Janice S. Cruz, D.C.

GENERAL INFORMATION - Please take a moment to fill the information below.

Name:______________________________ Date:__________

Home Phone:__________________ Cell Phone:__________________

Address:__________________ City:__________ State:______ Zip:________

Email:______________________________

Date of Birth:______________ Age:______ Handed (circle one): Right/Left

Sex: (circle): M F Date of Injury:__________ .Social Security:______________

Please initial if we may leave messages on your answering machine or voicemail:__________

Employer:______________ Occupation:______________

Primary Care Dr:______________ Phone #:______________

Chiropractor:______________ Phone#:______________

***Do you have health insurance? (Circle) Yes No**

Insurance:______________ ID:______________

Were you involved in personal injury? (Please answer question below)

***Do you have auto insurance? (Circle) Yes No**

Insurance:______________ ID:______________

Attorney (if applicable) ______________________________

Address:______________ City.__________ State.____ Zip:________

Attorney's Number:______________ Fax:______________

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Janice S. Cruz, D.C. to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Dr. Cruz to disclose my health information with the following people: PLEASE PRINT

Name:______________ Relationship.______________ Phone#:.______________

Name:______________ Relationship:______________ Phone #:______________

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE AND THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT.

Signature of Patient or Patient Representative:______________ Date:________

Janice S. Cruz, D.C.

MOTOR VEHICLE ACCIDENT QUESTIONAIRE

Thank you in advance for taking the time to develop this form. This will help us to better cover all of your pain complaints and provide you with the best treatment.

NAME: ____________________ DATE: ____________________

Date of Injury: ____________________ DOB: ____________________

Referring Doctor: ____________________ Last 4 of SS# ____________________

Accident Details:

1. Vehicle Information:

   Year- ____________________

   Make & Model ____________________ *(ex. Toyota Camry, etc.)*

2. Where were you seated (circle): Driver/Front passenger/Rear left/Rear right
3. Were you wearing your seatbelt (circle): Yes / No
4. Were the airbags deployed (circle): Yes / No
5. What was your body position at impact (circle):

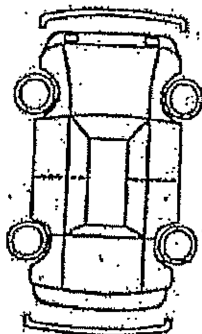
-Looking straight / looking right / looking left, Body twisted: Left / Right

-Both hands on wheel / Right hand on wheel / Left hand on wheel / Hands in lap

-Right foot on brake/ Right foot on gas/ Left foot on floorboard/ Both feet on floorboard

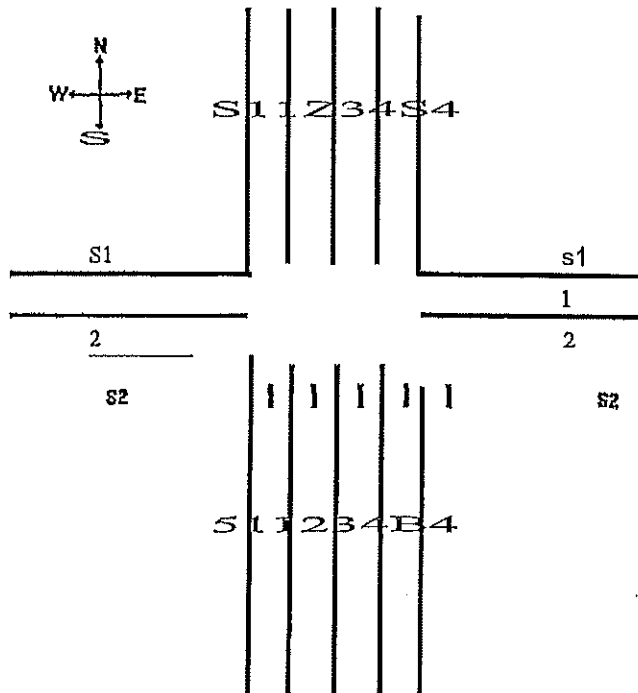
6. Where was the damage to your vehicle:

