COVID 19 INFORMATION &LIABILITY WAIVER

Client Name: _____ Date: _____

COVID –19 Information

1. Have you had a fever in the last 24 hours of 100° F or above? Yes☐ No☐

2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes☐ No☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has Coronavirus-type symptoms? Yes☐ No☐

Consent for Treatment

I understand that, because Chiropractic Treatment involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntary agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature: _____ Date: _____

Parent or Guardian signature (in case of minor): _____ Date: _____

CONFIDENTIAL PATIENT INFORMATION
(PLEASE PRINT)

PATIENT INFORMATION:

FULL NAME_____

ADDRESS _____ APT#_____

CITY_____ STATE_____ ZIP CODE_____

DATE OF BIRTH_____/_____/_____ AGE_____ MALE___ FEMALE___

SSN_____-_____-_____ EMAIL ADDRESS_____

HOME PHONE(____)_____ CELL PHONE(____)_____

MARITAL STATUS: SINGLE____ MARRIED____ WIDOWED_____

EMPLOYERS NAME_____ OCCUPATION_____

WORK ADDRESS_____CITY_____STATE____ZIP_____

WORK PH# (____)_____EXT._____

EMERGENCY CONTACT_____ PHONE (___)_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

DO YOU HAVE INSURANCE? YES_____ NO_____

INSURANCE NAME:_____

(PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD FOR OUR RECORDS)

IS YOUR VISIT DUE TO A:

_____ CAR ACCIDENT

_____ WORK INJURY

_____PERSONAL INJURY

_____OTHER (PLEASE EXPLAIN)_____

_____

INJURY START DATE:_____

WHAT ARE YOUR PRIMARY COMPLAINTS?_____

_____

_____

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PRODUCTS OR PROFESSIONAL SERVICES RENDERED WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT SIGNATURE_____ DATE_____

Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name: Last | First | MI — ○ Female ○ Male — Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) | 2. Federal tax ID(TIN) of entity in box #1

3. Name and credentials of the individual performing the service(s) — 1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type
1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode
1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery
1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other ____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1° | 2° | 3° | 4°

Nature of Condition
1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level
○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score
Neck Index | DASH | ____ (other FOM)
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

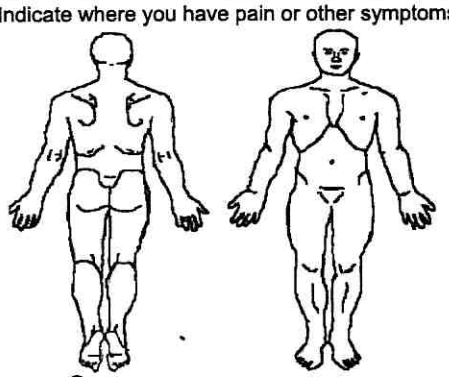
Symptoms began on:

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:
Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**
Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Indicate where you have pain or other symptoms:



4. How often do you experience your symptoms?
1. Constantly (76%-100% of the time) 2. Frequently (51%-75% of the time) 3. Occasionally (26% - 50% of the time) 4. Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)
1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

6. How is your condition changing, since care began at *this* facility?
0. **N/A — This is the initial visit** 1. Much worse 2. Worse 3. A little worse 4. No change 5. A little better 6. Better 7. Much better

7. In general, would you say your overall health right now is...
1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

Patient Signature: X _____ **Date:** _____

OPTUM®

MN010-W120, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free: (800) 873-4575 | Telephone: (763)595-3200 | Fax (763) 595-3333

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		No 0	Yes 1
1	Has your back pain spread down your leg(s) at some time in the last 2 weeks?	☐	☐
2	Have you had pain in the shoulder or neck at some time in the last 2 weeks?	☐	☐
3	Have you only walked short distances because of your back pain?	☐	☐
4	In the last 2 weeks, have you dressed more slowly than usual because of back pain?	☐	☐
5	Do you think it's not really safe for a person with a condition like yours to be physically active?	☐	☐
6	Have worrying thoughts been going through your mind a lot of the time?	☐	☐
7	Do you feel that your back pain is terrible and it's never going to get any better?	☐	☐
8	In general have you stopped enjoying all the things you usually enjoy?	☐	☐

9. Overall, how **bothersome** has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): _____ **Sub Score (Q5-9):** _____

Funded by Arthritis Research UK

FINANCIAL AGREEMENT
HEALTH INSURANCE

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled.

EXPLANATION OF INSURANCE COVERAGE

Most insurance policies cover chiropractic/medical care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for chiropractic/medical care. Due to variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company (companies) in a timely manner.

