DNA Sports Medicine & Wellness

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

_____

Check any activities which aggravate your condition:

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

List all prescription drugs you now take:

_____
_____
_____
_____

Are symptoms:

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

Other health issues not chiropractic issues:

_____
_____
_____

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**

X-Ray Consent

I hereby give my consent to DNA 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.)*

Financial Responsibility,

DNA Sports Medicine provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.
I have read and understood all the above information.

_____ _____
Patient Signature Date

Credit Card Authorization Payment, Recurrent/Treatments

I hereby give my consent to DNA Sports Medicine (Dr Chris Tsai, a professional chiropractic Corp) and its representatives to authorize regularly scheduled charges on my credit card. The charge will appear on your credit card statement as Dr Chris Tsai. I agree that no prior notification will be provided. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to provide written notice of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of US law. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization. I also understand that if I do not cancel my appointment 24 hours prior to appointment or missed my appointment, the credit card on file will be charged the full amount for that treatment.
I have read and understood all the above information.

_____ _____
Patient Signature Date

Minor Consent

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of_____,
(Name of minor)
a minor, do hereby authorize DNA Sports Medicine doctors and any therapists working within for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

_____ _____
Parent/Legal Guardian Signature Date

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 or preceptorship/postceptorship and interns 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 advice, 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 painkillers; 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**

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**

Credit Card Information

Credit Card Type: VISA MC AMEX DISC Verification Code: _____

CARD NO._____EXP. DATE_____

NAME ON CREDIT CARD:

_____
(PLEASE PRINT)

BILLING INFORMATION:

Billing Address_____Phone Number _____

City, State_____Zip Code_____

BY MY SIGNATURE BELOW, I AUTHORIZE, BIOMECHANICAL SERVICES INC. TO CHARGE THE ABOVE CREDIT CARD ACCOUNT. I UNDERDSTAND THAT A TRANSACTION AMOUNT WILL APPEAR ON MY STATEMENT UNDER THE MERCHANT'S NAME OF: "Dr Christopher Tsai, A Professional Chiropractic Corp.".

SIGNATURE_____DATE_____
(REQUIRED)