BACK TO TOTAL HEALTH WELLNESS CENTER

1106 N. La Cienega Blvd. Ste. 203 ● W. Hollywood, CA 90069 ● office 310.659.8500 ● fax 310.652.6562 ● www.backtototalhealth.com

Patient Contact

First Name_____ Last Name_____ M.I_____

Address_____ City_____ State _____ Zip_____

Home Phone_____ Cell _____

E-Mail_____

Patient Personal

Gender: Male / Female Date of Birth_____ Social Security # _____

Marital Status: Single / Married / Partnered / Other: _____

Employer Name_____ Occupation _____

Spouse Name _____ Phone_____

Who referred you to us? _____ Email _____

Current Injuries

Briefly describe the injury that you are coming in for in detail: _____

_____

What is the quality of your pain? □ dull □ sharp □ numb □ tingling □ burning □ spasm □other_____

Current pain level (circle one): 0 1 2 3 4 5 6 7 8 9 10

No pain high pain

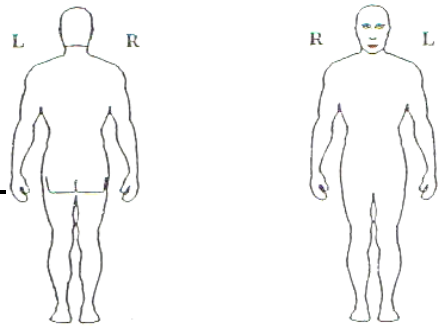
How often do you experience your symptoms? □ constantly □ daily □ weekly □ monthly □ yearly

How long have you been experiencing your symptoms? _____

What medications are you currently taking:_____

Primary Care Physician_____ Last Visit_____

Other_____ Last Visit_____



Please mark the areas of all your complaints on the diagrams above.

Assignment and release

I, the undersigning certify that I (or my dependant) have insurance coverage and assign directly to Back to Total Health all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Patient Signature Date

PLEASE TURN TO OTHER SIDE FOR ADDITIONAL SIGNATURE

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Financial Policy

1. **(Out of Pocket)** 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 will be terminated.
2. **(Balance deferred)** If you have insurance: All deductibles or co-pays are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care will be terminated. Our payment plans make care an affordable part of your family budget.
   If your carrier has not 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 of payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you discontinue care for any reason, all balances will become due immediately regardless of any claims submitted to your insurance company.

Consent for Examination and Treatment

I hereby consent to the performance of examination and treatment on me, by the licensed doctor(s) of chiropractic, medical doctor(s), licensed physical therapist(s), and/or massage therapist(s).

I further understand that there are certain degrees of risk associated with chiropractic health care and physical/massage therapy, which includes, rarely, but not limited to: fractures, disc injuries, strokes and strain/sprains, and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

(Females Patients) By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Office Policies

Our doctors have specifically created/recommended a treatment plan for you. The days they wish you to return to our office is all part of your overall care. Keeping your appointment(s) will ensure the quickest recovery possible. Since we want to ensure your recovery and allow everyone an opportunity to see the doctor in a timely manner. there is a **24-hour cancellation** policy on **massage/therapy** appointments. If an appointment is rescheduled or missed within 24 hours of your scheduled appointment time a **$45 cancellation fee for massage/therapy will be assessed** to your account. Please be advised that your insurance does not cover cancellation fees and that you are responsible for these fees. Our doctors and therapists want you to know they work hard to see you at your scheduled appointment time, however they want to make sure everyone is given adequate time for the care they need.

Notice of Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining you consent. You may request restrictions on disclosures.

You may inspect and receive copies of your records within 30 days of your treatment. There may be a reasonable cost-based fee for photocopying, postage and preparation.

We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.
Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

I have read the above sections of information regarding my financial obligation, consent for examination and treatment and office policies and information practices. I have had the opportunity to ask questions about my examination and treatment. By signing below, I agree to the terms and policies set forth by Back to Total Health, Inc.

_____
Patient's name (Please Print)

_____ _____
Patient's Signature Date