FEY CHIROPRACTIC
— AND —
THOUSAND OAKS SPINE

PATIENT INFORMATION

Last Name _____ First _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Cell Phone (___)_____ Home (___)_____ Work(___)_____

Date of Birth _____ Social Security No. _____ - _____ - _____

Sex: M / F _____ Pronouns_____Marital Status: Single / Married / Divorced / Widowed

E-Mail address _____

Who may we thank for referring you _____

EMPLOYER INFORMATION

Patient's Occupation _____

Employer Address _____

Employer Phone (___)_____ If Student, School _____

SPOUSE INFORMATION

Spouse's Name _____ Date of Birth _____

Spouse Phone _____

INSURANCE INFORMATION

Who is responsible for this account _____

Relationship to Patient _____ Phone (___)_____

Insurance Company _____

ASSIGNMENT AND RELEASE FOR INSURANCE

I certify that I (and my dependents) have insurance coverage with the above company and assign directly to Pierre Fey, D.C., Nicole Chiaro D.C., Fey Chiropractic, Thousand Oaks Spine & Injury Center, all insurance benefits, if any, payable for services rendered. I understand that I am fully financially responsible for charges that my insurance company will not cover if they say that an office visit, procedure or treatment is "not medically necessary", "preexisting", "deductible", or other related reason for non-payment. I also understand that what my carrier considers "non-medically necessary" may, on the contrary, be considered medically necessary by this office and its doctors. Therefore, I agree to hold Pierre Fey D.C.,Nicole Chiaro D.C., Fey Chiropractic, Thousand Oaks Spine & Injury Center harmless for any medical decisions made by my insurance/managed care carrier which may in any way compromise my best care and result in medical damage, loss or death. I authorize to release pertinent medical information to my insurance company when requested to or to facilitate payment of a claim. Your signature at the end of this document acknowledges you understand this and authorize this office to submit and collect from insurance for services rendered.

INITIAL YOU HAVE READ THE ABOVE: _____

****If you have your card please hand to front desk for a copy and skip to emergency contact**

ID# _____ Group # _____

Insurance Phone (___)_____ DOB of subscriber _____

EMERGENCY CONTACT

Name _____ Phone (___) _____

Name _____ Phone (___) _____

~ TURN OVER ~

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

FINANCIAL POLICY

As a courtesy, this office will bill your private health insurance if you have Chiropractic or Physiotherapy benefits. If previously requested, our office will pre-verify benefits for coverage.

****All insurance companies clearly state that even with a verbal, written or online verification of benefits, you are never guaranteed coverage. Ultimately, it is the patient's responsibility to know and understand their own insurance policy, co-pays, coinsurance, deductibles, pre-existing.**

- It is the patient's responsibility to provide accurate and complete personal and insurance information.
- We are **not** a participating provider for Medi-Cal or HMO policies COVERED CA does not have any coverage for chiropractic or massage.
- All applicable co-pays, coinsurance, deductibles, and personal balances (current and prior) are due at the time of service. Massages are not covered and are the patient's responsibility to pay.
- If you do not have insurance coverage all balances due must be paid at the time of service.
- Payment can be made by cash, check, Visa, MasterCard or AMEX.
- There will be a charge of $35.00 for all returned checks.
- There will be a charge of $30.00 charge for a cancelled massage or missed massage appointment without a 24- hour cancellation.
- Insurance processing can take up to 2 years. You, the patient, are always responsible for any services that insurance denies. Our office will bill, re-bill and appeal on your behalf. If the insurance service is denied you are ultimately responsible for all services rendered.
- All accounts that are sent to collections, including bankruptcy, will be discharged from this office and not permitted to return as a patient. There will be additional collection agency fees and service fees beyond your original balance if you are sent to collections.
- Auto Accident and 3rd party checks need to be endorsed within 30 days of receipt. A 18% finance charge will be incurred each month for non-payment.

ACKNOWLEGMENT AND SIGNATURE

I understand, and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand the Pierre Fey D.C., Nicole Chiaro D.C., Fey Chiropractic, Thousand Oaks Spine & Injury Center will prepare any necessary reports and forms to assist me in billing my insurance. I authorize this facility to be paid directly and if I receive any payment will endorse the check directly upon receipt back to this office. I acknowledge the above financial policies and understand them fully.

I hereby authorize this facility to examine and treat my, and my dependents, conditions deemed appropriate through the use of chiropractic and physical medicine modalities. I give authority for those procedures to be performed on myself and my dependents. All digital X-Rays will remain on the server in this facility unless requested by the patient. Patient may obtain copies of all records, reports and X-Rays upon request. Copy fees may apply.

I recognize that the practice of chiropractic and physiotherapy is not an exact science, and Pierre Fey D.C., Nicole Chiaro D.C., Fey Chiropractic, Thousand Oaks Spine & Injury Center and all of its associates do not guarantee the results of treatment.

Patient Signature_____ Date _____

Minor Name_____ Date_____

Authorization to treat Minor, Parent or Guardian Signature_____

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PATIENT HISTORY

NAME _____ When did you first notice this problem ____/____/____

Height_____'_____" Weight_____ Age_____ Sex at Birth: ☐ Male ☐ Female

Have you ever seen a Chiropractor before? ☐ Yes ☐ No

Have you had: ☐ MRI ☐ X-RAY ☐ CT-SCAN ☐ Spinal Exam

What treatment have you received for this condition? _____

Name of the doctor(s) who have treated you for this condition _____

INJURIES/SURGERIES	DESCRIPTION	DATE
Accidents/ Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Have you been hospitalized? If YES, why and when _____

