMENT OF BENEFITS

Eligibility Guarantee:

I, _____, hereby certify that I am eligible for chiropractic
(Patient's name/Guardian)

benefits offered by _____ as of _____.
(Name of Health Plan) (Today's Date)

I understand that if the above is not true, or if I am not eligible under the terms of health plan's Subscriber Agreement or Insurance Policy, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty (30) days of receiving a bill from the office of Dr. Kam or my health plan.

Assignment of Benefits:

I authorize the release of any health information necessary to process this claim. A photocopy of this authorization shall be as effective and valid as the original.

I authorize the payment of medical benefits to the chiropractor listed below who accepts assignment from my health plan.

I understand that Dr. Franklin S.S. Kam will not bill me for any charges over and above the insurance payment, other than the applicable co-payments, coinsurance, or deductibles, if the doctor is a provider for my health plan.

_____ _____
Signature of Member or Subscriber Date

AUTHORIZATION TO DEBIT A CREDIT CARD

I clearly understand and agree that all service rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. If there is any unpaid balance at 30 days from my last visit, it will be charged to my credit card. (Office will safeguard a photocopy of the card)

VISA/MC/DISCOVER/AMEX_____-_____-_____-_____

EXP DATE_____/_____ ZIP CODE on card_____

NAME on card (Please Print)_____

I have read and understand the above.

_____ _____
Signature Date

Franklin S.S. Kam, D.C.
230 N. Maryland Ave., Suite 108
Glendale, CA 91206
(818) 500-9440

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ understand that as part of my health care, Dr. Franklin S.S. Kam, D.C. –
(Patient's Name)

Glendale, CA, originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review *Dr. Franklin S.S. Kam, D. C. – Glendale, CA Notice of Privacy Practices* prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review *Dr. Franklin S.S. Kam, D.C. – Glendale, CA Notice of Privacy Practices* prior to signing this consent;
- That Dr. Franklin S.S. Kam, D.C. – Glendale, CA, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Franklin S.S. Kam, D.C. – Glendale, CA, is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Dr. Franklin S.S. Kam, D.C. – Glendale, CA, has already taken action in reliance thereon.

_____ _____
Printed Name of Patient or Legal Representative Witness Date

_____ _____
Signature of Patient or Legal Representative Witness Date