NEW PATIENT INFORMATION

REFERRED BY_________________________

NAME__________________________________Age:___________Birthdate____________________

STREET ADDRESS____

CITY_______________________STATE_____________ZIP__________________

PHONE #_________________CELL#____________________SS #_____________________

E-MAIL_______________________________RELATIVE'S PHONE #:_______________________

EMPLOYER_________________________OCCUPATION_______________________

ADDRESS___________________________WORK PHONE______________________

CITY_______________________STATE____________ZIP___________________

PRIMARY INSURANCE____
INSURED'S NAME_____________________INSURED'S BIRTHDATE____________
INSURED'S ID #_______________________RELATIONSHIP _________________
GROUP #____________________INSURED'S EMPLOYER______________________

INFORMED CONSENT FOR CARE: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Wasserman. I will have the opportunity to discuss with Dr. Wasserman and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. 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 risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I have read, or have had read to me, the above consent. I will have an opportunity to ask questions about its content, **and 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) or which I seek treatment here at this office.

I ALSO GIVE MY FULL AND COMPLETE PERMISSION FOR THIS MEDICAL GROUP TO TREAT MYSELF OR MY MINOR CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY, AND **ASSIGN ALL MY PAYMENTS DUE TO THE DOCTOR.** I HEREBY AUTHORIZE THE GROUP TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT REQUIRED FOR THE PURPOSE OF BILLING. A PHOTOCOPY OF THIS ASSIGNMENT WILL BE AS VALID AS THE ORIGINAL.

THIS COMPLAINT OF ___________________________WAS **NOT** CAUSED BY AN AUTOMOBILE ACCIDENT, RELATED TO EMPLOYMENT, OR OCCUR ON COMMERCIAL PROPERTY.

SIGNATURE____DATE_______________

STEVEN B. WASSERMAN, R.N., D.C. 3772 KATELLA AVE., STE. 100
LOS ALAMITOS, CA 90720 tel (562) 430-4949 fax (562) 430-7544

Initial Symptom History

Please state your primary complaint of why you are here today:________________________________
____

What caused this and how long have you had it:____
____

Have you had this condition in the past?____

Please put a check that applies to your present condition:

Frequency: ____rare ____occasional ____frequent ____constant

Symptoms: ____ pain ____stiffness ____spasms

Intensity: 0 (none)- 10 (severe) = _______neck _______mid _______low back _____extremity

Quality: ____sharp ____dull ____stabbing

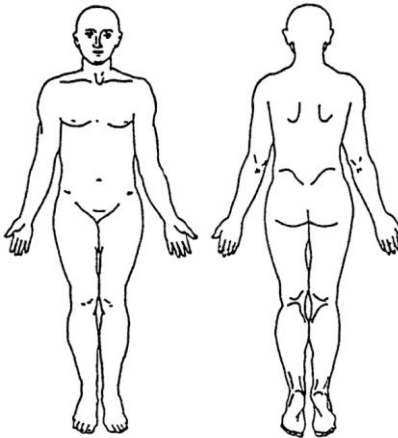
Assoc. Symptoms: ____weakness ____limited ranges of motion

radiating pain into______________________ numb/tingling of___________________________

Aggravated by prolonged: ____sitting ____standing ____walking ____lying down ____driving

Relieved by: ____rest ____movement ____stretching ____Rx ____ice ____heat

Please mark the areas where your current complaints are located:



Signature____**Date**__________________________

INITIAL HEALTH HISTORY

Allergies:____

Medications/Supplements____

Cholesterol Lowering Drugs:____

Surgeries/Hospitalizations:____

Pace Maker/Metal /Breast Implants____

Cancer:____
Diabetes:____
Heart Disease:____
Stomach/Colon:____
Etc.____

Spinal Injuries/Accidents:____

Previous Chiropractic Care: ____

Last Menstrual Period:________________ PREGNANT? ( ) YES ( ) NO

Previous MRI, CT Scans; X-Rays:______________________________________

Exercise/Sports Activities:_____________________________times per week: 1 2 3 4 5 6 7

Average Daily Emotional Stress Level: ( )very high ( )high ( )medium ( )minimal

Patient Signature______________________________________**Date**_______________

Comments:

STEVEN WASSERMAN, R.N., D.C.
3772 KATELLA AVE., STE. 100
LOS ALAMITOS CA 90720
(562) 430-4949

PPO FINANCIAL POLICY

Dear New Patient,

Please be advised that our financial policies take into account the requirements of the Insurance Companies, California Insurance Commission, and the ever-changing needs of this practice.

