CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Health Connection of Tustin
Amy B. Friedman, DC
165 Yorba St.
Tustin, CA 92780
P (714)832-8747
F (866) 572-2498
www.HealthConnectionTustin.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes

When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Age

Gender
○ Male ○ Female

Race
○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American
○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White
○ Decline to answer

Ethnicity
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)
○ Never A Smoker ○ Former Smoker
○ Current Every Day Smoker ○ Current Some Day Smoker
○ Heavy Smoker ○ Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status ○ Married
○ Single ○ Divorced
○ Widowed ○ Separated

City | State/Province | ZIP/Postal Code | Preferred Language

Home Phone | Cell Phone | Spouse's Name

Email Address | Child's Name and Age

Emergency Contact | Emergency Contact's Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer | Work Phone

Address

May we contact you at work?
○ Yes ○ No

City | State/Province | ZIP/Postal Code

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

Primary Care Provider's Name

Insurance Carrier | Policy Number

Insured's Last Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

Insured's First Name | Insured's Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

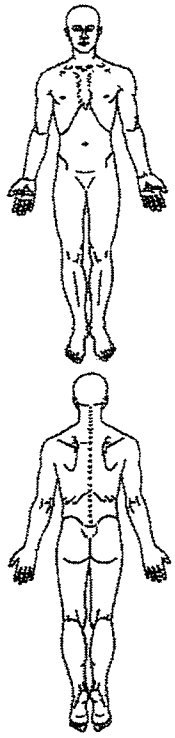
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



1. What else should Dr. Friedman know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	Initials ____

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Health Connection of Tustin
Amy B. Friedman, DC

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	Initials ____

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Low energy	○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	Initials ____

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Erectile dysfunction	○	○	PMS symptoms										

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	Initials ____

Had	Have		Had	Have		NONE ○
○	○	Weakness				

○ All other systems negative

Patient name _____

Patient Number (office use only) _____

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: _____

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

FAMILY

9. Family History

Some health issues are hereditary. Tell Dr. Friedman about the health of your immediate family members.

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	○	○	_____	_____	○	○
Father	_____	○	○	_____	_____	○	○
Sister 1	_____	○	○	_____	_____	○	○
Sister 2	_____	○	○	_____	_____	○	○
Brother 1	_____	○	○	_____	_____	○	○
Brother 2	_____	○	○	_____	_____	○	○
_____	_____	○	○	_____	_____	○	○

10. Are there any other hereditary health issues that you know about? _____

_____

SOCIAL

11. Social History

Tell Dr. Friedman about your health habits and stress levels.

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

Consultation Notes

Doctor's Initials

Health Connection of Tustin
Amy B. Friedman, DC

12. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? _____ **14. How much sleep do you average per night?** _____ **Hours**

15. What is the type and approximate age of your mattress and pillow? _____ **16. What is your preferred sleeping position?** _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

_____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

_____ _____
Patient (or Guardian's) signature Date (MM/DD/YYYY)

Consultation Notes

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Health Connection of Tustin
Amy B. Friedman, DC

Chiropractic Patient Information Form

Landmark Healthcare, Inc., 1750 Howe Ave., Suite 300, Sacramento, CA 95825

Practitioner Last Name	First Name	M.I.	License #	Phone #	Fax #

Patient to complete the following sections:

Patient Last Name	Patient First Name	M.I.	Gender ☐M ☐F	Age	Date of Birth (MM/DD/YYYY) / /
Insured I.D. or SSN	Insured Last Name	M.I.	First Name		Patient Daytime Phone
Patient Address	City		State		Zip
Employer Name	Insurance Company		Group Plan # or Union Local		
Is illness or injury related to: ☐Work ☐Auto ☐Other	Do you have other insurance that might cover this injury/illness? ☐Yes ☐No		If yes, please list other insurance company name:		

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), **circle** the number that best reflects your condition: ↓ none ..... to ..... severe ↓	Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:
1 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
2 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
3 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
4 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%

For each of the reasons or conditions listed above, please mark how it happened:

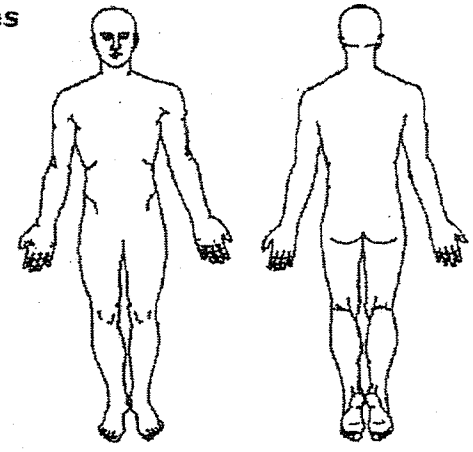
1. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know
2. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know
3. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know
4. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/ / / Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Running	☐	☐	☐
Resting in bed	☐	☐	☐
Intercourse	☐	☐	☐
Computer work/typing	☐	☐	☐
Normal work	☐	☐	☐
Household activities	☐	☐	☐
Recreational activities	☐	☐	☐
Other (list below)	☐	☐	☐
_____			

