Bend Chiropractic, Inc.

PATIENT APPLICATION FORM

WELCOME and *THANK YOU* for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do not accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your *TOP PRIORITY*. Thank you again for applying as a patient in our clinic.

____
PATIENT NAME

____
DATE COMPLETED

Patient Information

Name:____ Age:________ Gender: M F

Home Address:____ Home Phone: ( )______________

City, State, Zip: ____ Work Phone: ( )______________

Email Address: ____ Cell Phone: ( )______________

Birth Date: ____ / ____ / ______ Social Security #: _____ - ____ - ______ Marital Status: S M D W

How were you referred to this office? ____

Purpose For This Visit

Reason for this visit: ____

Is this related to an accident or specific injury (other than auto or work-related)? ☐ Yes ☐ No

If yes, when: ____ / ____ / ______

*If your symptoms are the result of an auto accident or work-related, please ask the front desk person for the corresponding application.

When did these symptoms begin? ____ / ____ / ______

Explain: ____

What activities aggravate your symptoms? ____

Is there anything that relieves your symptoms? ☐ Yes ☐ No If yes, explain: ________________________________

Have you experienced these symptoms before (if not accident/injury related)? ☐ Yes ☐ No

If yes, explain: ____

Have you been treated for this? ☐ Yes ☐ No When were you last treated? _____ / _____ / _____

Who did you see? ____

What treatment was performed? ____

How did you respond? ____

Experience in Chiropractic Care

Have you ever been to a chiropractor before? ☐ Yes ☐ No If yes, where? _______________________________

Did your previous chiropractor take "before and after" x-rays? ☐ Yes ☐ No

Were you recommended a specific treatment? ☐ Yes ☐ No

Were you recommended a home health care program? ☐ Yes ☐ No

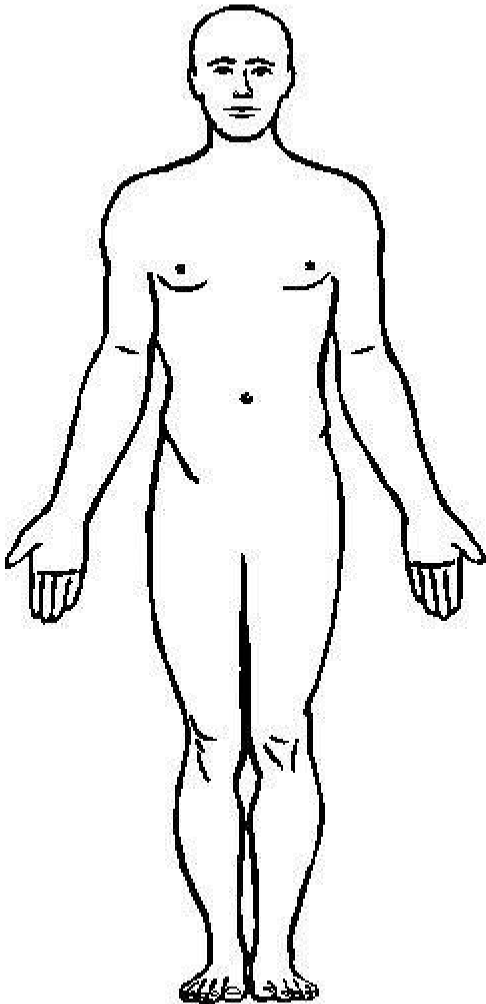
Do you know of any bad postural habits? ☐ Yes ☐ No

Is there a history of spinal problems in your family? ☐ Yes ☐ No

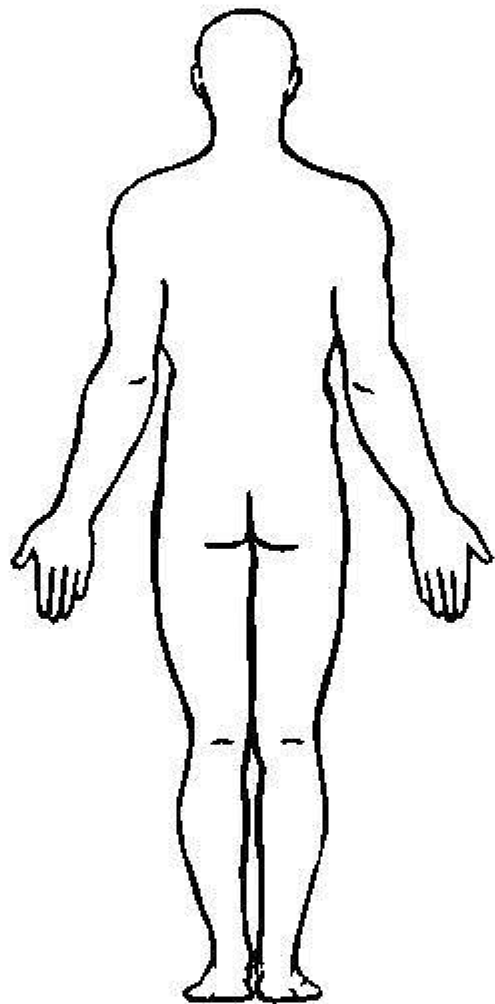
General Symptoms Chart

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE
B = BURNING
P = PINS & NEEDLES
S = STABBING
M = SPASMS
F = STIFFNESS
N = NUMBNESS
T = TINGLING
O = OTHERS