ASSIGNMENT OF BENEFITS

Attached is an "Assignment of Benefits" form which we would like you to sign, this form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form.

RELEASE OF INFORMATION

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

AUTHORIZATIONS

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself, furthermore, I understand that his office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

ASSIGNMENT & INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE & GROUP ACCIDENT & HEALTH INSURANCE

PATIENT NAME: _____
INSURANCE NAME: _____
GROUP NUMBER: _____
MEDICAL NUMBER: _____

I hereby instruct and direct the above mentioned Medical Insurance Company to pay directly to:

Delta Chiropractic
7103 Broadway
Lemon Grove, CA 91945
OR

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO DOCTOR, THEN I HEREBY ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

C/O
Delta Chiropractic
7103 Broadway
Lemon Grove, CA 91945

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees over the insurance payment by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

_____ _____

Signature Date

MEDICAL ASSIGNMENT AND RECORDS RELEASE

AUTHORIZATION AND ASSIGNMENT

I, _____ agree to the following:
(Patient's Name)

1. I hereby authorize you to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me.

_____ _____
(Patient's Signature) (Date)

RECORDS RELEASE

I hereby authorize you to release any information including the diagnosis and records of any examination or treatment rendered to me to the following person(s):

_____

Effective dates for this authorization:___/___/_____ through___/_____/_____
This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

_____ _____
Signature of Patient or Patient's Authorized Representative Date

Denise Soliz _____ _____
Authorized Facility Representative Date

Patient Name: _____ **Date of Birth:** _____

Social Security # _____ **Date:** _____

Patient Informed Consent

Congratulations on choosing chiropractic health care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (chiropractic manipulative therapy; C.M.T.) and other care procedures are safe and cost effective.

All health care professionals (anesthesiologist, chiropractors, dentist, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advance notice of any care risk, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risk and/or complications. Informed consent information regarding and risk such as paraplegia, quadriplegia, brain damage, stroke, disc injury breaks, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduated chiropractors who are licensed and recognized by government agencies regulating all the aforementioned health arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiological dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of the vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy-C.M.T.) Adjustments are made by chiropractors to correct and/or reduce and/or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A C.M.T. is the application of a specific force, applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risk. With C.M.T.'s these risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's syndrome, Vertebral Artery Syndrome (V.A.S.), stroke, etc. The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risk, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based on the facts then known. I have also had opportunity to ask questions regarding

the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

Patient Name Printed	Patient Signature	Date
Patient/Guardian Signature (if minor)	Denise Soliz Doctor/ Witness Name Printed	Date

Arbitration Agreement
Physician/Patient Out-Patient Form

Arbitration is a way to decide health care complaints without going to court.

By signing this agreement, my doctor(s) and I are choosing arbitration rather than going to court as a way of resolving any future claim about chiropractic care. This agreement only applies to the care that I receive in this office during the next year from undersigned chiropractor, associated or any office assistant or substitutes, employed by or assigned to my care by my chiropractor immediately following the execution of this form or during the time when this form is in effect. This agreement does not apply to disagreements over the fees charged.

State law gives me a choice of two ways to decide claims; either a trail by a judge, or by arbitration. I have a right to a lawyer for a trial or arbitration.

If I select arbitration, my case will be decided by a panel of three people instead of a judge or jury. The arbitration panel will contain a lawyer, a member of the public, and a Doctor of Chiropractic. My doctor(s) and I will take part in choosing the panel members who will decide the case. If the parties involved in the case cannot agree on the panel members, the American Arbitration Association and my doctor's state or national association representative may appoint the panel member. State laws and the rules of the American Arbitration Association will apply to all arbitration hearings and may vary from state to state. All parties are delegated to investigate on their own and/or seek counsel.

I am choosing arbitration of my own free will. This agreement applies to me, my heirs, and my legal representatives. This agreement also applies to any professional corporation or partnership that my doctor belongs to or works for. If I want to change my mind and cancel this agreement, I must notify my doctor in writing within 60 days after I sign. After 60 days, I cannot change my decision unless mutually agreed upon by all parties.

In most cases, a decision by an arbitration panel is final and cannot be appealed.

Delta Chiropractic Clinic Offered by:	Patient Name Printed	
Denise Soliz Signature of Chiropractic	Patient Signature	Date

I CERTIFY THAT I AM THE PARENT OF THE MINOR CHILD, THE GUARDIAN, OR OTHER LEGAL REPRESENTATIVE OF THE PATIENT INVOLED.

Parent/Guardian/Legal Representative Signature: _____ Date:_____