Welcome to Ed Simon Chiropractic. It is a pleasure to serve you!

Last Name:________________ First Name: ________________ MI: ______

DOB: ____________________ Circle Gender: M F SSN: ____________________

Circle: Married Single Other Occupation:________________ Employer: ________________

Address:____

Home Tel: ________________ Cell: ________________ Work: ________________ Circle Preferred

Email: ____________________ Primary MD:________________________ Phone:____________

How did you find us?:

☐ another patient: ______________________________ ☐insurance referral ☐ signage

☐my physician ☐my attorney ☐another chiropractor ☐ other: ______________________________

I *seek the following benefits from chiropractic care*:

☐Pain Relief ☐ Improved posture, flexibility and strength ☐ Improved activity ability

☐Relieve stress and tension ☐ Prevent future similar or worsening episodes ☐Slow spinal aging

☐Better overall health ☐ Reduce dependence on medications ☐ Unsure

Check all the following that apply to you:

☐Recent Fever ☐Diabetes ☐High Blood Pressure ☐Stroke ☐Cancer ☐Epilepsy

☐Birth Control Pills ☐Dizziness/Fainting ☐Numbness Groin or Buttocks ☐Osteoporosisis

☐Prostate Problems ☐Menstrual Problems ☐Urinary Problems ☐Currently Pregnant ☐Visual Disturbances

☐Sudden Weight Gain/Loss ☐Marked Morning Pain or Stiffness ☐Pain Unrelieved by Position or Rest

Surgeries: ________________________________Current Medications: ________________________________

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

I certify that to the best of my knowledge the above information is complete and accurate. I understand I am liable for all services rendered to me regardless of insurance coverage or third party determinations. I understand that should collection efforts be necessary on an overdue account I will be responsible for related costs. I agree to inform doctor if my health status changes. I agree to allow the doctor or associated managed care organizations to be contact my primary physician if necessary. I understand that all medical procedures contain a degree of risk and I do not expect doctor to explain all possible adverse possibilities to me but to use his best judgement in regard to my care. I understand I have the opportunity to address any concerns I may have at any time. I understand that at the discretion of the office manager missed appointments or appointments without 24 hours notice may be billed to my account. I understand this is a HIPPA compliant office and that my privacy will be protected and that only the minimally necessary information will be released to third parties in order for valid requests to be satisfied and insurance claims to be processed.

Patient Signature: ______________________________ Date: ____________

Automobile Injury Report

Information on this form may be subject to review by all parties involved in your accident. Please be thorough and specific. Do not hesitate to ask for assistance if necessary.

Today's date: __________ Name: ____

Date of Injury:_________ Time: _________ Your Vehicle: _______________ Thiers: ______________

Were you the: __ driver __ front Passenger __ rear passenger __ left __ center __ right

Were you wearing lap and shoulder belts? ___ yes ___ no

What was the direction of impact? (check all that apply): __ front __ rear __ side __left __ right

Approximate speed of your vehicle: ______mph. Approximate speed of other vehicle: ______mph

Please describe how the accident occurred: ____

____

Did you anticipate the impact __visually ___ heard screeching brakes __ horns honking?

__ I did not anticipate the impact and was struck unaware

Was your foot applied to the brakes: __ yes __ no

Did you brace yourself: __ on steering wheel__ on dashboard __ grabbed arm rest __ did not brace myself

Were you looking: __ straight ahead __ in rear view mirror __ in side view mirror __ over shoulder __ L __ R

How did your body move in response to the impact?

____

____

Did you strike your head: __ on headrest __on steering wheel __ window __ other: _______________________?

Did you loose consciousness? __ no __ yes: how long: __________

Did you bang any other body parts: __ no __ yes: explain ____?

How did you feel immediately after the accident?

____

Did you: __ conduct normal business __ go home __ to a hospital __ got to hospital by ambulance

Was a police report made? _ yes __ no

Have you missed work? __ no __ if yes: how many days __________?

Have you returned to full duty __ yes __ no __ part time or modified explain: __________________________?

Have you seen other doctors for the injuries from this accident? __ no __ yes

If yes, what did they do and recommend:

____?

Are there any activities that are difficult for you to perform? __ no __ yes

If yes, please list them:

____

Are there any activities that are impossible for you to perform? __ no __ yes

If yes, please list them:

____

Did you suffer from related symptoms prior to the accident? __ no __ yes

If yes, please compare your symptoms immediately prior to the accident with your current complaints:

____

____

Is there anything else that you feel is important for the doctor to know? __ no __ yes

____

Signed: ______________________________

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Condition Report

Name: ______________________

Date problem began ______________ ☐ Gradual ☐ Episodes ☐ Chronic

Is this ☐ Workers Comp Related ☐ Auto Accident Related ☐ Neither

Please describe your problem and tell us how you think it began:

