

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 _____

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

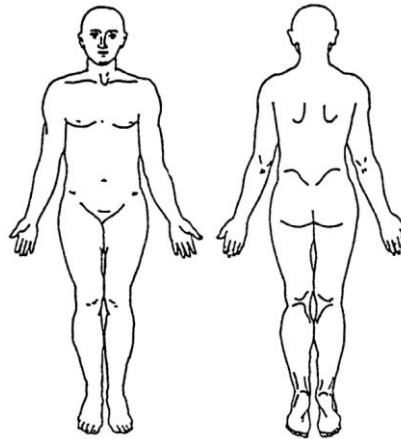
Assoc. Symptoms: ___weakness ___limited ranges of motion

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.
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LOS ALAMITOS CA 90720
(562) 430-4949

MONARCH MANAGED CARE 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 contracts with your insurance company either directly or indirectly with a third party managed care administrator. Under your Monarch IPA plan, our office has contracted and agreed to follow their financial and chiropractic care protocols regarding your care.

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.

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.

Basic Managed Care Policies:

- 1. Must pay your contracted amount of co-payment or percentage due at time of service.**
- 2. Your Chiropractic policy through Monarch allows for Chiropractic adjustments only. *Please note that physical therapy, supplies, or nutritional supplements are a non-covered benefit under your chiropractic plan,** therefore if you choose to have additional services; you are responsible for those services rendered that are not covered by your policy. All treatment plans will be discussed prior to your care. There will be an additional charge of \$5-\$55.00 for these non-covered services and due upon services rendered.
- 3. If you exceed your policy limits, you will be responsible for payment in full for those visits.**
- 4. Your PCP has authorized you to consult with Dr. Wasserman for a specific condition and area of your spine that you and your doctor believe would benefit from chiropractic adjustments.** Your diagnosis and specific area of your spine to be treated is written on your authorization form. Dr. Wasserman will only be able to treat the area of the spine that was authorized by your PCP. The authorization expires on the date that is written on your authorization form you have received.
- 5. When your treatment for your condition is resolved or stabilized, your PCP will receive a progress report about your condition.** If you have an exacerbation for the same condition or

new injury or illness, you will need to return to your primary care physician, and a new authorization for your condition will be generated if warranted. *Remember, no insurance company will cover maintenance care or wellness care.

6. If your injury is due to a auto accident, our office will not bill a third party. Our office will only give itemized statements of what you paid, not what was billed to Monarch, since you are in a capitated health plan. If there is a request for your records or chart notes to be copied by you, your attorney, or insurance company, there will be a charge of \$25.00. If a full narrative report is requested, there will be a charge of \$150.00 to \$250.00. All payments are due prior to record or report release. Our office does not accept attorney liens.

7. However, you must show improvement within a reasonable time, dependant on your diagnosis, or will be referred back to your PCP for alternative therapies and/or diagnostic tests.

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

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 that 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 managed care policy.

Signature Date: _____

Printed name _____