Patient Information

Name:						Gender	M ____ F ____
Home Phone:	( ) -	Cell:	( ) -	Work:	( ) -		
Date of Birth:		Add:					
Soc. Sec. #	- -	City:		State:		Zip:	

1. Chief Complaint?

   Pain on

   a. Neck

   b. Shoulder

   c. Knee

   d. Ankle

   e. Elbow

   f. Other: _____

- Lower Back Pain
- Digestion Problem
- Edema
- Chronic Fatigue
- Dizziness
- Vomiting
- Sprain
- Headache
- Other: _____

Signature _____ Date: _____

Our office offers appointment reminders via text messages OR E-Mail, which would you prefer?
If you prefer text message, what is your cell provider (i.e. Verizon, Sprint)?
When would you prefer to receive your reminder? **1 hour** **2 hours** **4 hours** **1 day** **2 days**

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Birthday _____ Sex ☐ M ☐ F

Address _____ City _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Work _____ Cell _____ E-Mail _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine Other _____

Other doctors or therapist who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name _____ City _____

Medications, dosage and frequency: _____

_____

_____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N Describe _____

_____

Signature _____ Date _____

Parent/Guardian _____ Date _____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. The policy reduces your out-of-pocket expense and allows you to place your family under care.

1. If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. If You Have Insurance: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Unruh Chiropractic, Inc., Thrive Medical, Inc. or FrankD'Ambrosio, PT. I assign and authorize payments to Unruh Chiropractic, Inc., Thrive Medical, Inc. or FrankD'Ambrosio, PT I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

Insurance figures are **ESTIMATES ONLY!** It is not easy for an office to become familiar with the exact details of every Insurance Plan it encounters. **It is the responsibility of the patient, NOT the doctors' office to know what is covered and what is excluded from their particular Insurance Plan.**

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. **We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.**

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 arbitrary schedule of fees bearing no relationship to the current standard of care in this area. **If your carrier has not been paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim.**

If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

As the patient you agree that you are seeking care under your accord, if your insurance denies your care for any reason, including but not limited to medical necessity, timely filing, etc.

Cancellation Fee: We do not over-book our physician's schedules. We want every patient to be able to receive the care that they need. Therefore, when you cancel or do not show up to your appointment you are preventing someone else from getting the care they need.

If you do not cancel your appointment within 24 hours or if you do not show up to your appointment you will be charge a $35 **cancellation fee** due on your next date of service.

Signature of Patient or Guardian _____ Date _____

Printed Name of Patient or Guardian _____ Relationship to Patient _____

HARDSHIP ADVISORY

I have assigned payments from my insurance company to go directly to _____, I have been advised that it is the policy of this office to collect directly from me all amounts not paid by the insurance company, including deductibles and co-payments.

This letter affirms that it would be a hardship for me to pay these amounts, and if required I would not be able to receive necessary treatment at this time.

I do agree to pay _____ deductible and _____ co-payment.

_____ _____

Patient Signature Patient Name

_____ _____

Witness Date

Patient Name: _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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 state and federal law provides 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 authority for any dispute to be decided on a class action basis. Anrbitration 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 health care 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 health care provider and/or other licensed health care 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 health care provider. Including those working at the health care provider's clinic or office or any other clinic or office whether signatores to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care 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 pro rata 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 **bifurite** the issues of liability and damage upon written request to the neutral arbitrator.

The parties cosent 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 the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall he arbitrated in one proceeding. A claim shall be waived end 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 health care 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 Signature (Or patient representative)	Date	(Indicate relationship if signing for patient)
_____	_____	
Office Signature	Date	

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

Informed Consent and Disclosure Form

I hereby request and consent to the performance of acupuncture treatment and other procedure within the acupuncture scope of practice on me (or, on the patient name below, for whom I am legally responsible) by the acupuncturist below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office below or any other office or clinic, whether signatories to this form of not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na(or Oriental Massage), oriental herbal medicine, nutritional counseling. I understand that the herbs maybe an unpleasant small or taste. I will immediately notify a member of the clinical staff of any unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally safe method or treatment, but that it may have some effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Burn and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risk may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Oriental medicine, although some may be toxin in large possible side effects of taking herbs are nausea, gas, stomachaches, vomiting, headache, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I understand that the provider will explain all known risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment.

By voluntary signing below, I show that I have read or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncturist and other procedure, and have had an opportunity to ask questions.

I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ Date: _____

Patient Signature (or Patient representative)

A. Young Kim L.A.c.

Acupuncturist's Name