Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Email: _____
Social Security #: _____ Driver's Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____

_____

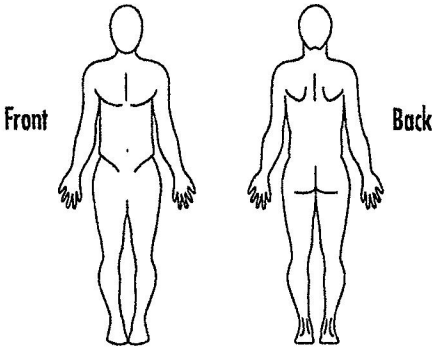
Is this? ☐ Work Related ☐ Auto ☐ Related ☐ N/A

DATE PROBLEM BEGAN: _____

Current complaint (How you feel today?)

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain



MARK AN "X" ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Can you perform your daily activities? ☐ Yes ☐ No Describe: _____

_____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ Yes ☐ No Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

NO	YES	CONDITION
☐	☐	History of Recent Infection
☐	☐	Recent fever
☐	☐	HIV / AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (Date)
☐	☐	Dizziness / Fainting
☐	☐	Numbness in Groin / Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer / Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

NO	YES	CONDITION
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births: _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy / Seizures
☐	☐	Visual Disturbances
☐	☐	History of Low / Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Surgeries / Medications: _____

_____

_____

_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____

Michael Goldman, D.C.
11620 Wilshire Blvd., Suite 710
Los Angeles, CA 90025

ALL INSURANCE PATIENTS: PLEASE READ

Dear Valued Patients:

We would like to share the following policies with you so that you understand your responsibility regarding charges for the services rendefed to you by our office:

Dr. Michael Goldman is a participating provider with most commercial U.S. insurance plans. We will gladly bill your primary and secondary insurance carriers, as a courtesy, for services rendered.
However, please be aware that you will be responsible for the payment of:

A – The annual deductible
B – Co-payments and/or Co-insurance amounts for your plan
C – Charges for non-covered services such as:

- **Active Release Technique**
- **Functional Evaluation**
- **Nutritional supplements, exercise equipment and orthopedic supplies if necessary**

If your insurance company denies coverage for a charge you thought was covered by your plan, you will be billed for that charge after we obtain denial from your insurance carrier.

Most insurance plans have a "co-insurance" amount which you will be billed for once we receive the Explanation of benefits from your insurance carrier for services rendered. Most insurance companies do not pay 100% of the contracted/allowed amounts, leaving a co-insurance balance to be paid by the patient. We recommend you contact the Member Services Department of your insurance company if you have questions about what is covered and amounts you will be responsible for.

In the event that your insurance carrier fails to pay for services rendered within the 90 days, you will be billed for any unpaid charges.

Patient due balances over 30 days will be assessed a 1.5% monthly (18% annual) service charge, unless other payment arrangements have previously been made with this office.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office. It also serves as an authorization for our office to charge the credit card you have placed on file for any outstanding balances.

For insurances that allow maximum dollar amount per visit, such as Guilds, MPIH, and SAG, your non-covered responsibility is the difference between the paid amount and the office minimum charge.

_____ _____

Patient/Responsible Party Signature Date

Michael Goldman, D.C.

INFORMED CONSENT FOR TREATMENT

My signature below certifies that I, _____, have read (or have read to me) this informed consent. I have had an opportunity to personally discuss it with a doctor or staff member and understand the following:

- In this office the chiropractic practice is augmented with the use of physiotherapy and rehabilitative exercise therapy. Although they might not be specifically licensed or degreed, the staff is skilled in the use of these adjunctive therapies. I personally request and consent to examination, diagnostic x-rays, and chiropractic treatments by the clinic's doctor. Further, I agree to any modality, manipulation, or rehabilitative exercises that the doctor feel is necessary in my case. I hereby give permission for clerical as well as health care staff to have access to my personal health records both during and after the time of treatment.
- When necessary, and with this document acting as proper release thereof, I hereby give (clinic and all staff) permission to release my records to legal and/or other health care professionals who present their request in a written and legal form.
- I knowingly and willingly accept treatment, understanding that although rare, there may be certain risks inherent with physical medicine, chiropractic, physiotherapy, and rehabilitative exercises and other clinical procedures. These risks rarely involve, but are not limited to, sprains/strains, spinal disc irritation, or in very rare incidents (with certain high-risk patients) stroke. I do not expect the doctor to anticipate, nor explain all of the risks, and/or complications that are possible. I will rely on the doctor's training and education or exercise professional judgment during the course of any procedure or protocol which he/she feels necessary based on the facts and diagnosis in my case, knowing that he/she will act in my best interests.
- This consent noted herein will remain in effect throughout my active treatment program until personally revoked by me.

Patient's Signature_____ Date_____

Print Name_____

11620 Wilshire Blvd., Suite 710 **Los Angeles, CA 90025**
Phone: 310.426.8229 **Fax: 310.477.4755** www.Goldman-Chiropractic.com