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 Wasserman, RN, DC
3772 Katella Ave., Ste. 100 Los Alamitos, CA 90720
(562) 430-4949 www.adjsutm.com

AUTOMOBILE ACCIDENT HISTORY FORM

1. Name_____Date_____

2. Accident: Date:_____
   Time:_____
   City:_____
   Street:_____

3. Did police come to the scene of the accident?_____Report taken?_____
4. Did paramedics come to the scene of the accident?_____
5. Road conditions at the time of the accident? Wet_____ Dry_____ Icy_____
6. Where were you seated in the vehicle?_____
7. Did the impact catch you by surprise?_____
8. Did you lose consciousness?_____
9. Were you wearing your safety belt?_____

10. Were you taken to the hospital?_____X-rays taken?_____
11. How did you get to the hospital?_____
12. Have you seen your primary doctor for this accident?_____
13. Was your car drivable after the accident?_____
14. If you did not go to the hospital after the accident, where did you go and who drove you there?_____

15. List year, make, and model of the vehicle you were in:_____
16. List year, make, and model of the vehicle that struck you:_____
17. Was your car stopped at the time of impact?_____
18. If your car was moving, how fast were you going at the time of impact?_____
19. What parts of your car was damaged?_____
    _____
20. What is the estimated cost of damage to your car?_____

21. Briefly describe what had happened:_____
    _____
    _____
    _____
    _____

Patient Signature:_____

STEVEN B. WASSERMAN, R.N., D.C. 3772 KATELLA AVE., STE. 100
LOS ALAMITOS, CA 90720 tel (562) 430-4949 fax (562) 381-9777

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

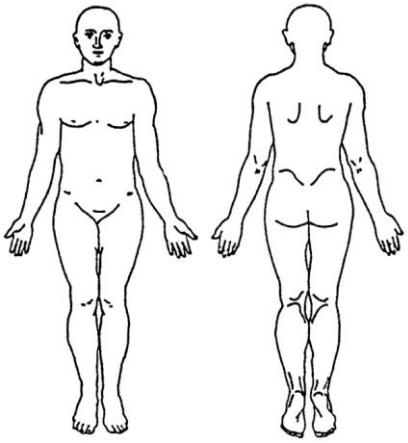
Assoc. Symptoms: ____weakness ____limited ranges of motion

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 B. WASSERMAN, R.N., D.C.
3772 KATELLA AVE., STE. 100
LOS ALAMITOS, CA 90720
tel (562) 430-4949 fax (562) 381-9777

PERSONAL INJURY OFFICE POLICY

Dear_____; Date: _____

Due to the complexity of motor vehicle accidents/slip and fall accidents/or any personal injury accidents; insurance company policies; policy limitations, police and accident reports, etc., it is best that the insurance, business, and legal aspect of your care be handled directly by you. Below are the possible ways to handle your case:

1. If you pay for care on your own without any insurance coverage, it is our office policy that during your course of treatment, that full payment is due as services are rendered at time of treatment. You must be informed that the insurance company you may be dealing with may or may not reimburse you. We will give you our itemized statement for services rendered to you at the end of each week. This is the bill that you will turn into your insurance or the other parties' insurance company.

2. There are some cases when our office will accept your medical insurance as payment for your motor vehicle injury, but this is determined on a case-by-case basis. If you choose to utilize your health insurance, you are responsible for all co-pay, co-insurance, or deductibles owed at the time of services rendered. If you overpaid the above, you will be reimbursed once the explanation of benefits from your health insurance company has been received for those dates of services rendered.

3. If we utilize your auto med pay insurance, you must put a down payment or pay in full each visit. When the insurance pays our office in full, you will be directly reimbursed your down payment minus any balance due, by our office. Again, is determined on a case-by-case basis.

Please note that just because a third party (the party that caused your injury) is at complete fault, does not mean that they will cover or take any financial responsibility for your injury. These decisions take place at a later date by parties involved. You are ultimately responsible for your bill, not yours or the other person's insurance carrier.

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.

I have read, understand, and agreed to the above office policy:

Patient's Signature_____Date_____

OFFICE FEES

Initial consultation, exam, adjustment, and physical therapy: $150.00
Initial consultation and exam only: $100.00
Adjustment and physical therapy: $60.00
Adjustment/thermal pack: $40.00
X-rays: $75-$150

Patient not seen > 90 days; consultation, re-exam, adjustment, with or without physical therapy: $75.00
Supplies: separate charge per item
Physical Therapy= electrical stimulation, manual traction, laser, ultrasound, thermal pack

OFFICE POLICY: OUR OFFICE DOES NOT BILL REMAINDER OF BALANCES DUE. ALL FINANCIAL MATTERS WILL BE HANDLED AT TIME OF SERVICES RENDERED.

THREE PAYMENT OPTIONS ONLY:

1. **CASH** (Please ask about our discount program "purchase10, and receive 12.")

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.

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

Our office wants your care to be about you, not about your insurance company. If you have any questions, please feel free to ask.

Sincerely,

Johanna W., Office Manager

I have read, understand, and agreed to the above office policy:

Patient's Signature_____Date_____

STEVEN B. WASSERMAN, R.N., D.C.
3772 KATELLA AVE., STE. 100 LOS ALAMITOS, CA 90720
tel (562) 430-4949 fax (562) 381-9777 www.adjustm.com

Q & A PERSONAL INJURY OFFICE POLICY

Due to the complexity of motor vehicle accidents, you may have some questions;

Q: I was not at fault from my accident, who is responsible for paying for my Chiropractic care each visit?
A: You are. No matter who is at fault, initially, you are responsible for the bill.