NEUROPATHY SYMPTOMS

☐ Hand/Foot Pain	☐ Burning Eyes	☐ Vertigo	☐ Loss of Concentration
☐ Low Back Pain	☐ Degenerative Disc	☐ Lightheaded	☐ Vascular Problems
☐ Hand/Foot Numbness	☐ Herniated Disk	☐ Balance Impairment	☐ Spinal Stenosis
☐ Neck Pain	☐ Bulging Disc	☐ Leg Pain	☐ Sciatica
☐ Poor circulation	☐ Joint Replacement		

PAST OR PRESENT SYMPTONS & CONDITIONS

☐ Aids/HIV	☐ Diabetes	☐ Herniated Disk	☐ Mono	☐ Prosthesis
☐ Anemia	☐ Emphysema	☐ Herpes	☐ Nausea	☐ Psychiatric Care
☐ Appendicitis	☐ Epilepsy	☐ High BP	☐ M S	☐ R A
☐ Arthritis	☐ Eating Disorder	☐ High Cholesterol	☐ Osteoporosis	☐ Ringing in Ears
☐ Asthma	☐ Gout	☐ Jaw Pain/TMJ	☐ Pacemaker	☐ Stroke
☐ Blood Clots	☐ Headache	☐ Kidney Disease	☐ Parkinson's	☐ Thyroid Disease
☐ Cancer _____	☐ Heart Disease	☐ Liver Disease	☐ Pinched Nerve	☐ Tumors
☐ Chemical dependent	☐ Hepatitis	☐ Loss of Memory	☐ Pneumonia	☐ Ulcers
☐ Depression	☐ Hernia	☐ Migraine	☐ Polio	☐ Visual Disturbances

☐ Other Conditions:_____

~ TURN OVER ~

When did your symptoms begin? _____

Is this condition getting progressively worse? ☐YES ☐NO ☐UNCERTAIN

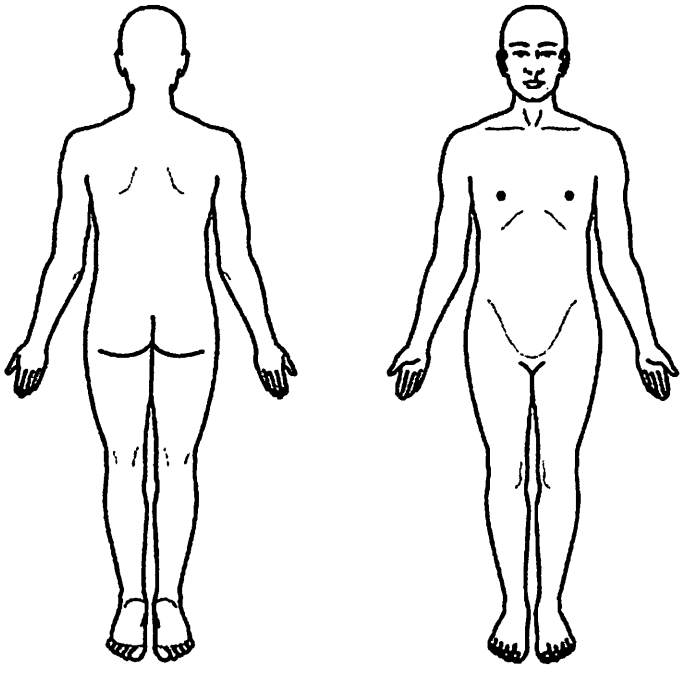
Are you pregnant? ☐YES ☐NO ☐UNCERTAIN

Exercise? ☐NONE ☐MODERATE ☐DAILY ☐ HEAVY

Work Activity? ☐SITTING ☐STANDING ☐LIGHT LABOR ☐HEAVY LABOR

Lifestyle: ☐SMOKE_____ PACKS A DAY ☐CANNIBIS USE _____ A DAY

☐DRINK _____A WEEK_____A MONTH ☐CAFFINE_____ A DAY _____ A WEEK



Mark an "X" for PAIN
Mark a "B" for BURNING
Mark a "N" for NUMBNES
Mark a "T' for TINGLING

Pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

Is the pain constant or does it come and go? _____

Does this interfere with:

☐Work ☐Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform:

☐Sitting ☐Standing ☐ Walking ☐ Bending

OTHER INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT:

_____

_____

_____

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CANCELLATION POLICY FOR PROCEDURES

We understand that our patients lead busy lives and are sometimes not able to keep appointments. We ask for your cooperation in calling at least 24 hours ahead of time if you need to cancel your massage appointment so that we have time to schedule another patient for that time..

Please note that there will be a fee of $30 charged to you if you cancel less than 24 hours before your massage or miss your massage completely. We reserve our massage therapists' time when we make your appointment, and we are usually not able to schedule another patient in that time slot if you cancel too close to your appointment time. Please understand that this fee is not payable by your insurance company.

If you have any questions, please don't hesitate to call us during office hours.

Thank you,

Fey Chiropractic Team

I understand this policy and agree to abide by it.

_____ _____

Patient Signature Date

128 Auburn Court Suite 100 ~ Westlake Village, CA 91362

P. 805-495-0110 F. 805-495-1390

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INFORMED CONSENT CHIROPRACTIC TREATMENT

TO THE PATIENTS: You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved in treatment. This information will assist you in making an informed decision whether to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the doctor my diagnosis and the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits to alternative treatment, including no treatment at all.

I understand there are some risks, although EXTREMELY RARE, to chiropractic treatment including, but not limited to:

- Broken bones
- Dislocations
- Sprains/strains
- Burns of frostbite
- Worsening/aggravation of spinal conditions
- Increased symptoms and pain
- No improvement of symptoms or pain

In rare cases there have been reported complications of arterial dissections (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions. All my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

Print Name

Patient Signature

Date signed

To be completed by the patient's representative:

Print name of patient (minor)

Print name of patient's representative

Signature of patient's representative

Relationship to Patient

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