ACTIVE THERAPY CENTER

Patient Registration Date of Visit: _____/_____/_____

First Name: _____ Last Name: _____

Preferred Name: _____

Patient Information

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____ Referred By: _____

Birth Date: _____/_____/_____ Age: _____ Social Security #: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Insurance Information

Insurance Company: _____ Address: _____

Name of the insured: _____ Relationship to insured: Self Spouse Child

Insured ID number: _____ Insured Birth Date: _____

Insured's Employer & Address: _____

Patient is (Please circle one): Policy Holder Spouse of Policy Holder Responsible Party

Do you have a Secondary Insurance: Yes No

Reason for Your Visit

Have you ever been treated by a Chiropractor before? Yes No

If so, please explain what you were treated for & when:_____

The reason for this visit is a result of (please circle all that apply): trauma or chronic sports work auto

Explain how your injury occurred: _____

When did the condition begin? _____/_____/_____

Please describe the pain and its location: _____

Is this condition getting worse? Yes No Constant Comes and goes

Is this condition interfering with your (please circle): Work Sleep Daily routine

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Are you receiving treatment by a Medical Physician for this condition? Yes No

If so, what is the name of the treating physician? _____

Medical History

Please mark to indicate if you have or have had any of the following:

☐ AIDS/HIV	☐ Cancer	☐ Gout	☐ Multiple Sclerosis	☐ Stroke
☐ Alcohol Abuse	☐ Cataracts	☐ Heart Disease	☐ Mumps	☐ Suicide Attempt
☐ Anemia	☐ Chicken Pox	☐ Hepatitis	☐ Osteoporosis	☐ Thyroid Problems
☐ Anorexia	☐ Diabetes	☐ Hernia	☐ Pacemaker	☐ Tonsillitis
☐ Appendicitis	☐ Drug Abuse	☐ Herpes	☐ Pneumonia	☐ Tuberculosis
☐ Arthritis	☐ Emphysema	☐ High Cholesterol	☐ Pollo	☐ Tumors
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Prostate Problems	☐ Typhoid Fever
☐ Blood Disorders	☐ Fractures	☐ Liver Disease	☐ Psychiatric Care	☐ Ulcers
☐ Breast Lump	☐ Glaucoma	☐ Measles	☐ Rheumatoid Arthritis	☐ Vaginal Infections
☐ Bronchitis	☐ Goiter	☐ Migraines	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bulimia	☐ Gonorrhea	☐ Mononucleosis	☐ Scarlet Fever	☐ Whooping Cough

Illness, Injury or Surgery	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any allergies: _____

Please list any medications you are currently taking: _____

Please list any vitamins/nutritional supplements you are taking: _____

Do you have any medical problems that you want to discuss with the doctor prior to your exam? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If so, how much (Pack/week)? _____ How long?_____

Do you wear (mark all that apply): ☐ Heel lifts ☐ Sole ☐ Inner soles ☐ Arch Supports

How often do you exercise (select from the following):

☐ No Exercise ☐ Light Exercise ☐ Moderate Exercise ☐ Heavy Exercise What type: _____

Women Only

Are you taking Birth Control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If so, how many months? _____ Are you nursing? ☐ Yes ☐ No

In The Event Of Emergency

Who should we contact? _____ Relation: _____

Home Phone #: _____ Cell Phone #: _____

The information provided on this form is true to the best of my knowledge. I understand that I may be billed administrative and filling fees for withholding information as it relates to my medical history and insurance coverage.

Print Name: _____

Signature: _____ Date: _____/_____/_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand however may also be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternative of chiropractic care have been explained to me to my satisfaction. I have read and full understand the above statements and therefore accept chiropractic care on this basis.

_____ _____

Print Name Signature

_____

Date

Consent to evaluate and adjust a minor:

I, _____ being the parent or legal guardian for _____ have read and fully understand the above *Informed Consent* and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

ACTIVE THERAPY CENTER

3435 Ocean Park Blvd.
Suite 101
Santa Monica, CA 90405
Phone: (310) 399-0337 Fax: (310) 399-3944

I hereby acknowledge that I am receiving (or about to receive) health care services at:
Active Therapy Center

I have been advised that the doctors (s) providing the services is/are willing to bill my group health insurance for these services, provided that there continues to be a reasonable chance that payment will be made by the insurance carrier.

