Balance your Health with Chiropractic

Synergy Chiropractic
Family Chiropractic Care • Sports Rehabilitation

HEALTH ASSESSMENT

PERSONAL

***** Please provide the front desk with your Driver's License or a Valid I.D., Auto Insurance Policy page and Health Insurance***

Date: _____ How did you hear about **Dr. Dilo (Who referred you)?**: _____

Name: _____ Home Tel: (____) _____-_____ Work: (____) _____-_____ Cell: (____) _____-_____

Address: _____ Apartment: _____ City: _____ State: _____ Zip: _____

Birth date: ___/___/_____ Age: ____ Sex: M / F SS#: _____-_____-_____ Marital Status: _____ Driver's Lic.#: _____ State: ___

Spouse: _____ Emergency Contact: _____ Phone: (____) _____-_____

eMail: _____ Would you like to receive an occasional newsletter? ☐Yes ☐No

Occupation: _____ Employer: _____ Address: _____

HEALTH INSURANCE

Your Health Insurance Co.: _____ Policy #: _____ Group #: _____

Address: _____ City: _____ State: ____ Zip: _____ Phone: (____) _____-_____

Coverage for Chiropractic: ☐**Yes** ☐**No** Deductible Amount: $ _____ Deductible. Met: $ _____

Subscriber's Name: _____ Relationship: ☐**Spouse** ☐**Father** ☐**Mother** ☐**Other** _____

Subscriber's SS#: _____-_____-_____ Subscriber's Date of Birth: ___/___/_____ Employer: _____

ABOUT YOUR COMPLAINT

Please describe your current complaint and how the problem started: **Date of ONSET**: _____

_____

_____

_____

Do you have these symptoms today? ☐**Yes** ☐**No** **How long have you had this condition?** _____

Please Rate your Pain by Circling a Number: **0** (No Pain) **1** **2** **3** **4** **5** (Moderate Pain) **6** **7** **8** **9** **10** (Unbearable Pain)

1. **Describe your <u>current</u> pain/symptoms:** ☐ Sharp/Stabbing ☐ Throbbing ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Numbness ☐ Shooting ☐ Gripping ☐ Burning ☐ Tingling ☐ Stiffness ☐ Spasm ☐ Other: _____
2. **How often are your symptoms present?** ☐ Constantly (81-100%) ☐ Frequently (51-80%) ☐ Occasionally (26-50%) ☐ Intermittently (25% or less)
3. **Your pains/symptoms are ...** ☐ Improving ☐ Getting Worse ☐ No Change ☐ Other _____
4. **What makes the problem(s) <u>BETTER</u>?** ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐ Exercise ☐ Inactivity/Rest ☐ Other: _____
5. **What makes the problem(s) <u>WORSE</u>?** ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement ☐ Exercise ☐ Inactivity/Rest ☐ Other: _____
6. **Were you treated for this?** ☐ Yes ☐ No ☐ Medications ☐ Injection ☐ Surgery ☐ Chiropractic ☐ Physical Therapy ☐ Acupuncture
   Approximate Dates: _____ Describe treatment/medications and the results: _____
   _____
7. **Are you currently taking any <u>medications</u>?** ☐ Yes ☐ No Describe: _____
8. **Have you had any <u>Diagnostic procedures</u>?** ☐ Yes ☐ No → ☐ MRI ☐ X-Ray ☐ CT-Scan ☐ Blood Tests ☐ Other tests for this condition
   _____
9. **Can you perform your daily <u>home</u> activity?** ☐ Yes ☐ Only Some ☐ Yes, only with help ☐ Not at all
10. **Do you <u>exercise</u>?** ☐ Yes, almost daily ☐ Yes, occasionally ☐ Not at all
11. **Describe your <u>job requirements</u>:** ☐ Mainly sitting ☐ Light Manual Labor ☐ Heavy Labor ☐ Operate Machinery
12. **Can you perform your daily <u>work</u> activities?** ☐ Yes, all activities ☐ Only some ☐ Not at all
13. **Describe your <u>stress level</u>:** ☐ None to Mild ☐ Moderate ☐ Highly stressed ☐ Work ☐ Home

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Patient Name: _____

HEALTH ASSESSMENT – PAST MEDICAL HISTORY

PAST MEDICAL HISTORY

If you are presently experiencing any of the symptoms or conditions listed below, please mark them in **YES** column. If you *ever* had any of the symptoms or conditions listed below in the past, please mark them in the **Past** *column.* **KNOWLEDGE OF THESE CONDITONS MAY ASSIST THE DOCTOR IN TYPE OF TREATMENT/THERAPY YOU RECEIVE.**

