PATIENT HISTORY

Please Print Date: _____

Name: _____

Address: _____ City: _____ ST: ____Zip Code: _____

#: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Birth Date: _____ Age: _____ For Medical and Insurance Purposes: o Male o Female

Spouse/Emergency Contact Name & Phone # _____ (____)_____

# of Children: _____ o Married o Single o Divorced o Widowed

Employed by: _____ Work Address: _____ Occupation: _____

City, State, Zip: _____

Email: _____

How were you referred to our office? _____

Have you ever had Chiropractic Care before? _____ If yes, when? _____

List your chief complaints in order of severity:

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

List other Doctors consulted for this condition:

1. _____ Address: _____

2. _____Address: _____

Is this injury or illness work-related? _____ Have you reported it to your employer? _____

Is this injury or illness related to automobile accident? _____
(If yes, please fill in the following information for YOUR Auto Insurance Company)

Auto Insurance Co: _____ Policy #: _____ Claim #: _____

Phone: ( ) _____ Address: _____ Agent: _____

Do you have any type of Health Insurance? _____ Company Name: _____

Phone: ( ) _____ Address: _____ Policy/ID #: _____

Are you covered under any other group or individual health policy through yourself or spouse?

If yes, Company Name: _____

Subscriber ID # _____ Spouse's Name & DOB_____ ___/___/_____

Notice Not all patients require x-rays to determine or verify diagnosis, type and length of care. If your examination warrants an x-ray analysis, the following office policy prevails:

1. All first visits charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be released.

Patient's Signature: _____

Pazera Chiropractic, Inc.
Brian Pazera, D.C.
1124 N. Hollywood Way, Ste. A
Burbank, Calif. 91505
Phone (818) 793-3783

Professional Fee Schedule

INITIAL CONSULTATION	NO CHARGE
CHIROPRACTIC EXAMINATIONS	$ 65 TO $ 250
CHIROPRACTIC OFFICE VISITS	$ 65 TO $ 180
CHIROPRACTIC X-RAYS STUDIES (AVERAGES)	$ 80 TO $ 250
DOCTOR – PATIENT CONFERENCE	$ 40

(ALL FEES ARE STANDARD AND PRIMARILY BASED ON OUR PROFESSIONAL ASSOCIATION GUIDELINES AND ON THE FEE SCHEDULE SET BY THE INDUSTRIAL COMMISSION OF CALIFORNIA)

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for you convenience and information. We offer several methods of payment for your chiropractic care at our office and you may choose the plan which best fit your needs. Please read carefully and choose the plan that you prefer. This information will enable us to better serve you and help avoid misunderstanding in the future. If special arrangements are necessary, please consult with the doctor. Our main concern is your health and well-being, and we will do our best to help you.

PLAN #1 – INSURANCE: If you have insurance that covers chiropractic care, we will bill your insurance directly. We bill full fees. Please bring us an insurance claim form on or before your second visit with your portion completed. Until we have the complete necessary insurance information to verify chiropractic coverage, you are considered to be a cash patient. If an insurance payment should be made directly to you, you will be responsible for bringing it to us. Remember, Insurance companies balk at "Maintenance" and "Long Term Rehabilitation". Usually you will not get much help after your initial corrective care. Most ordinary Health policies are designed and intended to only take care of acute problems, but in this office, we will make all care affordable if additional treatment is needed, please ask our Insurance Department for details.

PLAN #2 – CASH: Fees are to be paid at the time services are rendered unless special arrangements have been made in advance.

PLAN #3 – WEEKLY/ MONTHLY CASH AGREEMENT: This plan is for those non-transient, but active patients who qualify; we will extend knowledgeable credit through this plan. However, should you become inactive by discontinuing your care; your entire unpaid balance will be due immediately. This plan applies to all cases, except work injuries or auto injury claims.

PLAN #4 – AUTO INJURY: You need to supply us with the accident report, your car insurance, health insurance, liable party insurance, and attorney if applicable. If the necessary insurance information is not promptly gathered and verified, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are expected to bring the check to us within 30 days of receipt.

I qualify and understand PLAN # _____ Requirements.

Signature: _____ Date: _____

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Chiropractic Informed Consent to Treat

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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as a 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, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complication 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 further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscles relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 future condition(s) for which I seek treatment.

Chiropractor Name: Brian Pazera, D.C. **Pazera Chiropractic, Inc.**

Signature: _____ Date: _____
(Or Patient Guardian/Parent/Representative)

(Provide name and relation if signing for patient)

Pregnancy Release:
This is to certify that to the best of knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual cycle: _____

Signature: _____ Date: _____

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Personal Medical Information (PMI) Consent Form

The Health Insurance Portability Accountability Act (HIPPA) of 1996 requires that we receive your permission before we use the personal information in your medical records for ANY reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPPA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent at any time, although any services performed prior to revocation of this consent are covered by this consent.

Print Patient Name: _____

Signature: _____ Date: _____
(Patient or Parent/ Legal Guardian)

Restrictions: Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on your next office visit. The revised policies and practices will be applied to all protected health information we maintain.