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

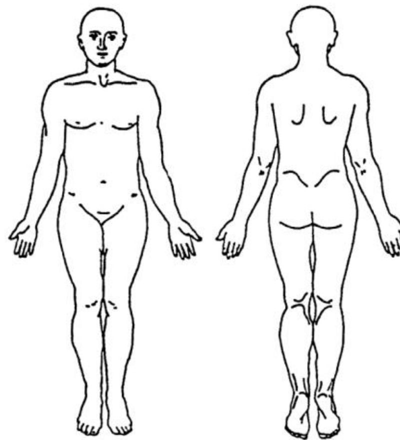
Assoc. Symptoms: ____weakness ____limited ranges of motion

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

MEDICARE 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.

Payment in full at time of service. We will bill Medicare for you; we do not bill secondary insurances. Please remember, Medicare or your secondary insurance may or may not pay for services. Therefore, we require that you the patient be responsible for knowing your benefits and policy limits.

a. Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits.
b. When you receive an item or service that is not a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.
Ask us to explain, if you don't understand why Medicare won't pay.

Medicare will pay for an adjustment only for subluxation of the spine; however, Medicare may not feel chiropractic care is medically necessary. Medicare will not pay for: Exam, consultation, extremity adjusting, x-rays, physical therapy, supplies, or maintenance care because it is not a covered Medicare benefit.

FEES

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

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

Signature____Date:_____________________

*PLEASE READ

SIMPLIFIED MEDICARE FINANCIAL

DEDUCTIBLE
Medicare requires that you pay a yearly deductible of $183, etc., towards your Part B medical expenses before they will begin paying for covered services. If you have already been treated by other doctors this year, you may apply those bills towards your deductible.

MEDICARE COVERAGE
Medicare in a chiropractic office only covers manual manipulation of the spine (commonly referred to spinal adjustment or CMT) Medicare pays 80% of the service and the patient is liable for 20% after deductible is met. All other services other than spinal manipulation are your responsibility and outlined below in detail.

1. **What is my responsibility each visit for Chiropractic care?** Payment in full for all services rendered that day. (see Medicare Financial Policy)

2. **Who bills Medicare for my services?** We will bill Medicare for you, even though we are a out of network provider.

3. **If I have a secondary insurance, who bill them?** Medicare will send Chiropractic charges to your secondary insurance; our office does not bill secondary insurances.

4. **Will my secondary insurance pay for care?** Your secondary insurance may or may not pay for services.

5. **What does Medicare cover for Chiropractic care?** Medicare will pay for an adjustment only; however, Medicare may feel chiropractic care is not medically necessary. It also depends on if your Medicare deductible has been met.

6. **What Medicare will not cover?** Medicare will not pay for: Exam, consultation, x-rays, physical therapy, supplies, or maintenance care because it is not covered under Medicare guidelines.

7. **What will Medicare reimburse me?** Approximately $23.00 for the adjustment only. Physical therapy is not a covered Medicare benefit.

8. **What will my secondary reimburse me?** They may or may not reimburse you for the adjustment; it depends on your individual secondary insurance benefit policy. It also depends on if your secondary deductible has been met.