ED SIMON CHIROPRACTIC - 6344 Laurel Canyon Blvd - North Hollywood CA 91606 - 818-761-1355

Si prefiere hablar espanol, favor de informanos!

Welcome to our Chiropractic Office

Last Name: _____ First: _____ MI: _____

Birthdate : _____ SSN: _____ ☐ Married ☐ Single

Address: _____ City: _____ Zip: _____

Home phone: _____ Work: _____ ext. _____ Cell: _____

Occupation: _____Employer: _____Tel: _____

Do you prefer to be called on your ☐ home ☐ work ☐ cell phone

Email: _____ I check my email: ☐ daily ☐ weekly ☐ rarely

Check all the results you are seeking from care in our office:	
☐ pain relief	☐ prevent future similar or worsening episodes
☐ improved activity ability	☐ improved posture, flexibility and strength
☐ slow aging changes in my spine	☐ relieve stress and tension
☐ better overall health	☐ unsure

How did you find us: ☐ another patient: _____ ☐ insurance referral

☐ our website ☐ signage ☐ my physician ☐ another chiropractor ☐ other: _____

I understand this office will protect my privacy and release only the minimum health information necessary to process my health care claims. I also understand that in all health care interventions, including chiropractic care, there are inherent risks. While chiropractic is extremely safe and the risk of any significal adverse effects is small, risks do exist. I do not wish the doctor to explain all potential risks to me, I wish the doctor to use his professional judgement to act in what he feels are my best interests. I understand I will have the opportunity to ask the doctor of any risks particular to my situation after he has become more familiar with my health status and has presented a treatment plan.

Signature: _____ Date: _____

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New Condition Report

Name: _____ Has your address or insurance changed? ☐ Yes ☐ No

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:

_____

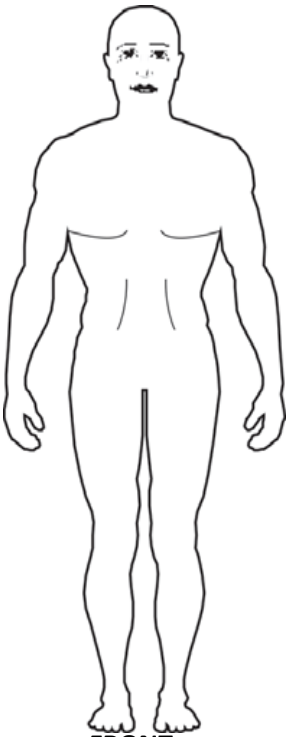
_____

_____

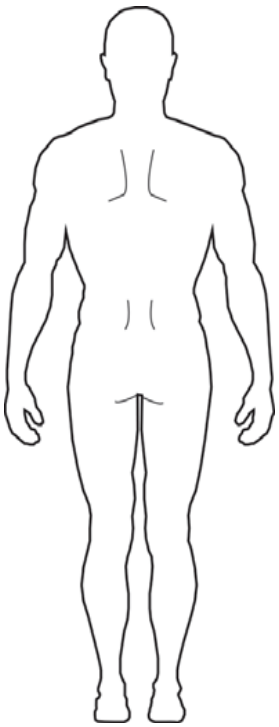
Pain Level ☐1(low) ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (high)

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

Please mark the diagram where your symptoms are present:



FRONT



BACK

Since your last update to our office have you had recent x-rays or other diagnostic tests: ☐ No ☐ Yes (describe)

_____

_____

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 HEALTH INSURANCE 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 DO NOT HAVE HEALTH INSURANCE that pays for chiropractic services 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 INJURED ON THE JOB 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 AUTOMOBILE ACCIDENT 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**: _____

WORK RELATED INJURY FORM

1. **INSURER NAME AND ADDRESS**:

2. **EMPLOYER NAME**:

3. Address:	City:	Zip:

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.):

5. **PATIENT NAME** (first name, middle initial, last name) :	☐ Male ☐Female	7. Date of Birth:
8. Address:	9. Telephone number ( )	
10. Occupation (Specific job title) :	11. Social Security Number: -	

12. Injured at Address: (No. and Street):	City:	County:

13. Date and hour of injury/onset of illness:	14. Date last worked:	15. Date and hour of 1st examination/treatment:
Date: / / Hour: ☐ AM ☐ PM		Date: / / Hour: ☐ AM ☐ PM

DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED. (Give specific object, machinery or chemical)

_____

_____

_____

_____

Patient Signature :_____ Date: _____

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