-Please Continue on Page 2-

Chiropractic Patient Information Form

Please continue ...

a. During what time of the day do you feel worse? _____

b. Do you sleep well? ❑ Yes ❑No What are your normal sleeping hours? _____to _____

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
❑ No ❑ Yes → For what condition? _____

Name of doctor/provider _____ Phone number _____

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
❑ No ❑ Yes If yes, please describe each event below:

Event _____ Year _____

Event _____ Year _____

e. Do you exercise? ❑ Yes ❑ No If yes, please describe activity _____

How many days a week? _____ How many minutes per session? _____

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- ❑ Neck pain with difficulty swallowing
- ❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain that worsens with exercise but is relieved by resting
- ❑ Loss of feeling in inner thighs
- ❑ Back pain with urinary problems

Types of pain

- ❑ Severe pain interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ❑ Unable to balance when walking
- ❑ Recent unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102°F
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Recent major accident such as a fall from height, whiplash or blow to the head
- ❑ Memory loss after injury

Previously diagnosed condition/ medical history

- ❑ Congenital bone or joint disorder
- ❑ Rheumatoid arthritis
- ❑ Severe degenerative arthritis
- ❑ History of compression fracture
- ❑ History of heart attack
- ❑ History of stroke or aneurysm
- ❑ Past history of cancer or currently diagnosed with cancer
- ❑ Diabetes with cold, burning or numb feet
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression such as from chemotherapy, organ transplant, etc.
- ❑ 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family history

❑ Autoimmune disorders ❑ Cancer ❑ Heart disease ❑ Mental illness
❑ Arthritis ❑ Diabetes ❑ Kidney disease ❑ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date: ____/____/____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ Relationship _____ Today's date: ____/____/____

AMY B. FRIEDMAN CHIROPRACTIC CORPORATION
OFFICE POLICY

You are ultimately responsible for any usual and customary charges incurred for any evaluations, treatment, or supply provided in your care regardless of expected payment by your insurance company or any other third party. Payment for the first visit is expected to be paid in full at the time of service unless other arrangements have been made. Our fee schedule is available for your review (Please ask our staff if you have any questions regarding our fees).

If you are covered for chiropractic under your health insurance plan we will verify your coverage and notify you of your responsibility. Billing your insurance is a service we provide through our billing company, Priority One Billing. You are responsible for payment of your co-pay on each date of service provided to you. You are responsible for any outstanding co-insurance percentage owed or deductible due as stated on your Explanation of Benefits processed by your insurance company.

If this is a work-related injury and we accept your case, we will obtain authorization for your care and complete the appropriate documentation as per the Labor code.

If this is an injury caused by a third party, arrangements must be made with the doctor. If you have health insurance or med-pay we will bill for you. If you have an attorney, they must sign a lien. Itemized statements will be sent regularly to update your attorney regarding your care received. In the case of a third party (See third party agreement) you are responsible for paying any outstanding balance on your account from the proceeds paid to you directly for your case. You are ultimately responsible for paying your balance in full.

All nutritional supplements and orthopedic supplies must be paid in full at the time received regardless of insurance coverage. (Most policies do not cover these items.)

We reserve the right to charge a full visit fee for any chiropractic or massage appointment missed or cancelled with less than 24 hour notice.

All accounts inactive over 60 days are considered overdue and are subject to collections.

INFORMED CONSENT
FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to receive chiropractic adjustments, physiotherapeutic procedures and chiropractic by Dr. Amy Friedman.

I understand that there are rare but possible risks to chiropractic treatment.

These include, but are not limited to, fractures, disc injuries, dislocations, sprains/strains, burns or frostbite (physical therapy), and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications (although they would be more than happy to do so if requested). I wish to rely on the doctor's experience and expertise to exercise good judgment when choosing the most safe and effective course of care based upon my history, physical exam and x-ray findings.

I have read, or have had read to me, the above consent. I understand that I have the opportunity to ask any questions before receiving treatment. By signing below I consent to care for the entire course of treatment for my present condition and for any future conditions for which I seek consultation and treatment.

AUTHORIZATION AND ASSIGNMENT

I authorize Dr. Amy Friedman to release any information that she deems appropriate concerning my treatment and physical findings to any insurance company, attorney, doctor or insurance claims adjuster in order to process any outstanding claims for reimbursement of charges incurred or for obtaining authorization for care if necessary.

I authorize the direct payment to Dr. Amy Friedman for any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case and/or 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.

This authorization and assignment is irrevocable and ongoing until all monies owed have been satisfied and paid in full. It will be in continual effect. A photocopy shall be as valid as the original document.

OFFICE POLICY

I acknowledge that I have read and understand the Amy B. Friedman Chiropractic Corporation Office Policy regarding my financial responsibility, insurance billing, worker's compensation or personal injury cases, massage therapy, and supplies.

_____

Printed name of practice member

_____ Date_____

Signature of practice member or guardian

_____

Name of parent or legal guardian

Amy B. Friedman, D.C.
Health Connection of Tustin

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

165 Yorba St.
Tustin, CA 92780

(714) 832-8747
(866) 572-2498 Fax
www.HealthConnectionTustin.com