Date _____

Personal History Form

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name _____ S.S.# _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Business phone _____

Cell phone _____ e-mail address _____

Gender: Male Female Birth Date _____ Age _____

Employer _____ Occupation _____

Employment address _____

In case of emergency contact _____ Phone _____

Referred by _____ Have you ever been treated by a chiropractor before? Yes No

How would you describe your chief complaint at this time?

_____

_____

When did it start? _____
(Include month and year, day if known)

What makes the pain worse? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is: Intermittent Constant

Have you had this problem in the past? _____ If so, how often? _____

Is your pain the result of a motor vehicle accident? _____

Have you filed a legal suit? _____

Is your pain the result of a work related injury? _____

If so, have you filed a worker's compensation claim? _____

Please list accidents, injuries, surgeries, and hospitalizations you have had.

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

Do you or other family members have a history of any of the following?

Arthritis	Self	Family member _____
Asthma	Self	Family member _____
Cancer	Self	Family member _____
Diabetes	Self	Family member _____
Heart Disease	Self	Family member _____
Hypertension	Self	Family member _____
Hypoglycemia	Self	Family member _____
Kidney Disease	Self	Family member _____
Depression	Self	Family member _____
Mental Illness	Self	Family member _____

Do you drink coffee or black tea? _____ If so, how much per day? _____

Do you smoke tobacco? _____ If so, how much per day? _____

Do you drink alcohol? _____ If so, how often? _____

What medications, vitamins, supplements, herbs do you take?

Name	**Reason**

Please list any allergies that you have.

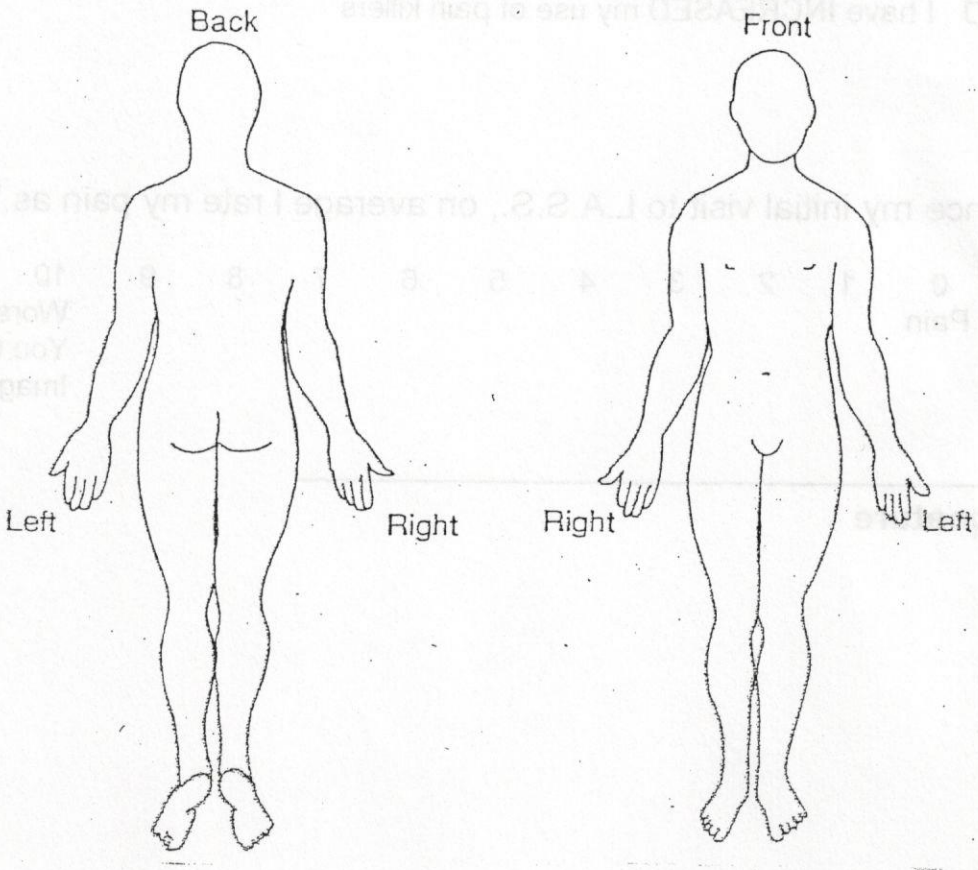
_____

Pain Drawing

Date: _____ Name: _____

Draw location of your pain on body outlines

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
ʌʌʌ	= = = =	ooo	.....	//////	XXXXX
ʌ	= = = =	oo	....	////	XXX