YES	Past	CONDITION
☐	☐	Neck Pain
☐	☐	Shoulder Pain · **R**ight ☐ **L**eft ☐
☐	☐	Pain in Upper Arm or Elbow **R** ☐ **L** ☐
☐	☐	Hand Pain · **R**ight ☐ **L**eft ☐
☐	☐	Wrist Pain · **R**ight ☐ **L**eft ☐
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip **R** ☐ **L** ☐
☐	☐	Pain in Lower Leg or Knee **R** ☐ **L** ☐
☐	☐	Pain in Ankle or Foot **R** ☐ **L** ☐
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headaches
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Ringing or Noises in Ear)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight **Gain** ☐ **Loss** ☐
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Breast **Soreness** ☐ **Lumps** ☐
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregular Bowel Habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

→ **Weight** ____ pounds **Height** ___ feet ____ inches

YES	NO	
☐	☐	Pregnancy; Number of Births: _____
☐	☐	Birth Control Pills, type: _____
☐	☐	Medications (list here) _____
		_____
☐	☐	Hospitalizations/Surgical Procedures:
		List/Explain: _____

YES	Past	CONDITION
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack Date: _____
☐	☐	Stroke Date: _____
☐	☐	Asthma
☐	☐	Cancer, Explain: _____
☐	☐	Tumor, Explain: _____
☐	☐	Prostate Problems
☐	☐	Blood Disorder _____
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis

YES	Past	CONDITION
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcers
☐	☐	Liver / Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV / AIDS
☐	☐	Other _____

FAMILY HISTORY

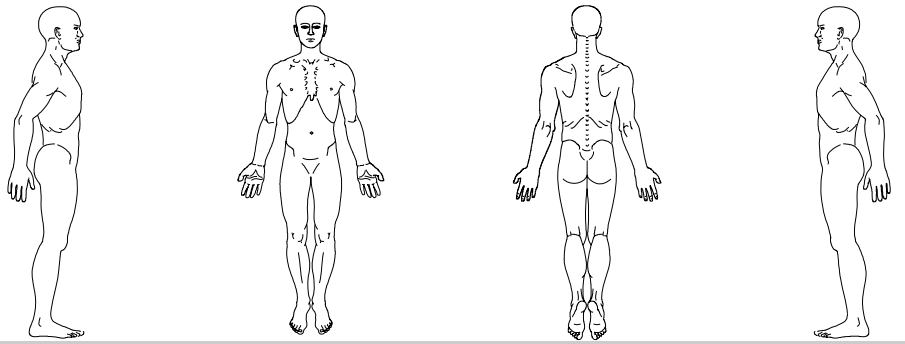
If a family member has had any of the following, please indicate.

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other _____
☐ High Blood Pressure	☐ Other _____

YES	Past	
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee / Tea / Caffeinated Soft Drinks > Cups/Cans per Day: _____

Yes	No	
☐	☐	Do you have a permanent disability rating?
		Location: _____
		Date Rating Received: ____/____/____
		Rating Percentage: _____ %

PLEASE MARK ON THE PICTURES BELOW WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF NUMBNESS, TINGLING, MUSCLE TIGHTNESS, SORENESS, ETC.



RIGHT SIDE **FRONT** **BACK** **LEFT SIDE**

I certify that the above information is complete and accurate to the best of my knowledge. I further understand that providing incorrect or misleading information may prevent me from getting the best care possible. I agree to notify the doctor immediately whenever I have changes in my health condition, changes in legal representation and health plan coverage in the future.

↘ **sign**

_____ _____

Patient's or Guardian Signature Date

I have reviewed the information contained on this form with the patient.

_____ _____

Provider Initials Date

Financial Agreement

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We are committed to providing you with the best possible care. The purpose of this agreement is to clarify the financial aspects of your care. This way we can devote our efforts to helping you get the best results in the shortest amount of time. Your clear understanding of our financial policy is important to our professional relationship. We would be pleased to discuss our professional fees with you at any time.

FORMS OF PAYMENT - We accept cash, checks, and most credit cards. Patients are responsible for full payment at the time of service. Any credit arrangements must be pre authorized.