Front: *Driver Side (front)* *Passenger Side (front)*



7. What kind of vehicle struck you:______________________________

8. If possible, please **roughly draw** out what happened in this accident:



Please briefly describe accident:

____

____

____

9. How fast was your vehicle traveling (approximately) ________ Mph

10. How fast was the other vehicle traveling (approximately):________ Mph

11. Were you prepared for the impact and /or did you brace yourself (circle): Yes / No

12. Did you lose consciousness (circle): Yes / No

13. Were you in a daze, felt dizzy, disoriented, confused, etc. (circle): Yes / No

A. For how long?________________(for ex. 5 minutes, 1 hour)

14. Where did you go for medical treatment :______________________________

15. Were you taken by ambulance: Yes / No

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms listed below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each one. **Please circle the number closest to your answer.**

0 =Not experienced at all, 1 =No more of a problem, 2 =A minor problem, 3 =A moderate problem, 4=A severe problem

Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	I	2	3	4
Nausea and/or Vomiting	0	I	2	3	4
Noise Sensitivity, easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Talking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

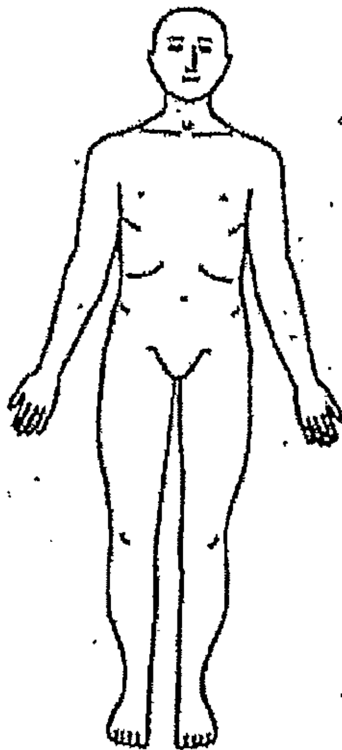
Are you experiencing any other difficulties? (please list)

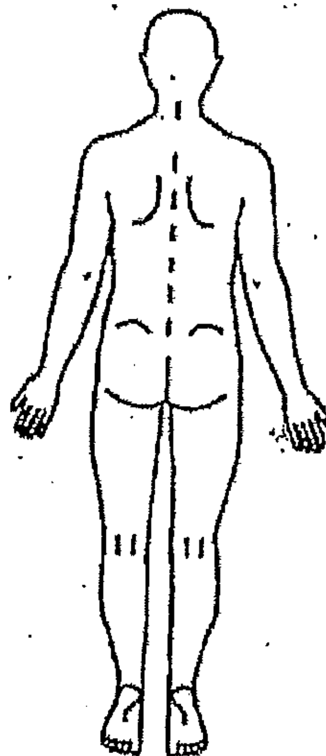
1. ______________	0	1	2	3	4
2. ______________	0	1	2	3	4

B2. Pain drawing

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness	......	INC Sensitivity	0000
Constant Throbbing Ache	xxx xxx	Sharp Twinge	////





What is your pain level at rest:

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

What is your pain level with activity:

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN IMAGINABLE

How would you describe your pain (circle):

Deep Pressure	Tightness	Spasms
Tingling	Numbness	Pinprick
Burning	Sharp Shooting	Stabbing

Is your pain (circle): Constant Intermittent

Since the accident, is your pain (circle): Unchanged Worse Better

What makes your pain worse (circle):

Activity- Bending / Lifting / Walking /Sitting /________________

What makes your pain better (circle):

Medications / Ice / Heat / Chiropractic / Rest /______________________

Do you have any weakness (circle): Yes / No.

If Yes, where (circle): Left: Arm Leg
Right: Arm Leg

Any loss of control of your bowel or bladder since the accident (circle): Yes / No

What treatments have you had following since this accident (circle):

Physical therapy Heatingpad Icepack Injections Chiropractic

Epidural injections Surgery Massage Medications Acupuncture

Are you having difficulty sleeping since the accident (circle): Yes / No

How has this accident affected your life? (Ex. difficulty driving)____________________

____

____

Have you missed work (circle): Yes/No, If yes how much:__________________

Have you returned to work (circle): Yes / No

Have you ever had another motor vehicle, work or any other type of injury?

