HEALTH ATLAST FOUNTAIN VALLEY

18837 BROOKHURST ST., STE 210, FOUNTAIN VALLEY, CA 92708

Last Name: ________________________________MI:_______ First Name: ___________________________________

Home Address: ____ Apt. _____City: ________________________

Zip: _________ Cell Phone: ____________________ WorkPh:____________________ Home Ph: _________________

Notify in case of emergency: ____ Tel:_____________________________

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

E-mail:___________________________Height:_______Wt:__________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:_________________Work Address: ___________________________

METHOD OF PAYMENT (Circle Choice)

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

Date of Injury:____/_____/_____ Auto 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: ____

Auto accident / Attorney: ____

Claim #:_________________________ Adjuster: ____

Address: ______________________________________City: ___________________ State: __________ Zip:__________

Tel: ____Fax:____

ASSIGNMENT OF INSURANCE BENEFITS / PATIENT INFORMATION

Patient hereby assigns to **HEALTH ATLAST FOUNTAIN VALLEY** ("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 FOUNTAIN VALLEY,** 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.

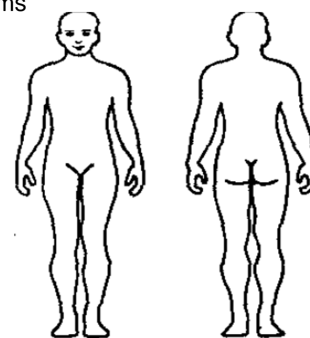
Signature of Patient or Beneficiary____Date:____________________

For Office Use Only:

Appointment Type: GC INS CASH PI

GROUPON ACU ______________________________GROUPON CHIRO _____________________________

Area of Complaint/Condition____ Mark Symptoms



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_____

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:

Condition		Condition		Condition		Condition	
Aids/HIV	□Yes □No	Epilepsy	□Yes □No	Measles	□Yes □No	Scarlet Fever	□Yes □No
Alcoholism	□Yes □No	Fatigue	□Yes □No	Memory Loss	□Yes □No	Shortness of Breath	□Yes □No
Allergy Shots	□Yes □No	G.I. problems	□Yes □No	Miscarriage	□Yes □No	Sleep Difficulty	□Yes □No
Anemia	□Yes □No	Glaucoma	□Yes □No	Migraine Headaches	□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 Incontinence	□Yes □No
Cancer	□Yes □No	Herniated Disc	□Yes □No	Pinched Nerve	□Yes □No	Vaginal Infections	□Yes □No
Cataracts	□Yes □No	Herpes	□Yes □No	Pneumonia	□Yes □No	Venereal Disease	□Yes □No
Chemical Dependency	□Yes □No	High Blood Pressure	□Yes □No	Polio Problems with Eyes	□Yes □No	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			

Exercise
□ None
□ Moderate
□ Daily
□ Heavy

Work Activity
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

Habits Right or Left Handed
□ **Smoking-(Circle one choice) Current every day, current somedays, 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 FOUNTAIN VALLEYINFORMED 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________________

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.
Sara Mehdizadegan, L.Ac.
Ke Yang, L.Ac.
Michelle L. Rhyner, FNP
Mariana Moualem, FNP

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

I hereby acknowledge receipt of this notice.

Signed: ___________________________________ Date: _____________

Name: ____________________________________

HEALTH ATLAST CM CANCELLATION POLICY

In order to serve all of our patients and provide the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. We realize circumstances occur and you may need to change an appointment. We ask that you notify us at least 4 business hours in advance of the appointment time, and 24 hours in advance for *massage therapy and acupuncture*. If at least 24 hour notice for massage therapy and acupuncture in not provided, no-shows and cancellations will be charged $20.00 for 30 minute appointments or $40 for 60 minute appointments.

The more notice you provide, the better we can serve all patients. If you reach our voicemail, please leave a message and we will call you back to reschedule. Thank you in advance for your cooperation!

ALSO, HEALTH ATLAST CM IS NOT RESPONSIBLE FOR ANY LOST OR STOLEN PERSONAL PROPERTY BROUGHT TO OUR OFFICE OR LEFT IN OUR OFFICE.

By signing below, I acknowledge that I understand and agree to the terms of the Cancellation Policy.

Signed: ______________________________ Date: ______________________

Name: ______________________________

Health Atlast Fountain Valley

Acknowledgement of Receipt of Notice of Privacy Practices

We are required by law to provide you with a copy of our Notice of Privacy Practices, which explains 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 our Notice of Privacy Practices.

Today's Date:_________________

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

Acknowledgement of Receipt of Notice of Privacy Practices by Individual

My Name:__________________________________

Birth Date:____/____/_______ Last 4 digits of my Social Security # ___ ___ ___ ___

Please sign on the line below to confirm that today we provided you with our Notice of Privacy Practices and to acknowledge you have received our Notice of Privacy Practices

____

My Signature

Acknowledgement of Receipt of Notice of Privacy Practices by Personal Representative for Individual

Name of Individual:________________________________

Name of Personal Representative:_________________________________

Relationship of Personal Representative to Individual:_______________________

Please sign on the line below to confirm that today we provided you with our Notice of Privacy Practices for the Individual named above and acknowledge its receipt for the Individual

____

Signature of Personal Representative

For Office Use Only
If Acknowledgement of Receipt of Notice of Privacy Practices is signed
Check 1 or 2

1. _____ Identity of Individual verified

2. _____ If Personal Representative signed on behalf of the Individual
Identity of Personal Representative and Authority to Act for Individual verified.

3._____ We made a good faith effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices

Confirmed by Health Atlast Fountain Valley

By: ________________________________ ______________________________
Signature Printed Name