INITIAL HEALTH STATUS

Janice S. Cruz, D.C.

Sex M/F

Patient Name:_____ Birthdate:_____ Age:_____

Address:_____ City:_____ State:____ Zip:_____

Phone ( )_____ Email:_____

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____

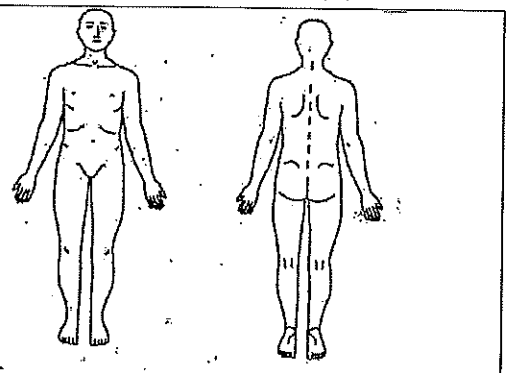
Date Problem Began:_____

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?

Occasional _____0 to 25% _____26 to 50% _____50 to 75% _____76 to 100% Constant

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

No Interference _____ Unable to carry on any activities

0 1 2 3 4 5 6 7 8 9 10

In general, would you say your overall health right now is:

Excellent_____Very Good_____Good_____Fair_____Poor_____

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:

_____Alcohol/Drug Dependence	_____Prostate Problems	Abnormal Weight Gain___ Loss____
_____Recent Fever	_____ Epilepsy/Seizures	Marked Morning Pain/Stiffness
_____Diabetes	_____Numbness in Groins/Buttocks	Pain Unrelieved by Position or Rest
_____High Blood Pressure	_____Cancer/Tumor (Explain)	Pain at Night
_____Stroke (Date)_____	_____Osteoporosis	Visual Disturbances
_____Corticosteroid (Cortisone, Prednisone,.etc.)	_____Dizziness/Fainting	Surgeries_____
_____Taking Birth Control Pills	_____Menstrual Problems	_____
_____Currently Pregnant #Weeks_____	_____Urinary Problems	Tobacco Use – Type_____
Medications_____	Other Health Problems_____	Frequency _____/day

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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my Chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ Date:_____

Janice S. Cruz, D.C.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND 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 the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks that have been associated with treatment, including, but not limited to fractures, disc injuries, strokes, TIAs, cardiac arrest, dislocations and sprains. It should be noted that the more severe risks are extremely remote. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to be able to anticipate and explain all risk and complications, and I wish to be able to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand an am informed that possible alternatives to chiropractic treatment include, but are not necessarily limited to rest, physical therapy, acupuncture, massage, over the counter medication, and osteopathic/medical care involving prescription drugs and/or surgery.

I have read or have had read to me, the above consent. I have also had 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) for which I seek treatment.

Signature of Patient

_____

Print Patient's Name

_____

Date Signed_____

Signature of Patient's Representative
If necessary (e.g. if Patient is a minor
Or physically/legally incapacitated

_____

Print Name of Patient's Representative

_____

Date Signed_____

Translated by (if applicable)

_____

Date Signed_____

-Below is for Office Use Only-

This form was verbally explained to the patient or this his/her representative by:
Initial here as evidence of having personally performed this duty:_____

Adopted from the CCA's Fact Sheet on Informed Consent

Janice S. Cruz, D.C.

AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ Date of Birth:._____

Previous Name:._____ SS#:._____

I authorize the following person, or facility to release my health information:

Name of Person or Facility:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Fax Number:_____

To be received by:

— **Janice Cruz, D.C.**

This will authorize you to permit the bearer to review, inspect, copy, and/or photocopy any of the following your possession or control:

1. X-rays- films and reports
2. Medical Reports, records, chart, and notes
3. Personal, attendance (work or school)

Photo static copies of this authorization will be considered as valid as valid as the original

This is not an authorization to discuss this case with any insurance company representative.

Patient Signature:._____ Date:_____

2204 El Camino Real, Suite 201 Oceanside, CA 92054
Tel: 760.757.0222 Fax: 760.757.0224

Janice S. Cruz, D.C.

THE FOLLOWING IS REQUIRED BY CALIFORNIA LAW

Doctors and Facilities

You may be referred to one or more of the doctors or-facilities listed below for services. Each of the doctors listed below has a financial interest with or provides services to one or more of the other doctors and/or facilities listed.