1. ____

2. ____

3. ____

MEDICAL CONDITIONS *(Please list: such as diabetes, depression, gastric reflux):*

____

____

MEDICATIONS *(Tylenol, ibuprofen, Motrin, Alleve):*______________________

____

SURGERIES:______________________________________

____

ALLERGIES:______________________________________

FAMILY HISTORY:

FATHER-Age___, Alive (circle): Yes/No
-major medical conditions:________________________________

MOTHER-Age___, Alive (circle): Yes/No
- major medical conditions:________________________________

SOCIALHISTORY:

Tobacco use (circle): Yes /No
Alcohol use (circle): Yes / Social / No
Drug use (circle): Yes/ No

REVIEW OF SYSTEMS: *(mark only if positive)*

General-
_Weight loss or gain
_Fatigue
_Fever or chills

Skin-
_Rashes
_Dryness
_Lumps

Head-
_Headache
_Head injury

Ears-
_Decreased hearing
_Ringing in ears
_Earache

Eyes-
_Glasses or contacts
_Blurry or double vision
_Flashing lights

Nose-
_Discharge
_Itching
_Nosebleeds

Neck-
_Lumps
_Swollen glands

Cardiovascular-
_Chest pain
_Tightness
_Palpitations

Respiratory-
_Coughing up blood
_Shortness of breath
_Painful breathing

Gastrointestinal-
_Constipation/Diarrhea
_Change in appetite
_Nausea

Urinary-
_Increased Frequency
_Incontinence
_Blood in urine

Musculoskeletal-
_Muscle or joint pain o
_Redness of joints
_Swelling of joints

Neurologic-
_Dizziness
_Fainting
_Seizures

Psychiatric-
_Nervousness
_Depression
_Memory loss

Thank you!

*Office use:*____________________

THE WHIPLASH DISABILITY INDEX

Directions: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section just ONE box that most applies to you. We realize you may consider two or more of these statements applicable to you, but mark the one box that most closely describes how you feel.

Section 1. Pain Intensity
- ☐ **A.** I have no pain at the moment
- ☐ **B.** The pain is very mild at the moment
- ☐ **C.** The pain is moderate at the moment
- ☐ **D.** The pain is fairly severe at the moment
- ☐ **E.** The pain is very severe at the moment
- ☐ **F.** The pain is the worst imaginable at the moment

Section 2. Personal Care
- ☐ **A.** I can look after myself without causing extra pain
- ☐ **B.** I can look after myself normally but it causes extra pain
- ☐ **C.** It is painful to look after myself and I am slow and careful
- ☐ **D.** I need some help but manage most of my personal care.
- ☐ **E.** I need help every day in most aspects of self care
- ☐ **F.** I do not get dressed, I wash with difficulty and stay in bed

Section 3. Lifting
- ☐ **A.** I can lift heavy weights without extra pain
- ☐ **B.** I can lift heavy weights but it gives me extra pain
- ☐ **C.** Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table
- ☐ **D.** Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ **E.** I can lift very light weights
- ☐ **F.** I cannot lift or carry anything at all

Section 4. Reading
- ☐ **A.** I can read as much as I want to, with no pain in my neck
- ☐ **B.** I can read as much as I want to, with slight pain in my neck
- ☐ **C.** I can read as much as I want to, with moderate pain in my neck
- ☐ **D.** I can't read as much as I want because of moderate pain in my neck
- ☐ **E.** I can hardly read at all because of severe pain in my neck
- ☐ **F.** I cannot read at all

Section 5. Headaches
- ☐ **A.** I have no headaches at all
- ☐ **B.** I have slight headaches which come infrequently
- ☐ **C.** I have moderate headaches which come infrequently
- ☐ **D.** I have moderate headaches which come frequently
- ☐ **E.** I have severe headaches which come infrequently
- ☐ **F.** I have headaches almost all the time

