

Koyama Chiropractic and Acupuncture Clinic

12629 West Washington Blvd. Los Angeles, CA 90066 | Telephone: 310-391-6125 | FAX: 310-391-7117

Date: _____

Last Name: _____ First Name: _____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Telephone: (H) _____ (C) _____

Email: _____

Date of Birth (mm/dd/yr): _____ Social Security#: _____

Age: _____ Gender: M / F Ht: _____ Wt: _____ Marital Status: _____

Occupation: _____ Employer/Phone#: _____

Emergency Contact: _____ Relationship: _____

Home#: _____ Cell#: _____

How did you hear about us? Please specify (Facebook, VJCC etc): _____

Whom may we thank for your referral? _____

Primary physician: _____ Ph#: _____ Fax#: _____

Address: _____

City: _____ State: _____ Zip: _____

Result/diagnosis: _____

Date of last physical exam: _____ Date of next physical exam: _____

Are you claiming all or part of our fee under insurance? If so, please provide:

Name of Primary Insurance Company: _____

Name of Responsible Party/Spouse: _____

Social Security# of Insured: _____ Birth Date of Insured: _____

Policy ID#: _____ Group#: _____

Name of Secondary Insurance Company: _____

Name of Responsible Party/Spouse: _____

Social Security# of Insured: _____ Birth Date of Insured: _____

Policy ID#: _____ Group#: _____

NEW PATIENT QUESTIONNAIRE

Primary Complaint: _____

How long have you had? _____ If you had this before, when? _____

What makes it better? _____ What makes it worse? _____

If experiencing pain, intensity in the pain scale 1-10: _____ (0: no pain and 10 worst pain ever)

What kind of pain? (stabbing, dull etc) _____

List all surgery/injury/hospitalization (Also list dates)

Do you currently have? Pacemaker Metal Implants Pregnant

Allergies: _____

Please indicate if you had (or currently have) any of the following:

Hepatitis HIV (AIDS) Skin disease (or infection) Herpes STD

Other infectious disease: _____

Medications (List all including prescription drugs, vitamins, supplements, herbs)

Name: _____ For: _____ Dosage: _____ How long: _____

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Name: _____ For: _____ Dosage: _____ How long: _____

Have you experienced any of the following in the last 12 months?

Recurring persistent infection in bladder skin gums genitals

Sudden weight loss of 10 pounds or more Bruise easily Decreased energy

Change in bowel function (constipation, diarrhea, black stool, difficulty controlling): _____

Change in urinary function (frequency, incontinence, dark urine, bloody): _____

YOUR Medical History

Cancer HIV Diabetes Heart Disease High Blood Pressure Low Blood Pressure Stroke Epilepsy

Asthma Kidney Disease Anemia Bleeding Disorder STD Hepatitis Jaundice Thyroid Disease Chronic

Fatigue Sudden Weight Gain Others _____

FAMILY Medical History

Cancer HIV Diabetes Heart Disease High Blood Pressure Low Blood Pressure Stroke Epilepsy

Asthma Kidney Disease Anemia Bleeding Disorder Hepatitis Thyroid Disease

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OUR PATIENT CARE FINANCIAL AGREEMENT POLICY

Dear Patient,

Thank you for choosing Koyama Chiropractic and Acupuncture Clinic, as your healthcare provider. We are committed to your treatment being successful, and our office policy has been established to ensure that the best health service can be provided to you and your family. Thank you for understanding our financial policy. Please let us know if you have any questions.

Missed Appointments and Cancellations

In order to prevent being charged a cancellation fee we agree to, give at least 24 hours notice of cancellation. Sufficient cancellation notice allows us to offer your time to another patient who may be waiting for an appointment. Uncanceled or missed appointments without 24 hours notice will be charged full amount. For patients arriving more than 15 minutes late, you may be asked to reschedule your appointment if there is not sufficient time to provide the best treatment to you, or to have shortened session. We will do our best to provide sufficient treatment as schedule permitted. Please help us provide the best care to you by keeping scheduled appointments in a timely manner. Late cancellation due to emergencies are understandable, in those cases the cancellation fee will be waived.

Insurance

Please remember that medical services are rendered to you, not to your insurance company. Check with your insurer to find out if chiropractic or/and acupuncture is/are included in your benefits. We are happy to verify your coverage for you after your first session. Important: until we can verify your coverage, payment is due in full at the time of each visit. If you have insurance that covers chiropractic and acupuncture, we will do our best to determine what co-pay amount you are responsible for. We will submit and process your claims to receive partial payment. The full cost of services is ultimately your responsibility, even if your insurance provider denies payment for any portion of your bill for any reason. Some insurance companies send payments directly to the patient. In this case, we ask that you pay for services in full at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance programs. Insurance companies do not reimburse for cancelled sessions. Please note that supplements and/or herbal formulas supplied as part of your treatment are no typically covered by insurance.

Rate Schedule

- Comprehensive New Patient Initial Consultation, including Chiropractic Treatment: \$100.00
- Established Patient Consultation & Chiropractic Treatment: \$60.00
- Re-examination: \$70.00
- Medical Report: \$200.00 per case
- Support, braces and supplement: prices vary from \$10 - \$50

Unused braces/supports and unopened supplements may be returned for a full refund. There is a \$25 fee for all returned checks. Payment is due in full at time of service.

My signature below certifies that I have read and understand the above Financial Policy and agree to be responsible for full payment of all services rendered to myself and/or any member of my family.

X _____ Date _____

Signature of Patient or Responsible Party

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PRIVACY RIGHTS/HIPAA NOTICE

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Authorization for other uses of Protected Health Information (PHI)

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific description of the information to be used or disclosed, including the specific purpose: Office promotions, holiday/birthday cards, newsletters, change of address for individuals who may use or disclose this information.

Expiration date of this Authorization: Ongoing until patient indicates in writing otherwise

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above.

You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

I hereby acknowledge that I have received a copy of Koyama Chiropractic and Acupuncture Clinic’s Notice of Privacy Practices.

Patient Name (Please Print) _____

Patient Signature _____ Date _____