PATIENT INFORMATION

Name_____ Birth date_____ Age_____

Address _____ Cell phone _____

City_____ State _____ Zip Code _____ Home Phone _____

E-mail _____

Employer's Name _____ Position _____

Marital status – *circle one* [S M W D] Are You Insured? [Y N] Ins. Company _____

Spouse's name _____ Are you Pregnant? [Y N] Number of children _____

Referred by _____

Have you had chiropractic care before? _____When?_____

What is your current complaint? _____

Is this condition due to:

□ Auto accident □ Work injury
□ Other accident □ Illness
□ Unknown cause

Date symptoms appeared
_____

Are symptoms:
□ Improving
□ About the same
□ Getting worse
□ Intermittent [come and go]

Check any activities which aggravate your condition:

□ Standing □ Lying
□ Bending □ Coughing
□ Twisting □ Walking
□ Sitting □ Lifting

Other health issues not chiropractic issues:
_____
_____
_____

List all prescription drugs you now take:
_____
_____
_____
_____

List all non- prescription drugs you now take:
_____
_____
_____

Have you had these symptoms Before?
□ No
□ Yes When? _____

List all previous accidents:
_____
_____
_____

Check here if you
□ smoke
□ don't exercise regularly

Are you allergic to any medications? □Yes □No **If yes, please list:** _____

Who is your general practitioner? Dr. _____

List all surgical operations:

_____

_____

Check here if you have a family history of :
□ arthritis
□ cardiovascular disease
□ diabetes
□ cancer

Please check the type of care desired so that we may be guided by your wishes when possible:

[ ] Temporary relief [ ] Control of immediate problem [ ] Total healthcare [ ] I prefer the Dr. to select the type of care he feels is best for me

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: _____ _____ ____Hour _____ AM __ PM __ Location _____ _____

How did Accident Occur? □ Auto Collision □ On-the-Job Injury □ Other _____

If not an auto collision, please describe the circumstances:

_____

Did you report the injury to your foreman or employer □ YES □ NO

Did he (they) recommend care at our office? □ YES □ NO

If auto accident, were you: □ Driver □ Passenger □ Pedestrian

Type of your vehicle:_____

Type of vehicle that hit you:_____

If auto collision, were you struck from: □ Behind □ Right Side □ Left Side □ Front □ Auto was Parked

Did your car strike the other(s) involved? □ YES □ NO

OR did the other car strike yours? □ YES □ NO □ UNDETERMINED

As a result of the accident, were traffic citations issued to you? □ YES □ NO

To the driver of the other car? □ YES □ NO To the driver of your car? □ YES □ NO

Your approximate speed: _____mph Other vehicle approximate speed: _____mph

Seatbelt: □ YES □ NO Looking straight/Right/Left Hands on steering: Left/Right/None

Did you see the accident coming before the impact? □ YES □ NO

What occurred at the moment of impact? (Check ALL that apply)

□ Tensed body for impact □ Neck whipped backward & forward □ Thrown from side to side

□ Body torqued & twisted □ Thrown from the vehicle □ Pinned in vehicle □ Bruised □ Cut

List the extent of the injuries as you know them

_____

Did you require post-accident hospitalization? □ YES □ NO Were you unconscious? □ YES □ NO

List hospital/ER/Urgent Care:_____ Any X Rays/Images taken? □ YES □ NO

Check symptoms you have noticed since accident:

□ Headache	□ Dizziness	□ Light Bother Eyes	□ Diarrhea
□ Neck Pain	□ Head Seems Too Heavy	□ Loss of Memory	□ Feet Cold
□ Neck Stiff	□ Pins and Needles in Arms	□ Ears Ring	□ Hands Cold
□ Sleeping Problems	□ Pins and Needles in Legs	□ Face Flushed	□ Stomach Upset
□ Back Pain	□ Numbness in Fingers	□ Buzzing in Ears	□ Constipation
□ Nervousness	□ Numbness in Toes	□ Loss of Balance	□ Cold Sweats
□ Tension	□ Shortness of Breath	□ Fainting	□ Fever
□ Irritability	□ Fatigue	□ Loss of Smell	□_____
□ Chest Pain	□ Depression	□ Loss of Taste	□_____

Symptoms other than above _____

Have you lost any days of work? □ YES □ NO Dates: _____

Insurance Companies involved:

My Company_____

Company of person responsible for injuries? _____

Have you been contacted by an insurance adjuster or company representative regarding this claim?