Section 6. Concentration
- ☐ **A.** I can concentrate fully when I want to with no difficulty
- ☐ **B.** I can concentrate fully when I want to with slight difficulty
- ☐ **C.** I have a fair degree of difficulty in concentrating when I want to
- ☐ **D.** I have a lot of difficulty in concentrating when I want to
- ☐ **E.** I have a great deal of difficulty in concentrating when I want to
- ☐ **F.** I cannot concentrate at all

Section 7. Work
- ☐ **A.** I can do as much work as I want to
- ☐ **B.** I can only do my usual work, but no more
- ☐ **C.** I can do most of my usual work, but no more
- ☐ **D.** I cannot do my usual work
- ☐ **E.** I can hardly do any work at all
- ☐ **F.** I can't do any work at all

Section 8. Driving
- ☐ **A.** I can drive my car without any neck pain
- ☐ **B.** I can drive my car as long as I want with slight pain in my neck.
- ☐ **C.** I can drive my car as long as I want with moderate pain in my neck.
- ☐ **D.** I can't drive my car as long as I want because of moderate pain in my neck
- ☐ **E.** I can hardly drive at all because of severe pain in my neck
- ☐ **F.** I can't drive my car at all

Section 9. Sleeping
- ☐ **A.** I have no trouble sleeping
- ☐ **B.** My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐ **C.** My sleep is mildly disturbed (1-2 hours sleepless)
- ☐ **D.** My sleep is moderately disturbed (2-3 hours sleepless)
- ☐ **E.** My sleep is greatly disturbed (3-5 hours sleepless)
- ☐ **F.** My sleep is completely disturbed (5-7 hours sleepless)

Section 10. Recreation
- ☐ **A.** I am able to engage in all my recreation activities with no neck pain at all
- ☐ **B.** I am able to engage in all my recreation activities with some pain in my neck
- ☐ **C.** I am able to engage in most, but not all, of my recreation activities because of pain in my neck
- ☐ **D.** I am able to engage in a few of my usual recreation activities because of pain in my neck
- ☐ **E.** I can hardly do any recreation activities because of pain in my neck
- ☐ **F.** I can't do any recreation activities at all

PATIENT NAME:____________________

DATE:________________ Score:______/______

For more information regarding this questionnaire, please contact THE DOCTORS INJURY NETWORK at 800-371-3731

THE OSWESTRY DISABILITY INDEX FOR BACK PAIN

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday-life activities. Please answer every section, and mark in each section the one box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that most clearly describes your present-day situation.

SECTION 1—PAIN INTENSITY
- ☐ My pain is mild to moderate; I do not need painkillers.
- ☐ The pain is bad, but I manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain.

SECTION 2—PERSONAL CARE
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3—LIFTING
- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, i.e. on the table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently proportioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4—WALKING
- ☐ I can walk as far as I wish.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can walk only if I use a cane or crutches.
- ☐ I am in bed or in a chair for most of every day.

SECTION 5—SITTING
- ☐ I can sit in any chair for as long as I like.
- ☐ I can sit in my favorite chair only, but for as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6—STANDING
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing more than 1/2 hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7—SLEEPING
- ☐ Pain does not prevent me from sleeping well.
- ☐ I sleep well, but only when taking medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

SECTION 8—SOCIAL LIFE
- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ☐ Pain affects my social life, and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 9—SEXUAL ACTIVITY
- ☐ My sexual activity is normal and causes no extra pain.
- ☐ My sexual activity is normal, but causes some extra pain.
- ☐ My sexual activity is nearly normal, but is very painful.
- ☐ My sexual activity is severely restricted by pain.
- ☐ My sexual activity is nearly absent because of pain.
- ☐ Pain prevents any sexual activity at all.