____

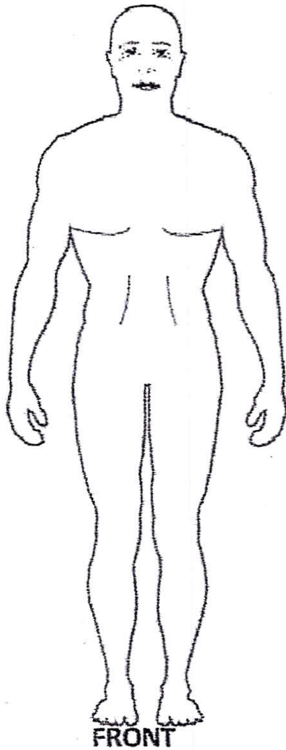
____

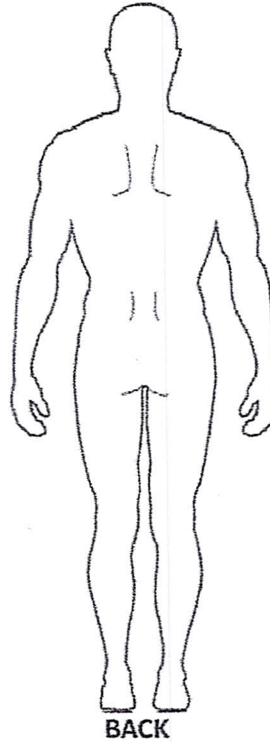
____

Pain Level ☐1(low) ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (high)

How often are the symptoms present: ☐Less than 25% ☐ 25-50% ☐ 50-75% ☐ 75-100%

Please mark the diagram where your symptoms are present:





____

____

Have any activities become difficult or impossible to perform? ☐ No ☐ Yes (describe)

____

____

Signature: ______________________ **Date:** ____________

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Financial Policies and General Information

If you HAVE HEALTHINSURANCE that covers our services we will attempt to collect fees directly from the responsible insurance company. It is important for you to provide correct, current and complete information to our office. If we are unable to verify insurance coverage on your initial visit, then we ask you to pay for that visit and we will adjust your bill accordingly after insurance is verified. After your benefits are verified, our office will ask you for an estimated co-payment at the time services are rendered. After the insurance has paid their portion your account will be updated and you will be billed for any remaining balance or provided a either choice of credit to your account or a return of the credit balance. Our efforts to collect directly from insurance companies are a courtesy on the part of our office staff. Please remember that ultimately you, as the patient are responsible for paying for the services you are to receive. Also, as policyholder, you may need to work with your insurance in order for claims to be processed fairly and completely.

If you DONOTHAVEHEALTHINSURANCEthatpaysforchiropracticservices you will be responsible for payment of services as they are rendered. If this is a hardship for you let us know. If possible we can grant credit to established patients. For your convenience we accept cash, personal checks, MasterCard, Visa and Discover. Our office offers discounted services when they are prepaid, please ask for details.

If you were INJUREDONTHEJOB your services may be paid in full by worker's compensation. Until this treatment has been authorized by the worker's compensation carrier you are responsible for using your personal health insurance or by paying for services as they are rendered.

If you were injured in an AUTOMOBILEACCIDENT your treatment may be paid either by your health insurance, by your automobile insurance, by a third party auto insurance or by your attorney. Policies vary so please consult with the office staff regarding insurance and the facts of the accident. Be aware that before treatment is rendered on a "lien basis" we must obtain full co-operation of your attorney by having him sign and return the lien. Once you have completed care, if settlement is not reached in **90 days**, we ask that you make regular payments of at least $100/month towards your balance. A payment schedule can be created upon request.

If you are using MEDICARE, be aware that Medicare pays 80% only for the "spinal manipulation" portion of your visit. It does not pay at all for x-rays, examinations, physical therapy or supplies. Your secondary or "Medicare supplementary" policy may pay some or all of these fees, depending on the policy. If secondary does not cover all services, a copayment will apply.

At the discretion of the office/accounts manager, missed and canceled appointments without customary 24 hours notice may be charged to my account.

In the event collection efforts became necessary to collect overdue account, the patient will be responsible for the additional costs.

Signature: ______________________________ **Date:** ______________________________

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AUTO ACCIDENT INSURANCE FORM

Name Patient: ______________________________

Your Car Insurance: ________________

Claim # ________________________

Adjustors Name ____________________

Adjustors Phone #: __________________

Fax#: __________________

MedPay ☐ Yes ☐ No

Benefit Limit: $_____________

3rd Party Insurance:________________

Claim # ______________________

Adjustors Name: __________________

Adjustors Phone # :_________________

Fax #: ________________

Attorney's Name _____________________

Attorney's

Address:___________________________________

____

Attorney Phone: __________________

Attorney Fax: __________________

SPECIFIC AND IRREVOCABLE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

☑ I hereby direct my attorney to acknowledge said Lien and to pay doctor for services rendered associated with my accident from any settlements or insurance benefits received.

Attorney's Signature:_________________________

Date: ____________________

☑ I irrevocably assign my insurance rights and benefits regarding above referenced insurance policy to ED SIMON CHIROPRACTIC and ask you to pay Dr. Simon med-pay benefits directly.

If my policy prohibits direct payment, please mail check made out to me to his office address listed below.

I also irrevocably instruct any third party insurance to pay Dr. Simon directly for services rendered or send entire settlement to his office C/O:

Ed Simon Chiropractic
6344 Laurel Canyon Blvd.
N. Hollywood, CA. 91606

Adjustor's Signature:____________________

Date: ____________________

PATIENT SIGNATURE :________________________ DATE: ______________

FAX: 818-761-8705

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