Our office makes no representation that your insurance policy will positively cover all or some of your Chiropractic care, therefore, we require that you the patient, be responsible for knowing your benefits and policy limits.

All insurance plans have policy limits. These may include dollar amounts, number of visit, and some services or supplies that may or may not be covered. We will inform you prior to rendering these services or supplies. These services that may not be included are: electrical stimulation, hot pack, ultrasound, laser, x-rays, and supplies, therefore, you are responsible for those services rendered that are not covered by your policy.

*****<u>Please come prepared to pay your deductible, co-pay, and co-insurance</u> at the time of service. Our office will calculate an estimated amount due, taking into account usual insurance payments. We accept cash, credit cards, and checks with credit card on file only. Any overpayment of deductible or co-insurance will be reimbursed directly to you.**

Our charges for chiropractic services rendered are: 1) exactly within the medical fees of Southern California 2) according to each insurance company our office is contracted with, and 3) set by each insurance company according to their procedure code fees and copayment schedules or percentages due. All charges for services rendered vary depending on what procedure was done and according to the complexity of the problem. For example, we may bill your insurance company $100.00, but our contract with that insurance company or the insurance company's own policy for chiropractic coverage only allows $60.00 payment to the doctor for services rendered and allows our office to collect from the patient $10.00 for the co-payment, percentage due, or coinsurance. The remaining $30.00 is waived per insurance company's contract with our office. These breakdowns of charges and payments are printed on your explanation of benefits that you will receive in the mail from your insurance company. **You, however, are ultimately responsible for your bill and if you exceed the policy limits, you will be responsible for payment in full for those visits.**

Your **initial consultation and exam** may vary from $75 to $375 and our average fees per **routine visits** will vary from $55.00 to $225.00. Again, depending on insurance plan coverage, what procedures were done; exam, adjustment, physical therapy modalities, and x-rays, fees will vary.

OUR OFFICE DOES NOT BILL REMAINDER OF BALANCES DUE. ALL FINANCIAL MATTERS WILL BE HANDLED AT TIME OF SERVICES FOR DEDUCTIBLES, COPAYS, AND CO-INSURANCE.

DEDUCTIBLE: Any deductible owed is payable in full (up to the total charge of the office visit) and is due at time of service. Most deductibles will vary from $100-$5000 per calendar year. Your estimated deductible portion first visit will be:
$175.00 with x-rays, $ 100.00 without x-rays.

COPAYMENTS OR PERCENTAGE DUE ARE COLLECTED PRIOR TO TREATMENTS, cash or credit card only.

1. Must pay your contracted amount of co-payment or percentage due at time of service
2. Must pay for additional services that may not be covered by your policy, which we will inform you prior to rendering those services or supplies to you. These additional services that may not be covered are: hot pack, electrical stimulation, ultrasound, and/or muscle therapy.

THREE PAYMENT OPTIONS ONLY:

1. **CASH**

2. **PAYMENT WITH CHECKS:** If you choose to pay with a check, it is our office policy that a copy of your credit card be left on file. If a check bounces, your credit card will be automatically charged the amount of check plus a $25.00 bounced check fee, no exceptions. We will send you notification that your credit card has been debited. No checks under $20 will be accepted.

3. **VISA, MASTER, AND DISCOVER CARD.**

*Please note this office does not bill remainder of balance due. All financial matters are handled at time of service. If payment is not received or other arrangements have not been made, your credit card will be charged within 5 working days of date of service.

I have read the above, and agree to the terms of this office's policy.

____Date:____________________
Signature

Printed name ____