CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

DR. AMIR AHMADIYAR, D.C.

Your Back to Health Choice for All Ages

Confidential Health History

Last Name: _____ First Name: _____
Address: _____

City:_____ State:_____ ZIP: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Female: _____ Male

SS#: _____ Driver's License #: _____

Employer:_____ Type of Work: _____

Employment Status: _____Full Time _____ Part Time _____ Not Employed _____Retired_____

Marital Status: _____ Single _____ Married _____Widowed: _____Divorced _____ Separated: _____

Name of Spouse:_____Spouse SS#: _____

Spouse Employer:_____ Work Phone:_____

Emergency Contact Name:_____ Phone:_____

******Referred to this office by:_____**

PLEASE CIRCLE TYPE OF PATIENT:

SELF PAY INSURANCE AUTO ACCIDENT WORKER'S COMP

HEALTH INSURANCE INFORMATION

Primary Insurance: _____
Policy Holder: Self Spouse Other _____

ID#: _____
Group #: _____

Policy Holder's Name: _____

Date of Birth: _____

SS #: _____

Sex: _____ Male _____ Female

Secondary Insurance: _____
Policy Holder: Self Spouse Other_____

ID#:_____
Group #: _____

Policy Holder's Name:_____

Date of Birth: _____

SS #: _____

Sex: _____ Male _____ Female

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I understand and agree that health and accident insurance policies are an arrangement between insurance carriers and my self. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized should be paid directly to the Doctor's Office will be credited to me account on receipt. However, I clearly understand and agree that services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In the event my account is past due for 60 days from the date of service, and is turned over to an attorney for collection, I will also be liable for attorney's fees in the amount 1/3 of the principal balance, plus court costs.

PATIENT'S SIGNATURE:_____ DATE: _____

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Health History Form

1. Reason for seeking chiropractic care
   a. PRIMARY REASON _____
   b. SECONDARY REASON _____
2. How long have you had this problem? _____ Years _____ Months _____ Weeks
3. Is this your first episode of this pain? _____ YES _____ NO
4. Does anything make the complaint better? _____
5. Does anything aggravate the complaint? _____
6. Have you seen another doctor for this problem? _____ YES _____ NO
7. Please circle the quality of pain: Dull Aching Sharp Shooting Burning Throbbing Deep Nagging Other _____
8. Grade intensity/severity (0-No pain. 10 Worst pain) 0 1 2 3 4 5 6 7 8 9 10
9. Rate Frequency: Occasional (20% awake time) Intermittent (26-50% of awake time) Frequent (51-75% of awake time) Constant (76-100% of awake time)

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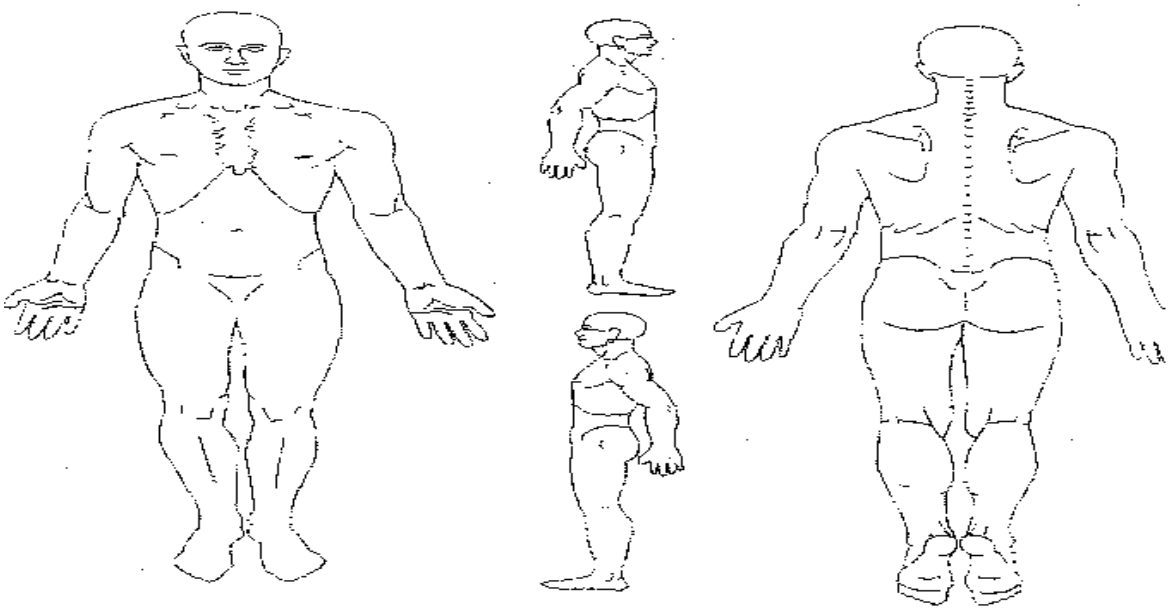
Please mark the location of your pain or discomfort on the images below.
Use symbols shown to represent type (s) of pain.

D – DULL
S – STABBING
B – BURNING
T – TINGLING (PINS & NEEDLES)
N – NUMB
C – CRAMPING



Name: _____ Date: _____

Signature: _____

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FOR DOCTOR USE ONLY

DIAGNOSIS: ___.__ ___.__ ___.__ TREATMENT PLAN: _____

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Notice of Practices Acknowledgement

I understand that, under the Health insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more description of the uses and disclosures of my health information. I understand that this organization has the right to charge its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

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Office Financial Policy

Please be informed of the following office financial policy:

_____ **I am a Cash/Self-Pay Patient**

- I am responsible for all charges incurred for my treatment during each of my visits.
- I will get a 10% discount fee if I pay for **10** consecutive visits in advance.
- Birthday Rule: I get a 50% discount if I bring my birthday postcard sent to me by the office on my birthday month.
- Complimentary Referral Rule: I get a choice of a free visit or a free ½ hour massage if I refer someone to the clinic and is seen by my doctor.

_____ **I am an Insurance/Medicare Patient**

- I am agreeing to pay my co-payment at the time of each service.
- I am responsible and will be billed for my insurance deductible and coinsurance as reflected on my EOB(Explanation of Benefits)
- I am responsible to obtain any referrals needed prior to my visit from my insurance company or primary care physician's office. If seen without a referral, I agree to be financially responsible for all charges incurred for all services rendered.
- Birthday Rule: My co-payment is waived at the time of service if I bring my birthday postcard sent to me by the office on my birthday month.
- Complimentary Referral Rule: I get a choice of a free ½ hour massage or my co-payment being waived for one visit if I refer someone to the clinic and is seen by my doctor.

Acknowledgement

- I understand that payment is expected when services are rendered unless other arrangements have been made.
- I understand that I will be financially responsible for the recommended care whether or no the anticipated results and benefits are achieved.
- I understand that I will be billed directly for the $20 Fee for massage cancellation done less than 24 hours notice.
- In the event that my participation with my healthcare network is terminated, I wish to continue my treatment as a private paying patient and I would be personally responsible for the charges associated with my care.
- If outside collection services or attorneys are employed by this facility for the individual who disregards our office policy, he/she agrees to pay those charges, including court costs and attorney fees of 33+1/3% in the event this file is turned over to an attorney for collection.

_____ _____
Patient Name Date

_____
Signature