Q: What if I have medial-pay on my auto insurance policy?
A: Our office will bill the total amount due for all services rendered each visit to your auto med-day policy. Your insurance may or not pay, or they may not pay in a timely manner.

Q: Since my insurance may or may not pay, what is this going to cost each visit?
A: It is our office policy for personal injury cases; you must put a down payment or also called a partial payment of the total amount that is being billed to your insurance company or med-pay. When your insurance pays our office in full, you will be directly reimbursed your down payment/partial payment you personally paid.

Q: Why do I have to pay a down payment/partial payment each visit?
A: Due to the complexity of a personal injury case, fault factors, there is no guarantee that our office will be paid by an insurance company, therefore, if no money is received in your case, we will waive the balance due, and consider your case paid in full at that time.

Q: If I pay for care on my own without any health insurance or med-pay coverage, what is my cash fee for each visit?
A: Our cash fee, see cash fee office policy.

Q: If I have health insurance, can you just bill them?

A: Case by case basis, but regardless of your health insurance and because it is a auto accident, a down payment/partial payment is still required per visit.

Q & A PERSONAL INJURY OFFICE POLICY (continued)

Q: If I have Medicare, can you just bill them?
A: Yes, and since we are a non-provider for Medicare, full payment is at time of service. Medicare will reimburse you according to their schedule and your policy contract.

Q: Will you bill the third party that is at fault?
A: No, nor do we do any business with a 3rd party, all business and claims are handled directly through you or your insurance company.

Q: What if I retain an attorney in the middle of the case?
A: If you do retain an attorney, you will considered a cash case for services rendered or you can choose to pay the total amount that our office bills to your insurance company. When an attorney is retained by you, they may request all services rendered payments at this office be forwarded to their office, again, our office does not deal with attorneys or with signed liens, no exceptions.

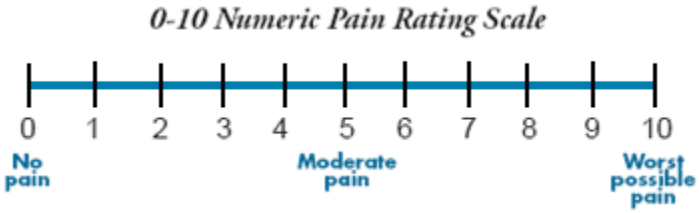
Patient Signature:_____Date:_____

VAS – Visual Analog Scale

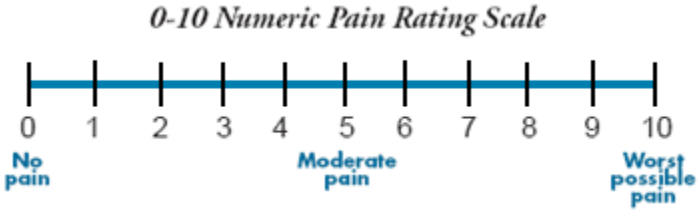
Patient:_____Date:_____

WHERE IS YOUR PAIN LOCATED? head neck mid back low back_____

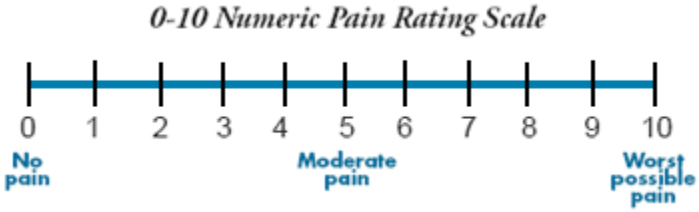
WHAT IS PAIN LEVEL <u>RIGHT NOW</u>? Please circle



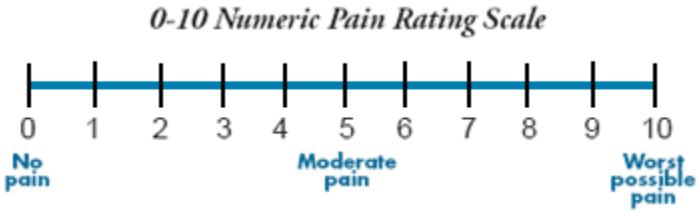
1. **WHAT IS YOUR PAIN AT <u>ITS WORST</u>?** Please circle



2. **WHAT IS YOUR PAIN LEVEL <u>AT ITS BEST</u>?** Please circle
3.



4. **WHAT WAS YOUR INITIAL PAIN LEVEL <u>BEFORE</u> BEING TREATED AT THIS OFFICE?** Please circle



PATIENT SIGNATURE:_____DATE:_____

SYMPTOM SURVEY

DATE:_____

Please circle the below injuries you directly suffered from your accident and that you are now feeling sicne the accident:

1. Headaches
2. Neck pain
3. Middle back pain
4. Low back pain
5. Shoulder pain, right, left
6. Arm pain, right, left
7. Leg pain, right, left
8. Numbness/tingling of hand, right, left
9. Numbness/tingling of leg, foot, right, left
10. Other_____

COMMENTS:

PATIENT SIGNATURE_____