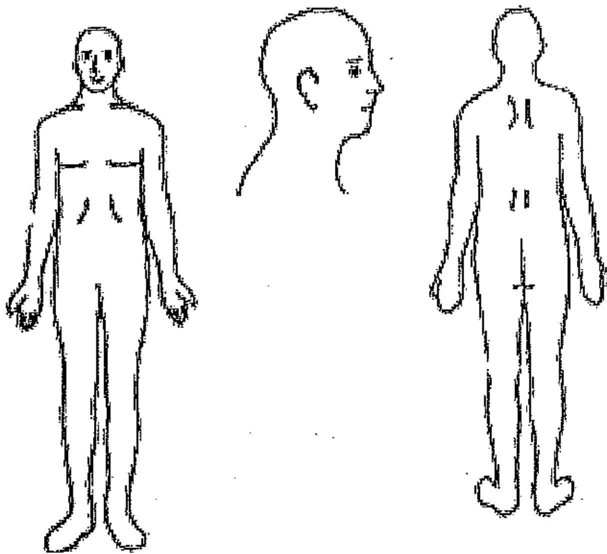
SECTION 10—TRAVELING
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to necessary journeys under 1/2 hour.
- ☐ Pain prevents traveling except to the doctor/hospital.

PATIENT NAME________________________ DATE______________ SCORE______/______

DESCRIPTION OF SYMPTOMS/DESCRIPCION DE SINTOMAS

Please mark with the following symbols your areas with pain/Por favor de marcar con los siguientes simbolos sus áreas con dolor:

Numb/Entumido	XXXXX
Sore/Adolorido	\\\\\
Burning/Ardiente	OOOOO
Stabbing/Como una puñalada	+++++
Tingling/Hormigúeante	::::
Sharp/Agudo	*****
Shooting/Punzadas	<<<<<
Aching/Doloroso	ZZZZZ



SIGNATURE ______________________________ DATE ______________

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 other licensed, doctors of chiropractic who now or in the future treat me while employed by, working and/or associated with or serving as backup 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 or 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 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 and 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

____

Signature of patient's representative, if necessary, (e.g., If patient Is a minor or physically/legally Incapacitated)

____

Print Patient's Name

____

Print Name of Patient's Representative

____

Date Signed____________________

Date Signed____________________________

Translated by (If applicable)

____

Date Signed____________________________

– Below is for Office Use Only–

This form was verbally explained to the patient or to his/her representative by____________________

on________ Initial here as evidence of having personally performed this duty:__________

Adapted from the CCA's Fact Sheet #800 on Informed Consent

Janice S. Cruz,D.C.

Authorization and Medical Lien

I, ____________________(hereinafter referred to as "PATIENT") desire to undergo an examination, consultation and any potential treatment regarding any possible injures PATIENT sustained as a result of an accident/ accident causing injury (hereinafter referred to as the "Claim") which occurred on or about ____________. Patient, therefore, agrees as follows:

1. Provider's Lien. Patient hereby grants Dr.Janice.Cruz,D.C.(hereinafter, "PROVIDER") a lien in the form of all rights to payment from any and all proceeds derived from PATIENT's claim for personal injury arising from the Claim, in the amount of PROVIDER'S standard billing costs of services provided to PATIENT/PATIENT's children, spouse or other medical charge(s) by PROVIDER. Patient understands this agreement constitutes a lien in favor of PROVIDER, against any proceeds derived from the Claim, PATIENT authorizes and instructs his/her attorney of record,____Esq. and any subsequent ATTORNEY'S (hereinafter, "ATTORNEY"), to pay PROVIDER all amounts owing under this lien from the proceeds of any collection of settlement of, or award or judgment on, the Claim, upon receipt of any such proceeds and before any payments are made to PATIENT. PATIENT acknowledges that this Lien is made solely for PROVIDER's additional protection and as a precondition to PROVIDER'S willingness to provide services to PATIENT. PATIENT acknowledges that he/she is directly and fully responsible to PROVIDER for payment of all medical bills submitted by PROVIDER for services rendered, that such obligation to pay is not contingent or conditioned upon the occurrence of any collection, settlement, judgment or award which PATIENT may eventually receive on the Claim, and that the collectability of the receivable(s) secured hereby is also not so contingent or conditioned on the Claim.