Patient's Freedom of Choice

You are free to choose any doctor or organization you wish for obtaining services that may be ordered or requested for you by any of the doctors listed below. This choice, however, may be affected by restrictions imposed by your insurance plan. Your doctor would be happy to discuss alternatives with you.

Potential sources of information concerning alternatives relevant can also be obtained from the Yellow Pages, the internet, or the county medical association.

The following addresses are provided for the filing of any complaints relevant to this notice or the services provided: Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95834; Board of Chiropractic Examiners, 2525 Natomas Park Drive, Suite 260, Sacramento, CA 95833-2931.

Doctors and Facilities:

Janice S. Cruz, D.C.
Chiropractic Director

_____ _____

Patient Signature Date

2204 El Camino Real, Suite 201 Oceanside, CA 92054
Tel: 760.757.0222 Fax: 760.757.0224

Janice S. Cruz, D.C.

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FOR HEALTH INSURANCE, PRIVATE INSURANCE, AND/OR GROUP ACCIDENT

I hereby instruct and direct the _____ Insurance Company to pay Janice S. Cruz, D.C. by check made out and mailed directly to:

Janice S. Cruz, D.C.

2204 El Camino Real, Suite.201
Oceanside, CA 92054

If my current policy prohibits direct payment to the doctor, then I will make payment directly to the doctor.

The professional or medical expense benefits allowed, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional service rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness, to the above mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

CALIFORNIA STATE LAW, INSURANCE CODE SECTION #10133, MAKES IT MANDATORY, RATHER THAN PERMISSIVE THAT INSURANCE COMPANIES HONOR ASSIGNMENT OF BENEFITS.

_____ _____

Signature of Policyholder Date

_____

Signature of Claimant, if other than Policyholder

Janice S. Cruz, D.C.

2204 El Camino Real, Suite 201 Oceanside, CA 92054
Tel: 760-757-0222 Fax: 760-757-0224

HIPAA-ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have reviewed/received a copy of **HIPAA NOTICE OF PRIVACY PRACTICES** documents.

Patient Name (Please Print)_____

Patient Signature:_____Date:._____

OR

Signature of Personal Representative: _____

Authority of Personal Representative to Sign for Patient (check one)

Parent_____Guardian_____.Power of Attorney_____Other:_____

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of **HIPAA NOTICE OF PRIVACY PRACTICES,** but it could not be obtained because:

_ An emergency prevented us from obtaining acknowledgement.
_ A communication barrier prevented us from obtaining acknowledgement.
_ The individual was unwilling to sign.
Other:_____

Staff Member Signature:_____Date:._____

Janice S. Cruz, D.C.

Financial Policy

The following is an explanation of our policies and procedures. We will be happy to answer any questions you have regarding our policy, your account, and your insurance coverage.

Payments

Your health care needs are our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in an attempt to assist you in meeting your financial obligations without increasing stress in your life.

If you do not have insurance ALL payments are expected at the time of service.
If you have insurance ALL COPAYS AND/OR CO-INSURANCE are due at the time of service.
If you have a deductible it must be satisfied before any coinsurance/copay take into effect.
There will be a $25.00 charge on all returned checks There will be a $30.00 charge if any additional forms need to be completed by Dr. Cruz , or a massage appointment is missed.

*Initial*_____

Insurance Coverage/ Verification

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area. If your carrier has not paid a claim within (60) days of submission, you agree to take active part in the recovery of your claim. If your insurance carrier has not paid within (90) days of submission, you accept responsibility for payment in full of any outstanding balance. As a courtesy to our patients, our office will attempt to pre-verify your primary insurance coverage. It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance. Please be advised that the information provided by your insurance is not a guarantee of payment.

*Initial*_____

Personal/ Auto Injury

In the nature of a personal/auto injury, payments of medical bills can go months or sometimes years until the case settles and satisfies our charges. We must ask you to provide any/or all of the following benefits that apply:

1. Automobile Insurance- Medical Pay
2. Health Insurance
3. Lien- signed by you and your attorney

*Initial*_____

Appointment/Treatment

We require that you give us a 24 hour cancellation notice if you need to miss your appointment. For personal/auto injury cases appointments missed are to be made up within the same week to assist you in reaching your maximum therapeutic benefit.

*Initial*_____

Patient Health Information Consent

By signing you agree to allow this office to use your Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As a patient you have the right to obtain a copy of your health records at any time. For your security, all staff has been trained in the area of patient record privacy. If you refuse to sign this consent for the purpose of treatment, payment, and health care operations our office has the right to refuse to give care.

_____ _____

Patient/Parent/Guardian Signature **Date**

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE