HEALTH ATLAST CM

1835 Newport Blvd., Suite D251, Costa Mesa, CA 92627 File #:_____ X-ray #: _____

Last Name: _____ MI:_____ First Name: _____

Home Address: _____ Apt. _____City: _____State:_____

Zip: _____ Cell Phone: _____ Work Ph: _____ Home Ph: _____

Notify in case of emergency: _____ Tel: _____

Date of Birth: _____/_____/_____ Sex: M / F SSN #: _____ Married / Single / Divorced

E-mail:_____ Height: _____ Weight: _____ Preferred Language: _____

Race/Ethnicity: American Indian or Alaska Native / Asian / Black or African American / Hispanic or Latino / Native Hawaiian or Pacific Islander / White

Employer: _____ Occupation: _____

METHOD OF PAYMENT (Circle Choice)

Self-Pay: Cash / Check / Credit Card / Private Insurance / Medicare

Date of Injury:____/_____/_____Work Comp / Accident Attorney / Other:_____

INSURANCE INFORMATION

Insured Name (if other than patient): _____ Insured Subscriber #: _____
Insured Date of Birth:_____ Soc. Sec # of insured:_____
Medical Insurance _____ Subscriber Number:_____
Policy: _____ Group: _____ Tel of Insurance:_____
Address: _____

****

Worker's Comp/ Auto accident / Attorney: _____
Claim #:_____ Adjuster: _____
Address: _____City: _____ State: _____ Zip:_____
Tel: _____Fax:_____

ASSIGNMENT OF INSURANCE BENEFITS / PATIENT INFORMATION

Patient hereby assigns to **HEALTH ATLAST CM** ("Provider") all rights to payment and benefits and all legal and other health plan, ERISA plan, or insurance contract rights that I (or my child, spouse or dependent) may have under my/our health plan(s) or health insurance policy(ies), and I hereby instruct and direct my health insurer or plan to pay by check made out and mailed to **HEALTH ATLAST CM,** the medical expense or other professional healthcare provider benefits allowable under my current insurance policy for services rendered to me or my dependent(s). This assignment includes, but is not limited to, a designation that Provider can act on my/our behalf, as my/our representative or ERISA representative, as to any initial or subsequent claim determination or adverse notification/denial, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to Provider as a result of services rendered by Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer to accomplish, inter alia, payment of Provider. This assignment and designation remains in effect unless revoked in writing, and is a direct assignment of my rights and benefits under this policy. A photocopy of this Agreement shall be considered as effective and valid as the original. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all information of this sheet and have completed the above answers I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Patient or Beneficiary_____Date:_____

Area of Complaint/Condition: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? __Yes __No __Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Weakness □ Other

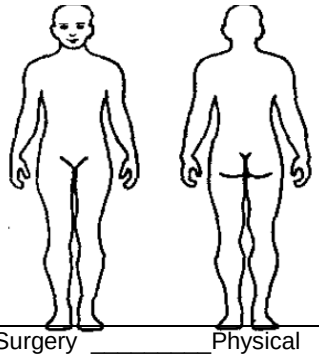
How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ____Work ____Sleep ____Daily Routine ____ Recreation

Activities or movements that are painful to perform:
___Sitting ___Standing ___ Walking ___Bending ___Lying down

Mark Symptoms



What treatments have you already received for this condition? _____Medications _____ Surgery _____Physical Therapy

_____Chiropractic Services _____ None _____Other/ Home Treatment_____

Name and Phone Number of other doctor(s) who have treated you for your condition_____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT, Bone Scan_____

Place a mark on yes or no to indicate if you have or had any of the following:

Aids/HIV	□Yes □No	Epilepsy	□Yes □No	Memory Loss	□Yes □No	Scarlet Fever	□Yes □No
Alcoholism	□Yes □No	Fatigue	□Yes □No	Miscarriage	□Yes □No	Shortness of Breath	□Yes □No
Allergy Shots	□Yes □No	G.I. problems	□Yes □No	Migraine Headaches	□Yes □No	Sleep Difficulty	□Yes □No
Anemia	□Yes □No	Glaucoma	□Yes □No	Miscarriage	□Yes □No	Stroke	□Yes □No
Anorexia	□Yes □No	Goiter	□Yes □No	Mononucleosis	□Yes □No	Suicide Attempt	□Yes □No
Appendicitis	□Yes □No	Gonorrhea	□Yes □No	Multiple Sclerosis	□Yes □No	Thyroid Problems	□Yes □No
Arthritis	□Yes □No	Hiatal Hernia	□Yes □No	Mumps	□Yes □No	Tingling	□Yes □No
Asthma	□Yes □No	Headaches	□Yes □No	Nausea	□Yes □No	Tonsillitis	□Yes □No
Bleeding Disorders	□Yes □No	Hearing Difficulty	□Yes □No	Nervousness	□Yes □No	Tuberculosis	□Yes □No
Bowel Problems	□Yes □No	Heart Burn	□Yes □No	Numbness	□Yes □No	Tumors, Growths	□Yes □No
Breast Lump	□Yes □No	Heart Disease	□Yes □No	Osteoporosis	□Yes □No	Typhoid Fever	□Yes □No
Bronchitis	□Yes □No	Hepatitis	□Yes □No	Pacemaker	□Yes □No	Ulcers	□Yes □No
Bulimia	□Yes □No	Hernia	□Yes □No	Parkinson's Disease	□Yes □No	Urinary	□Yes □No
Cancer	□Yes □No	Herniated Disc	□Yes □No	Pinched Nerve	□Yes □No	Incontinence	□Yes □No
Cataracts	□Yes □No	Herpes	□Yes □No	Pneumonia	□Yes □No	Vaginal Infections	□Yes □No
Chemical		High Blood	□Yes □No	Polio	□Yes □No	Venereal Disease	□Yes □No
Dependency	□Yes □No	Pressure	□Yes □No	Problems with Eyes		Vomiting	□Yes □No
Chest Pain	□Yes □No	High Cholesterol	□Yes □No	Ears, Nose, Throat	□Yes □No	Weakness	□Yes □No
Chicken Pox	□Yes □No	Itching	□Yes □No	Prostate Problems	□Yes □No	Whooping Cough	□Yes □No
Depression	□Yes □No	Kidney Disease	□Yes □No	Prosthesis	□Yes □No	Other_____	
Diabetes	□Yes □No	Liver Disease	□Yes □No	Psychiatric Care	□Yes □No		
Difficulty Voiding	□Yes □No	Loss of Appetite	□Yes □No	Rheumatoid Arthritis	□Yes □No		
Emphysema	□Yes □No	Loss of Concentration	□Yes □No	Rheumatic Fever	□Yes □No		
		Measles	□Yes □No				

Exercise

□ None
□ Moderate
□ Daily
□ Heavy

Work Activity

□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

Habits

Right or Left Handed
□ **Smoking (Circle choice) current every day, current some days, former, never, smoker-current status unknown**
□ Alcohol Drinks/Day_____
□ Coffee/Caffeinated drinks Cups/Day_____
□ High Stress Level Reason_____

Are you pregnant? □ Yes □ No Due date_____

	Description	Date
Accidents/Workers Comp/ Car Accidents	_____	_____
Falls/ Injuries	_____	_____
Broken Bones / Dislocations	_____	_____
Surgeries	_____	_____

	Drug name	Dosage	Purpose	Prescribing Dr. Name and Phone #
Medications	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Allergies: _____

HEALTH ATLAST CM INFORMED CONSENT

PERSONAL

Patient's Name_____

INFORMED CONSENT

The determination of an appropriate plan of medical and/or chiropractic management for medical, orthopedic or chiropractic conditions may involve or include the utilization of physical examinations, muscle testing, physiotherapeutic exercise or rehabilitation procedures done in office or at home utilizing devices appropriate for same, spinal adjustments, diagnostic imaging including but not limited to x-rays, ultrasound or MRI, electrical stimulation or TENS unit application or ultrasound applied to muscles, nerve conductive velocity testing, acupuncture, venipuncture, injections into large or small joints or muscles, or prescriptions. Should these procedures be deemed appropriate in your case, you will be examined by a doctor or his or her mid-level provider ("Provider") to determine if you have any conditions that indicate you should not engage in any of the foregoing.

I the Patient ("Patient") acknowledge and understand that the above procedures carry with them a small inherent risk of injury, which include but are not limited to: minor strains of the specific muscles being used during testing or rehabilitation, muscle strains, dislocations, skin irritation, costovertebral sprains, fractures, disc trauma, minor burns, dizziness, bruising, local swelling, stroke or fatality, stomach upset, allergic reactions, electrical shock, injection site pain irritation or infection, bleeding or erythema, high levels of anesthetic in central nervous system in the event of inadvertent injections into blood vessels, temporary anesthesia or numbness or weakness in area injected, vasovagal reaction (fainting), soft tissue swelling, hematoma formation, nerve trauma or compartment syndrome requiring possible surgical decompression, joint stiffness, vessel nerve or joint injury, pneumothorax requiring possible intubation, gastrointestinal upset, nausea, headaches, hoarseness, difficulty swallowing or strange tastes, dimpling of skin, and rare side effects of medications utilized may include retention of salt and water, transient disturbances of blood sugar, blood, hemorrhage or pus in affected area, and allergic reactions which in rare cases can be severe, disability or fatality, seizure, arrhythmia, anaphylaxis, paralysis, or cardiac arrest. If you are receiving an injection involving Hyaluronate, you need to inform your provider if you have an allergy to chicken, eggs, feathers, or vaccine products derived therefrom. The Patient is at all times free to engage in alternatives to procedures which include not receiving or refusing the procedure, or other appropriate medical or surgical management. Patient always has the right to refuse any procedure at any time. It is Patient's responsibility to inform Provider if Patient does not want the procedure or wishes to stop the procedure after it has started. It is Patient's responsibility to inform Provider of any prior adverse outcome or reaction to a similar treatment previously, or if such a reaction occurs during or after a procedure in this office. Patient understands that the doctor may not be able to anticipate and explain all potential risks and complications, and wishes to rely on the doctor to exercise his or her clinical expertise and best judgment based on the facts then known to him or her to determine a reasonable course of action which the doctor feels at the time – based upon the facts then known to him or her – is in Patient's best interests. Patient has read, or has had read to him or her, this entire informed consent form, in a language that Patient understands. Patient has had an opportunity to ask questions about its content, and by signing below, Patient indicates Patient's understanding that results are not guaranteed and that Patient has had the opportunity to discuss the purposes, procedures, risks and other factors and ask all questions Patient has about his treatment in the office. Patient also agrees to hold this office and its staff harmless for injuries caused by the use of durable medical equipment due to improper use or manufacture defects. Patient intends this consent form to cover the entire course of treatment for Patient's present condition and for any future condition(s) for which Patient seeks treatment at this office. Patient has read and understands the preceding statements and hereby consents to voluntarily participate in one or more of the above-described treatments, and/or other medical management procedures as deemed appropriate by Provider. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