Name _____ Date_____

My Chief Complaint is _____ My Secondary Complaint is _____

I) CURRENT STATUS -

1. Since my most recent episode of pain, my overall status is:

□ Very Much (80%) better

□ Much (50%) better

□ Minimally (20%) better

□ No Change

□ Minimally (20%) Worse

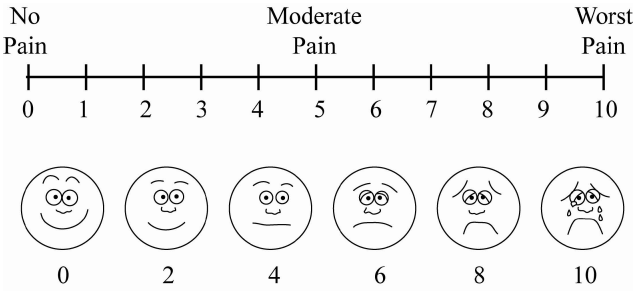
□ Much (50%) Worse

□ Very Much (80%) Worse

II) PAIN -

2. Please indicate your usual level of pain & worst pain during the past week:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain



3a. Are you taking any MEDICATION (PAIN KILLERS) for your symptoms? (pick ONE)

□ Never □ Rarely □ Sometimes □ Every day

SKIP 3b. if the answer to 3a. was Never

3b. If you are taking any MEDICATION (PAIN KILLERS) pick ONE:

□ I have ⬇️ them □ I am taking about the SAME amount □ I have ⬆️ them

4. If you had to spend the rest of your life with your <u>condition as it is right now</u>, how would you feel about it?

Delighted 0 1 2 3 4 5 6 7 8 9 10 Terrible

III) ACTIVITY TOLERANCE -

5. On a scale of 0 to 10, how certain (confident) are you that you will be doing normal activities or working in <u>six months</u>?

Very certain 0 1 2 3 4 5 6 7 8 9 10 Not certain at all

6. How confident are you that you are moving in the right direction?

Very confident 0 1 2 3 4 5 6 7 8 9 10 Not confident at all

7. Physical activity (in general) makes my pain worse?

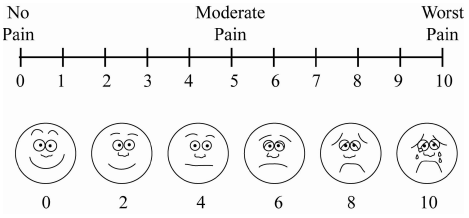
Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

8. What specific daily tasks give you the most problems, & rate the pain (0-10) of each?

1:_____ Pain:_____

2:_____ Pain:_____

3:_____ Pain:_____



IV) FITNESS -

9. List your 3 most strenuous weekly activities or workouts - time (min), level of exertion (RPE), frequency/week

Activity 1:_____

Avg. Duration of Activity:_____ Min.

RPE:_____Days/week _____

Activity 2:_____

Avg. Duration of Activity:_____ Min.

RPE:_____Days/week _____

Activity 3:_____

Avg. Duration of Activity:_____ Min.

RPE:_____Days/week _____

_____

Signature

LA SPORTS AND SPINE
Roy Page, D.C., M.S.

10474 Santa Monica Blvd., Suite 304
Los Angeles, CA 90025
email: roypagedc@gmail.com
web: lasportsandspine.com
tel: 310.470.2909 fax: 310.470.3286

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Dr. Roy Page.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with the opportunity to read and or have a copy of the Notice of Privacy Practices of Chiropractor prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

LA SPORTS AND SPINE
Roy Page, D.C., M.S.

10474 Santa Monica Blvd., Suite 304
Los Angeles, CA 90025
email: roypagedc@gmail.com
web: lasportsandspine.com
tel: 310.470.2909 fax: 310.470.3286

INFORMED CONSENT

The determination of an appropriate plan of chiropractic/physical rehabilitation management for neuromusculoskeletal conditions may involve or include the utilization of orthopedic, neurologic and physical performance testing and physical, manipulative and exercise/rehabilitative therapies. Should these procedures be deemed appropriate in your case, you will be evaluated by a doctor/therapist to determine if you have any conditions that indicate you should not engage in any particular test or therapeutic procedure.