Front



Back

If you marked "O" for Other on any part, please explain below.

Health and lifestyle

Do you exercise? ☐ Yes ☐ No How often? ___ (days) per week.
Do you smoke? ☐ Yes ☐ No How much? / How often? ________________________________
Do you drink alcohol? ☐ Yes ☐ No How much? / How often? ________________________________
Do you drink coffee? ☐ Yes ☐ No How much? / How often? ________________________________

Do you take any supplements (i.e. vitamins, minerals, herbs)? If yes, please list: __________________________

____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to all the areas of the spine. These distortions are reflected in abnormal posture which leads to chronic pain, disease and possibly a shortened lifespan. Answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Sinusitis
___ Allergies/Hay fever
___ Recurrent colds/Flu
___ Low Energy/Fatigue
___ Weakness in Grip
___ TMJ/pain/clicking in the jaw

THORACIC SPINE (UPPER BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Tachycardia
___ Heart Attack/angina
___ Recurrent Lung Infection / Bronchitis
___ Asthma / Wheezing
___ Pain on Deep Inspiration / Expiration

THORACOLUMBAR SPINE (MID BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

______Nausea
_____ Diabetes
_____ Pain in Ribs/Chest
_____ Ulcers/Gastritis
_____ Hypoglycemia/Hyperglycemia
_____ Indigestion/Heartburn

LUMBAR SPINE (LOW BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

_____ Weakness/injuries in hips/knees/ankles
_____ Recurrent bladder infections
_____ Frequent/difficulty urinating
_____ Sexual dysfunction
_____ Menstrual irregularities/cramping (females)

Other

Please list any health conditions not mentioned: ____

Please list any medications (include name, dose, for what condition, and how long you've been taking it):

____

Please list any surgeries (include type of surgery and date it was performed): ___________________________

____

Family Health History

Have any of your family members ever been diagnosed with the following? **(Please indicate "Y" for You, and "O" for Other than you, or both if applicable.)**

___ Diabetes	___ Varicose Veins	___ Neurological Problems	___ Lung Disease
___ Rheumatic Fever	___ Circulatory Problems	___ Stroke	___ Heart Murmur
___ High Blood Pressure	___ Heart Disease	___ Cancer	___ Osteoporosis
___ Kidney Disease	___ Paralysis	___ Migraine Headaches	___ Arthritis
___ Liver Disease	___ Metal Implants	___ Infectious Disease	___ Gallbladder
___ Broken Bones/Fractures	___ Appendectomy	___ Tonsillectomy	___ Hernia
___ Pneumonia/Bronchitis	___ Polio	___ Tuberculosis	___ Anemia
___ Whooping Cough	___ Chicken Pox/Shingles	___ Mumps	___ Measles
___ Thyroid Problems	___ Smallpox	___ Influenza	___ Pleurisy
___ Blood Sugar Problems	___ Epilepsy/Seizures	___ Eczema/Psoriasis	___ Lumbago

Other: ____

____

Pregnancy Release

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ / _____ / _____

Patient's Signature ____ Date _____ / _____ / _____

Authorization of Care

I authorize and agree to allow the doctor and/or her designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I also understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or her staff will not be held responsible for any health conditions or diagnosis which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's and/or staff's specific recommendations at this clinic, that I will not receive the full benefit from these programs and that if I terminate my care prematurely, that all fees incurred will be due and payable at that time.

Patient's Signature ____ Date _____ / _____ / _____

Patient's Name Printed ____ Date _____ / _____ / _____

In Case of Emergency

Name ____ Relationship ____________________________

Work Phone ( ) _______ - ____________

Home Phone ( ) _______ - ____________

Cell Phone ( ) _______ - ____________

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. **Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. Insurance does not always 100% cover your visit. Expect a co-pay to be affixed with your 1st day visit and plan.** We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically transferred to your credit card or the extended payment plan.