Should I decide to receive treatment, I understand that I will be ultimately responsible for any and all charges incurred at this office. After a charge is 30 days past due a finance charge of 1.5% per month and penalty fee may be added. If any of my checks bounce, I will be billed a service fee. I hereby authorize this office to disclose medical information pertaining to my case to medical/technical consultants deemed appropriate by my doctor and submit claims to my insurance carrier on my behalf. However, I understand that verification of my eligibility and benefits is not a guarantee of payment.

The clinic is not liable for any lost or stolen property, or property damaged on the premise or in the parking lot. All supplements, supplies and durable medical equipment purchases are final. There are no exchanges or returns.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Patient Signature: _____ Date_____

Guarantor Signature: _____ Date_____

Health Atlast CM

Acknowledgement
Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and disclose your health information and your rights and our legal obligations with respect to your health information.

By signing this form you acknowledge you have received the Notice of Privacy Practices.

You may refuse to sign this acknowledgement, if you wish.

Name:		Today's Date:	
Date of Birth:		Last 4 digits of Social Security #	xxx-xx- ___ ___ ___ ___

Acknowledgement by Individual:

Please sign your name to acknowledge receipt of the Notice of Privacy Practices of Health Atlast CM on this line:

_____

Acknowledgement by Personal Representative acting for an Individual:

If you are signing this acknowledgement on behalf of the Individual named above, please print your name on this line:

_____

Please write your relationship and authority to act for the Individual on this line:
(documentation may be requested)

_____

If you are signing this acknowledgement on behalf of the Individual named above, please sign your name on this line:

_____

Important Security Warning - Email

Email that is not sent by a secure, encrypted method is not a secure method of communication. It may be intercepted and read by unauthorized persons. An email communication from us to you identifies you as a patient of Health Atlast CM and may put your personal, protected health information at risk of being compromised, misused or stolen. Personal identity theft including medical identity theft is a serious and growing problem. If you request our Notice of Privacy Practices or any other communication from us by email please understand that by this Warning, Health Atlast CM has informed you of the risks of using email and text messaging for confidential communications.

_____ By checking here I agree that Health Atlast CM may send me a copy of its current Notice of Privacy Practices by email if I request that it be sent to me by email although I understand that email is not a secure form of communication. I accept full responsibility for any adverse consequences to me resulting from the use of email to send me a current Notice of Privacy Practices at my request.

For Office Use Only

Name of Individual:

_____

____ Identity of the Individual verified, documentation on file

Name of Personal Representative (if applicable):

_____

____ Identity and Authority to Act of Personal Representative verified, documentation on file

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the Individual, but it could not be obtained because:

____ The Individual or Personal Representative refused to sign the acknowledgement

____ Due to an emergency situation it was not possible to obtain acknowledgement (Please provide specific details)

____ Other (Please provide specific details)

Confirmed by Health Atlast CM

Signature	Printed Name and Title

The Following is a Requirement of California Law

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.

You are free to choose any organization you wish for obtaining services may be ordered or requested for you by any of the doctors listed below. Your doctor would be happy to discuss alternatives with you. Potential sources of information concerning alternatives can be obtained from the Yellow Pages, the internet, or the county medical association.

Anna Steiner Medical, Inc.
Health Atlast Fountain Valley
Health Atlast CM
Karen Tafreshi, D.C.
Gregory Brown, D.C.
Sean Ataee, M.D.
Errajith Bertrand R. De Silva, M.D.
Nancy Garcia, NP
Ke Yang, L.Ac.
Jin Woo Park, L.Ac

The following addresses are provided for the filing of any complaints relevant to this notice or the services provided: Medical Board of California, 2205 Evergreen Street, Suite 1200, Sacramento, CA 95815; Osteopathic Medical Board of California, 2720 Gateway Oaks Drive, Suite 350, Sacramento, CA 95833; Board of Chiropractic Examiners, 2525 Natomas Blvd, Suite 180, Sacramento, CA 95834

Disclaimer for Lost or Stolen Property

I understand that ***Health Atlast CM*** is not responsible for any lost or stolen personal property brought to or left in their office.

I hereby acknowledge receipt of this notice.

Signed: _____ Date: _____

Printed Name: _____