□ YES □ NO

Amount of damage to your vehicle $_____

□ Minor Damage □ Moderate Damage □ Total Loss

Amount of damage to the other vehicle $_____

□ Minor Damage □ Moderate Damage □ Total Loss

Do you have an attorney that has advised you in this care? □ YES □ NO

Attorney Name:_____

Mailing Address:_____

Phone Number:_____

Fax Number:_____

Ref/Claim Number:_____

Patient Name:_____

Date of Injury:_____

Date of Birth:_____

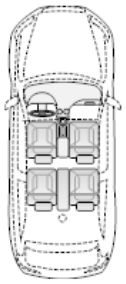
_____ _____ _____

Patient Name **Patient Signature** **Date**

DNA Sports Medicine & Wellness

Patient Name:_____ Date:_____

DIAGRAM OF ACCIDENT



Date of Accident:_____

Description of Accident

How you feel immediately after the accident?

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Dr Christopher Tsai, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of above signature Relationship to Patient

X-Ray Consent

I hereby give my consent to USA Sports Development – Dept of Sports Medicine and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

_____ _____

Patient Signature Date

Clinical Summary (a required EMR question)

___ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Affidavit

I, the undersigned, declare as follow:

1. That at the accident occurring the _____ day of _____, 20_____, in the vicinity of _____, I was present in the vehicle involved, and I sustained injuries as a result of said accident.

2. I further declare that prior to the accident; I had no knowledge regarding the driver of the other vehicle involved.

3. I understand that according to the laws of State of California bringing of a fraudulent claim is crime punishable by imprisonment and/or fine, and that I declare that the above mentioned accident was not fraudulent in any manner

4. I have read and understood the foregoing.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this _____ day of _____ , 20_____

_____ _____

Patient Name **Patient Signature**

ATTORNEY-PATIENT LIEN AGREEMENT TO PAY DOCTOR

TO: LAW OFFICE OF _____

_____

_____

RE: MEDICAL REPORTS AND DOCTOR'S LIEN

PATIENT: _____DATE OF ACCIDENT: _____

I do hereby authorize the above clinic to furnish you, my attorney, with a full report of his examination, diagnosis, treatments, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said clinic (doctors) such sums as may be due and owing him for medical service rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said clinic (doctors). And I hereby further give a Lien on my case to said clinic (doctors) against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said clinic (doctors) additional protection ad in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said clinic (doctors) of any change or additions of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by singing below and returning to the clinic. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

DATED:_____PATIENT SIGNATURE:_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said clinic (doctors) name above. Attorney further agrees that in the event this lien or the underlying debt is litigated, the prevailing party will be awarded reasonable attorney's fees as well as costs.

DATED:_____ATTORNEY SIGNATURE:_____

Attorney: please date, sign and return one copy of this lien to doctor's office at once. Reply envelope attached. Keep one copy for your records.

DATED:_____DOCTOR SIGNATURE:_____

Mail: 4021 W Burbank Blvd
Burbank, CA 91505

301 W Huntington Dr #217
Arcadia, CA 91007

Fax: 818-848-7701

Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy 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 whole 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 the office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. The doctor will use his/her hands or a mechanical device to manipulate the area treated. I may feel or hear a "click" or "pop" and may feel movement. Chiropractic treatment also includes activity advices, exercise, hot/cold packs or electric stimulation. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further 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, sprains, irritation of nerves or spinal cord or in rare incidences death. 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 to which the doctor feels at the time, based upon the facts then known, is in my best interests. I will inform my chiropractor of all medications I am taking, including blood thinners, any surgeries I have had, and any other medical conditions I have, including osteoporosis, heart disease, cancer, stroke, fracture of previous severe injuries.

I further understand that there are treatment options available for my conditions 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 pain-killers; 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.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Cancellation Policy. Please call 24 hours in advance for any cancellations or to reschedule, otherwise you will be charged for a missed appointment. The charge for missed appointment is your responsibility and not billable to your insurance carrier. If you are late to your scheduled massage, you will only receive the remaining time of the appointment but will be responsible for full payment.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**
_____	_____	_____
Doctor Name	**Doctor Signature**	**Date**

DNA
SPORTS MEDICINE & WELLNESS

DNA Sports Medicine & Wellness

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether and 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 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 healthcare provider including any errors 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 occurrence giving rise to any claim. This agreement was intended to bind the patient and healthcare provider and/or licensed healthcare providers or preceptorship/postceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as back-up for the health care provider, including those working at the health care providers 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 healthcare 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, and 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 third arbitrator (neutral arbitrator) she'll be selected by the arbitrator's appointed by the parties within 30 days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such parties pro rata share of the expenses and fees of the new show arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including council 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 damaged 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 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 judgement for future damages can form data 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 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 IP YOUR RIGHT TO A JURY OR COURT TRAIL. SEE ARTICLE 1 OF THIS CONTRACT

_____	_____	_____
Patient Name	**Patient Signature**	**Date**
_____	_____	_____
Staff Name	**Staff Signature**	**Date**