ITEMIZED RECEIPTS aka "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred to as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover. If this is the case, I am willing to pay for these services. ☐ Yes ☐ No

Patient's Signature ____ Date _____/_____/_______

Signature of Person Authorizing Care ______________________________________ Date _____/_____/_______

Relationship to insured ____ Date of Birth _____/_____/_______

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. Chiropractic care is not used for the treatment for, or to cure cancer. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Prior to receiving chiropractic care in this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan to help you become healthier prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give any consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other modalities, as reported following my assessment.

______________________________	______________________________
Patient Name	Relationship to Patient
______________________________	______________________________
Patient or Legal Guardian Signature	Date
______________________________	______________________________
Office Staff Witness	Date

PATIENT NAME:

ARBITRATION AGREEMENT AND INFORMED CONSENT PAGE 1/2. PLEASE SIGN BOTH SIDES.

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 law, and not by a lawsuit or resort to court process except as California 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.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate 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 and/or other licensed health care providers or preceptorship 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 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 or punitive damages. Filling of any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the health care provider, any fee dispute, whether or not subject to any existing court action, shall also be resolved by arbitration.

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 (30) days and the arbitration appointed parties within thirty (30) days thereafter shall select a third arbitrator (neutral arbitrator). The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such parties pro rata share of all 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 parties 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 invention and jointer 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 jointer, 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 the 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 judgement 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 be arbitrated in one (1) proceeding. A claim shall be waived and forever barred if 1: on the date noticed 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 thirty (30) days of signature and if not revoked will govern all professional services received by the patient.

Article 6: Retroactive Effect: If a patient intends this agreement to cover services rendered before the date it is signed, (for example: emergency treatment) the patient should initial here, ___________. Effective the first date of 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 A COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** **Date** _______________

(Or patient representative) **(Indicate relationship if signing for patient)**

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2/2 - PLEASE SIGN BOTH SIDES

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 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 the 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 of 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, 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 complications, and I wish to rely on the doctor to exercise judgement 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 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.

PATIENT SIGNATURE **X** **Date**
(Or patient representative) **(Indicate relationship if signing for patient)**

PATIENT SIGNATURE **X** **Date**

OPTIONS FOR PAYMENT

Our experience has shown that it is wise to have an understanding with your patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your Chiropractic Care at our office and you may choose the plan which best fits your needs. Please read carefully and choose the plan, which you prefer. This information will enable us to better serve you and help to avoid misunderstandings 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, which covers Chiropractic care, we will bill your insurance directly. Until we have the completed, necessary insurance information to verify chiropractic coverage, you will be required to pay for your care. Most patients with “deductible plus 80% insurance” pay a required copayment fee periodically in addition to meeting their yearly deductible. In the event the insurance check should come to you, you are expected to bring the check 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 so you should plan to get off insurance and be on your own when you get down to once a week or less (except, certain types of injuries). At this point, refer to the Health and Life Extension Plan (ask Doctor for details).

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

PLAN #3 - WEEKLY/MONTHLY CASH AGREEMENT: 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 Injury or Auto Injury claims.

PLAN #4 - CASH PRE-PAY: Ask Doctor for details.

PLAN #5 - INDUSTRIAL: You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

PLAN #6 - AUTO INJURY: You need to supply us with the accident report, your car insurance, health insurance and liable parties insurance, and an attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, 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 required to bring the check to us.

I QUALIFY AND UNDERSTAND PLAN #________ REQUIREMENTS.

SIGNATURE ____ DATE _____ / _____ / _____

American Specialty Health Member Billing Acknowledgement

P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746 For questions, please call ASH at 800.972.4226

Chiropractic

IMPORTANT NOTICE: You may have additional coverage options for these services through your medical insurance benefits. ASH recommends that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I, ____________________________, a member being treated by Dr. Amie Bend, do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with American Specialty Health. I understand and agree to be responsible for self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Procedure	Charge
99412 - Office Visit	$ 00.00
99203 - Exam 30 minutes	$ 00.00
99412 - Radiologic Exam 6 views	$ 100.00
99412 - EMG	$ 99.00
	Total: 199.00

Additional Procedure	
98941 - Chiropractic Adjustment	Total: 65.00

Separately list each date of service on which non-covered services will be rendered and have the member initial the charge. Please attach additional Member Billing Acknowledgement form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services may also include services determined by ASH to be maintenance-type services.

The ASH Contracted Chiropractor may not bill the member during the course of an ASH approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered services.

The ASH Contracted Chiropractor may not bill the member for the difference between what the ASH Contracted Chiropractor bills and what the ASH Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Chiropractor agreed contractually to waive.

This agreement may not be used as a “blanket” or “retroactive” agreement to bill members for any services not reimbursed by ASH. Such use will render this agreement “void” and non-binding on the Member. This agreement may only be used to allow the member to agree to “self pay” for specific services ***in advance.***

I acknowledge that I have reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, including non-covered services as described above, and agree to make financial