2. Subsequent Attorneys. Should an attorney other than ATTORNEY be substituted/ associated in this matter, PATIENT hereby instructs that substituted/associated attorney to honor this lien as though it had been executed by that attorney. "ATTORNEY" as herein used, shall refer to the attorney named herein, and/or any attorney who is subsequently substituted or associated in the handling of the PATIENT's Claim. The ATTORNEY named herein or as may be substituted/associated is directed to honor this lien whether or not it contains the signature of the ATTORNEY herein below.

3. Assignments. PATIENT acknowledges that all of PROVIDER's rights under this Lien, and the underlying obligation this Lien secures, are freely assignable/alienable, and PROVIDER may assign these rights in full to a third party (hereinafter referred to as "ASSIGNEE"). PATIENT expressly authorizes PROVIDER to furnish ASSIGNEE with all bills, medical records, and other documents which are the subject of the Lien; PATIENT expressly waives his/ her right of privacy with regard to all medical information provided to ASSIGNEE by PROVIDER.

4. Authorization. PATIENT authorizes PROVIDER to furnish ATTORNEY and witl1 all medical records pertaining to PATIENT's treatment, including reports on examination, diagnoses, treatment, prognosis, and other medical bills on record.

5. Arbitration. Any controversy, claim, or dispute between the parties, directly or indirectly, concerning this Agreement or the breach hereof, or the subject matter hereof, including questions concerning the scope and applicability of the arbitration clause, shall be finally settled by binding arbitration as provided herein. The parties shall use an arbitrator, a retired Judge in North County of San Diego, California, and

Janice S. Cruz,D.C.

Authorization and Medical Lien

Judgment upon the award rendered may be entered in any court having jurisdiction thereof. The arbitration shall commence no later than sixty (60) calendar days after demand is made and shall continue from day to day until completed. The prevailing party in said arbitration shall be entitled to an award of his/her/ or its reasonable attorney's fees, costs, and other arbitration expenses relating to that dispute, including the conduct of the arbitration proceeding.

6. **No Interpretation against the Drafter.** This agreement shall not be construed against the party preparing it, but shall be construed as if all parties jointly prepared this Agreement, and any uncertainty or ambiguity shall not be interpreted against any party.

7. **Modification.** No supplement, amendment, or modification of the Lien shall be binding unless it is in writing and signed by PATIENT and PROVIDER (or if an assignment has been made, by PATIENT and ASIGNEE).

8. **Integrated/Entire Agreement.** This Agreement and PROVIDER's statement of fees and costs which will be generated subsequent to PROVIDER's provision of services to PATIENT constitute the final, complete, and exclusive statement of the terms of the agreement between the parties and supersedes all prior and contemporaneous understandings or agreements of parties. No party has been induced to enter into this Agreement by, nor is any party relying on, any representation or warranty outside those expressly set forth in this Agreement.

9. **Severability.** If a court or an arbitrator of competent jurisdiction holds any provisions of this Agreement to be illegal, unenforceable, or invalid in whole or in party for any reason, the validity and enforceability of the remaining provisions, or portions of them, will not be affected, unless an essential purpose of this Agreement would be defeated by the loss of the illegal, unenforceable, or invalid provision.

10. **Execution.** PATIENT is represented by the counsel of his/her own choosing. PATIENT has read this Lien and PATIENT's counsel has fully explained contents to the PATIENT. PATIENT consents to the terms of this Lien and agrees to be bound by it. PATIENT understands that in the event ATTORNEY does not sign this agreement, PATIENT and ATTORNEY will still be bound by the provisions set forth herein.

11. **Construction/Choice of Law.** The law of the State of California shall apply in determining the meaning, effect and enforceability of this Agreement and all of its provisions.

READ, UNDERSTOOD & AGREED

PATIENT NAME:____

PATIENT SIGNATURE:________________________ DATE:______________

ATTORNEY'S NAME:____

ATTORNEY'S SIGNATURE:____________________ DATE:______________

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 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

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

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**

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:.______________

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

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