I understand that, as with any form of physical activity or exercise, orthopedic, neurologic and physical performance testing and physical, manipulative and exercise/rehabilitative therapies carry with them a small inherent risk of injury which includes but is not limited to minor strains, intevertebral disc compromise, and compression fractures. Additionally, as is the case with most health care interventions, there is a certain (albeit rare) inherent risk of complications associated with chiropractic and rehabilitative procedures. These complications include but are not limited to muscle strains, dislocations, skin irritation, costovertebral sprains, fractures, disc trauma, and cardiovascular accidents. I understand my doctor/therapist will not be able to anticipate all potential complications, but elect to rely on his/her clinical expertise and judgment to determine courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

We may use your de-identified medical information for research purposes. I have read and understand the preceding statements and hereby consent to voluntarily participate in orthopedic, neurologic and physical performance testing and physical, manipulative and exercise/rehabilitative therapies as deemed appropriate by my doctor/therapist. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor/therapist of such and not participate in these forms of evaluation or treatment.

Patient/Guardian's Signature_____ Date_____

ROY PAGE, D.C, M.S, CCSP
10474 Santa Monica blvd. Suite 304
Los Angeles CA 90025

Financial Responsibility

Financial Responsibility

1. Payment in full is due at the time of service in the form of cash, check, or card. We currently do **NOT** accept AMEX.
2. We are **NOT** a Medicare Provider.
3. We do **NOT** bill insurance company. You may receive a detailed receipt (superbill) for your records to submit to your insurance company. Regardless of the level of reimbursement to your insurance company, you are financially responsible for all services rendered by Dr. Roy Page. You may wish to contact your insurance company directly should you have any concerns regarding insurance coverage for medical services rendered by and out-of-network provider. We will be happy to provide you a pro-forma superbill if necessary.
4. Dr. Page's current rate is $350.00 for the first visit and $150 for subsequent 30min visits or $300.00 for subsequent 60min. visits.

Cancellation Policy

To better serve all patient, our office requires at least **ONE** business day's notice ***(at least 24hrs, exclusive of weekends and holidays)*** to cancel any office visit. You will be **charged at regular's rates for missed appointments**. ***Our office*** **DOES NOT** give reminder calls so you are ***responsible*** for remembering your appointment date and time.

Cancellations **MUST** be made either in person or over the phone by calling 310-470-2909.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____

Patient/responsible party Date

_____

Print Name

LA SPORTS AND SPINE
Roy Page, D.C., M.S.

10474 Santa Monica Blvd., Suite 304
Los Angeles, CA 90025
email: roypagedc@gmail.com
web: lasportsandspine.com
tel: 310.470.2909 fax: 310.470.3286

My signature acknowledges that I have read and agreed to the office policy for broken or missed appointments. We require at *least* 24 hours notice (Friday within business hours for a Monday appointment) for any appointment changes in days or time slot, and will charge $150 for each occurrence. Messages outside of business hours do not count for 24 hours notice, one day prior to appointment.

NAME DATE

I have read these terms and understand my financial responsibility. I will receive a copy of this policy upon request.

LA SPORTS & SPINE
10474 SM Blvd, # 304, LA, CA 90025

Credit Card Authorization Form

All information will remain confidential

Cardholder Name: _____

Billing Address:_____

Credit Card Type: _____ Visa _____ MasterCard ____ Discover

Credit Card Number: _____**exp**:_____

Security Code: (3 digits): _____

Amount to Charge: **$350** (initial visit up to 90 mins) / **$150** (subsequent visits up to 45 mins, or broken appointments without 24 hr **business day** notice). Initial consultation or follow-up visits that extend beyond the normal time are charged at a prorated amount of $50 (for initial) and $40 (for subsequent) per 15 minute increment.

I authorize **Roy Page** to charge the agreed amount listed above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Name: _____

Signed: _____

Dated: _____

Once signed, this authorization represents an acknowledgment of patient responsibility for the office charges listed above, for any missed or canceled appointments outside of the 24 hours notice policy. We reserve all rights to modify or waive this or any other fee when appropriate for any office visit, re-examination, broken appointments or discounts.

Signature of responsible party: _____

PATIENT NAME:

ARBITRATION AGREEMENT

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 and federal law, and not by a lawsuit or resort to court process except as state and federal 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating 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 born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or 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 health care provider, and/or the health care 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, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

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 days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the 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 party's 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 intervention and joinder 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 joinder, 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 this 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 judgment 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 proceeding. A claim shall be waived and forever barred if (1) on the date notice 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 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

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

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist 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 understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Requests for correspondence or documentation $130-150

• Letter writing, treatment summaries or documentation beyond customary expectations may be requested.
• Adequate notice is required to allow time to prepare documents.

_____

Signature Date