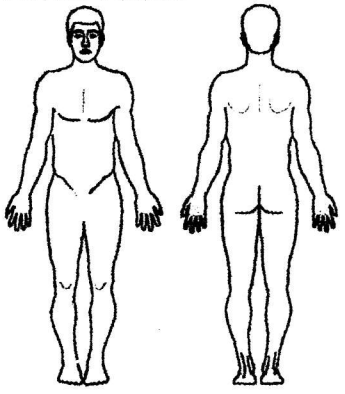
E-mail Address: _____

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name _____ Birthdate _____ Sex M / F
Address _____ City _____
State _____ Zip _____ Telephone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan: _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain
☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken: _____ **What areas were taken?** _____

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) _____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) _____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) _____
_____
_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
_____
_____
☐ Medications _____
_____
_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS

(UNDER CALIFORNIA STATE INSURANCE CODE #10133)*

TO: _____(Insurance Co.)

_____

_____

Telephone Number: _____

Date _____

***This office holds an assignment/lien on this case for services rendered. Any settlement of this claim without honoring this assignment/lien will cause you to be responsible to this office for payment.**

You are instructed to pay directly to the below named doctor at his/her office for all professional services rendered to me by his/her office.

This instruction to you is an assignment of my rights under medical coverage to the extent of this bill.

Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. Also, I am personally liable for any unpaid accounts for hospital, diagnostic and consultant services.

Pay to Doctor:

Martin Geoffreys, DC
24863 Del Prado
Dana Point, CA 92629

Patient's Name: _____

Signature: _____

Address: _____

_____

Witness: _____ **Policy Number:** _____

ACKNOWLEDGMENT OF INSURANCE COMPANY

This insurance company hereby acknowledges receipt of the above instruction and agrees to mail payment of medical coverage benefits of the policy directly to the office of and to the order of the doctor only.

Date: _____ **Authorized Signature:** _____

Note: If this acknowledgment is not signed and returned to the office of the doctor within seven (7) days, and if the patient continues under treatment after seven (7) days, it will be assumed and relied upon that the company has agreed to and acknowledges medical coverage and payment directly to the doctor.

Keep this copy attached to patient's chart. Do not send out bill or medical report until insurance company sends back signed copy. Call company in seven (7) days if no response.

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or canceled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hour notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses—you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for canceled appointments, please realize how important it is to keep your reserved time. However, we do charge a $15.00 fee should you not call us to cancel. Any "no shows" will be charged the additional fee.

Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

_____

Signature

_____

Date