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

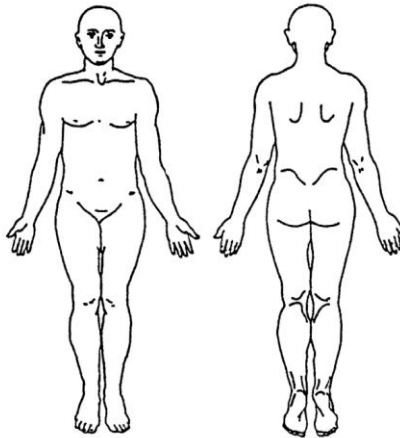
Assoc. Symptoms: ____weakness ____limited ranges of motion

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:

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fax (562) 430-7544

Out-of-Network, and Non-Participating, and Out of State Policies; Provider Acknowledgement:

Patient's Name:________________________________ Date:___________________

I____, understand that Dr. Wasserman is no longer a participating provider with my insurance company. Therefore, I will be responsible for all services rendered at time of service.

Dr. Wasserman's office may as a courtesy bill my insurance company (if applicable). I am aware that I may or may not receive a reimbursement check in the mail from my insurance company, depending on my insurance company's contract and benefits, for services provided by Dr. Wasserman.

I understand that payment will be due at the time of services rendered.

I understand this is not a guarantee that my insurance will cover the services received by me and that all services may be subject to review by my insurance company. (Please consult your insurance company to verify eligibility and benefits.)

I fully understand and agree with the above terms above.

____ ______________________________
Patient's Signature Date

FEES

Initial consultation, exam, adjustment, x-rays, with or without PT: $175.00
Initial consultation, exam, adjustment, with or without PT: $100.00
Adjustment and PT: $60.00
Adjustment with or without hot pack: $40.00
Patient not seen > 90 days; consultation, re-exam, adjustment, and PT or hot pack: $75.00
X-rays: $75.00-$150.00
Supplies: separate charge per item **(PT=electrical stimulation, manual traction, laser, and /or ultrasound)**

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www.adjustm.com

Out of Network Provider Policy

Our office is an "Out of Network Provider" with your insurance company as of January 1, 2016, our office has adopted a policy regarding this change.

1. Our office will bill your insurance company our fee for services that are rendered to you at this office. Some services rendered may or may not be covered; therefore, you will be responsible for them.

2. We are out of your network with your insurance company, therefore, they may mail you our reimbursement check instead to us.

3. If you receive the check in the mail, please let us know within 10 days.

4. Since most banks do not take checks signed over to another party, the check amount you received in your name can be paid to our office by: cash, check, or credit card. The check you received by your insurance company can then be cashed by you after payment is made to our office.

5. Again, you are responsible for any deductible and co-insurance due that is listed on your explanation of benefits for all services rendered. If any overpayment should occur, our office will reimburse or credit you.

6. 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

If there are any further questions, please do not hesitate to call us regarding the above.

Johanna,
Office Manager
02/01/2019