Furthermore, I understand that if any of the following is determined by my health plan; I agree to accept financial responsibility for all services rendered to myself or any member on my health plan.

These include but are not limited to:

1. My insurance provider refuses to acknowledge or denies claims based on;
    a. Deductible not being met.
    b. Co-insurance/Co-pay amounts being patient responsibility.
    c. Medical Necessity
    d. Max benefit coverage has been reached on the health plan.

2. My health plan denied claims due to my negligence in responding to any questionnaire or information requested of me or any member on my health plan.

3. I acknowledge my insurance carrier may send, directly to me, monies meant for reimbursement to the Company for services provided. In the event I receive this reimbursement, I agree to endorse and forward to the Company within five (5) business days of the day of receipt. I understand it is the Company's policy to pursue collection, to the fullest extent. If payment is not forwarded within the allotted five (5) business days, the Company has the authorization to charge the credit card on file.

4. If partial payment is made by my insurance company for some services, or disallows services provided, such as; manual therapy, massage therapy, PEMF, Kinesio tape, cervical pillows, etc.-as these items are not covered or are only partially covered under my policy.

Print Name: _____ Date: _____

Patient Signature: _____

Chiropractic: Member Billing Acknowledgement

Active Therapy Center
3435 Ocean Park Blvd.
Suite 101
Santa Monica, CA 90405

I, _____, a member being treated by Dr. _____,
(Name of Patient) (Treating Chiropractor)
do hereby acknowledge that a certain portion of my care will not be covered by my insurance company or health plan under the terms of my Benefit Plan with _____.
(Name of Health Plan)

I understand and agree to be responsible to self-pay for the following services:

List of services to be paid by member; but not limited to:

Procedure
Manual Therapy (i.e. A.R.T., massage, etc.)
Taping
Spinal/Extraspinal Manipulation
Decompression
Traction

This form is only if a member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered procedures are determined by your health plan to be maintenance-type services.

I acknowledge that I have reviewed my coverage options and that I have been told in advance of what portion of my treatment/care I will pay for, including non-covered services as described above.

Additionally, upon receiving my explanation of benefits (EOB) if services rendered are determined to be only partially covered or not covered at all, I agree to have Active Therapy Center provide me with a bill/statement of the remaining balance. **If I neglect to respond or pay these statements, I authorize to have the credit card on file be charged for the amount due *(See credit card authorization form).***

Dated at: _____*Santa Monica*_____, __*CA*__, this, _____ day of _____, 20 _____
(Date) (Month) (Year)

_____ _____
Member Signature Printed Name

_____ Date: _____
Practitioner/Administrative Signature

Active Therapy Center

APPOINTMENT CANCELLATION/NO SHOW POLICY

In the event you wish to make any changes to your appointment (i.e. cancel/reschedule), please call our office at (310) 399-0337. A 24-hour notice is required for cancelled appointments via phone or email. Changes or cancellations should be made during business hours (8:00 a.m. to 5:00 p.m. – Monday through Friday) when possible. **Please be advised, a $50 charge will be automatically charged to the credit card on file for ANY missed appointment(s) or those cancelled less than 24 hours.**

It is not our intent to inconvenience any of our patients, however in order to run our office efficiently and fairly, we need to utilize cancelled appointment for other patients.

Please complete the information below:

I, _____ authorize Active Therapy Center to charge my credit card
(Full Name)
indicated on this Cancellation Policy form.

Signature: _____ Date: _____

I authorize Active Therapy Center to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above only, I certify that I am an authorized under of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Credit Card Authorization Form

I authorize Active Therapy Center to charge the card below if I neglect to send payment for services my health plan determined to be patient's responsibility.

Date: _____

Patient Name: _____ Card Holder Name: _____

Billing Address: _____

Credit Card Type: _____ Visa _____ Mastercard

Credit Card Number: _____ - _____ -_____ -_____

Expiration Date: ____ / ____ Billing Zip Code: _____ CVV Number : _____

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