INITIAL HEALTH STATUS
Chiropractic

PATIENT INFORMATION

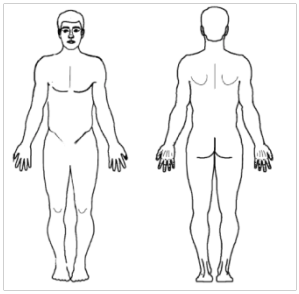
Patient Name _____ Birthdate _____/_____/_____ Sex: M / F
Address _____ City _____ State _____
Zip _____ Home Phone (_____)_____ Cell Phone (_____)_____
Occupation _____ Employer _____ Work Phone (_____)_____
Address _____ City _____ Zip _____
E-mail Address _____ Subscribe to Office Newsletter ☐ Yes ☐ 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 FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic treatment and other procedures, including physical therapeutic and diagnostic x-rays, on me (or the patient named below for whom I am legally responsible) by Dr. Franklin S.S. Kam or any trained individual under his supervision.

I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all of the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have read to me, the above consent. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

The supervising doctor will discuss any further risks inherent for my particular condition during a report of findings procedure and document this discussion in my file. Any questions that I may have will also be addressed at this time.

_____ _____

Patient's Name (Please Print) Date

_____

Patient's Signature (or Guardian's, if the patient is a minor)

Acknowledgement of Receipt of Information Practices Notice ((§164.520(a))

I_____ understand that as part of my healthcare, Dr. Franklin S.S.
(Patient's Name)

Kam, D.C. – 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 acknowledge that I have been provided with and understand that ***Dr. Franklin S.S. Kam, D.C. – Glendale, CA Notice of Privacy Practices*** provides a complete description of the uses and disclosures of my health information. 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 acknowledgment;
That Dr. Franklin S.S. Kam, D.C. – Glendale, CA, reserves the right to change the Notice of Privacy Practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested.

_____ _____

Printed Name of Patient or Legal Representative Witness Date

_____ _____

Signature of Patient or Legal Representative Witness Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)_____

_____ _____

Printed Name of Employee Date

_____ _____

Signature of Employee Date

Franklin S.S. Kam, D.C.
230 N. 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.

All patients must fully complete our Information and Insurance (if applicable) forms before seeing the doctor.

> ***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 your insurance company unless you give us your accurate insurance information. 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 extended 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.

Adult Patients
Adult patients are responsible for full payment at time of service.

Minor Patients
For minor patients, the adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment at the time of service. 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.

Interest
We reserve the right to charge interest in the amount of 18% as provided by state law.

Thank you for understand our Financial Policy and helping us provide you with the best treatment possible. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to 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

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