GROUP OR INDIVIDUAL INSURANCE (PPO/HMO/POS Contracts)

Most insurance policies cover chiropractic care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage. As a courtesy to our patients we will bill your insurance directly. The normal office procedure is for the patient to pay any deductible amount at the beginning of care. In all cases, the initial examination must be paid at the time of services. If there is overpayment, we will promptly refund it. After the deductible is met, you are responsible for any percentage/co-payment amounts due. These are due at the time of service.

- Some insurance policies require physician referral. If insurance require pre-authorization, we may be able to get your care pre-authorized. However, you are responsible for necessary but unauthorized services.
- HMO (Health Maintenance Organization) policies such as with Kaiser, Some Medicare managed by a HMO as with Kaiser Senior Advantage and variety of other HMO plans only pays for manipulation of the spine. Therefore, you are responsible for payment for other adjunctive therapy services related to and necessary for the appropriate and adequate treatment of the condition. You will be informed of these additional fees in advance and you have the right to deny or refuse such therapies.
- If we are a participating provider with your insurance, we will handle your treatment claims according to our agreement with your insurance company.
- If your insurance requires reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.
- Any claims over 60 days will become the patient's responsibility. Please contact your insurance company on those claims and we may also assist you.
- Overdue accounts may be subject to an interest charge after 90 days and may be subject to collection attempts.
- Monthly or periodic statements are sent to inform you of your account activity.
- All patients are responsible for deductibles, co-payments, denied charges or any service not covered by your insurance.

PAYMENT PLANS - Payment plans may be arranged on a one-to-one basis during financial difficulties prior to treatment.

BILLING - Any outstanding balances are billed monthly and considered past due 15 days after the invoice date or when special arrangements are not met. Return checks are subject to a $35.00 fee. A balance older than 30 days will accrue interest charges of 1.5% per month, plus any legal or collection fees. Please be aware that your unpaid balance may be subject to be turned over to a collections agency.

PATIENT AGREEMENT - I have read and understand the above financial policy and I agree to comply under the terms described.

Patient Name	Patient/Responsible Party Signature	Date	Dr. Dilojan Abayaratna, D.C. Clinic Representative	Date

Arbitration Agreement

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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.

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, 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 or preceptorship 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.

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.

Patient Name	Patient/Representative Signature	Date	Indicate relationship if signing for patient

Clinic Representative Name	Clinic Representative Signature	Date
Dr. Dilojan Abayaratna, D.C.		

Revised: 6-1-2012

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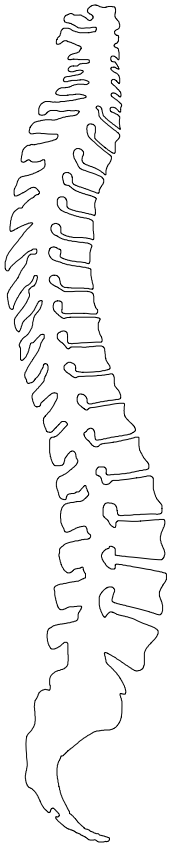
Dr. Dilojan Abayaratna, D.C

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT



Patient Name _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic 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 have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and I am being informed that, as in the practice of medicine, in this case with chiropractic care and like all other health modalities, results or outcomes are not guaranteed, and there is no promise of cure.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains or joint injuries. In isolated cases, there may be underlying physical defects, deformities or pathologies such as weak bones due to osteoporosis. When osteoporosis, degenerative disk, or other abnormality is detected, this doctor will proceed with extra caution. I also understand strokes involving chiropractic adjustments are rare, and according to recent statistics, about once in one million to once in ten million cases. Physiotherapy procedures in rare cases may cause minor burns and subsequent increase of pain and blistering. This should be reported to the doctor. Furthermore, I may experience soreness following the first few treatments; there is a rare possibility of having temporary symptoms like dizziness and nausea. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, that are in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

Reasonable alternatives to theses procedures, which may or may not be applicable to me at this time, have been explained to me including rest, home application of therapy, exercises, other medical referral for consultations and possible surgery.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to my signing this consent form. I further understand that I may receive treatment procedures rendered by an employee or a person trained and designated by the doctor, in the event where he is not available to render care to me. 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. I have made my decision voluntarily and freely and attest to my consent for treatment with my signature below.

_____ _____

Patient's Signature (Or Guardian/Parent/Representativ Date

Please sign, date and promptly return one copy to the front desk.