NECK AND BACK
MEDICAL CENTER, INC.
26072 Merit Circle, Suite 119
Laguna Hills, Ca 92653
(949) 859-6600

Patient Information

Date _____

Name _____ Primary Phone_____ Secondary Phone _____

Address _____ City_____ State_____ Zip_____

□ Male □ Female D.O.B. ___/___/___ Age _____ Height_____' _____" Weight _____lbs

Marital Status: □ M □ S □ W □ D Email _____

Name of Employer_____ Employer Phone_____

Employer Address _____ City _____ State _____ Zip_____

Emergency Contact _____ Phone _____

Primary Physician _____ _____ City _____

Health Insurance (If you have your insurance card skip this section)

Primary Insurance_____ □ HMO □ PPO □ OTHER

Subscriber _____ Soc. Sec. No. _____

D.O.B. ____/____/____ Group No. _____ Policy No. _____

Secondary Insurance _____ □ HMO □ PPO □ OTHER

Subscriber _____ Soc. Sec. No. _____

D.O.B. _____/_____/_____ Group No. _____ Policy No. _____

Auto Injury: □ Yes □ No (If NO skip this section)

Auto Insurance Co. _____ Phone _____

Policy No. _____ Claim No. _____ Adjuster _____

Insured _____ Soc. Sec. No. _____ D.O.B. ____/____/_____

Work Injury: □ Yes □ No (If NO skip this section)

Insurance Co. _____ Phone _____

Claim No. _____ Date of Injury ____/____/____ Adjuster _____

Primary Doctor _____

Attorney Contact Information:

Attorney _____ Phone _____

Address _____ City _____ State _____ Zip _____

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Patient History/Illness

Name _____ Date _____

Please list each area of complaint:

Primary Area: _____

How Long? _____

What makes it better? _____

What makes it worse? _____

Type of Pain: Sharp Dull Achy Numb Tingling

Does your pain radiate? Yes No If yes, where? _____

How severe is your pain? (1-10) _____

Secondary Area: _____

How Long? _____

What makes it better? _____

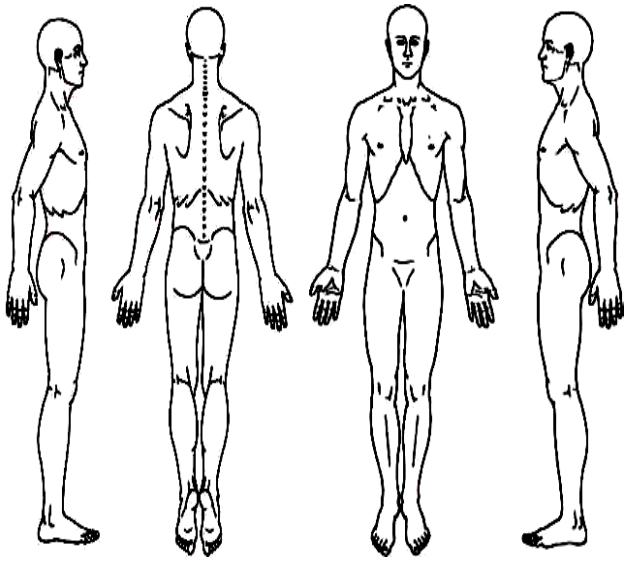
What makes it worse? _____

Type of Pain: Sharp Dull Achy Numb Tingling

Does your pain radiate? Yes No If yes, where? _____

How severe is your pain? (1-10) _____

Please mark your areas of complaint below



How much of the day do you have pain?

☐ 25% ☐ 50% ☐ 75% ☐ 100%

Please list additional complaints (if any): _____

Please describe all prior treatment.

Chiropractic ☐ Yes ☐ No When _____

Physical Therapy ☐ Yes ☐ No When _____

Surgery ☐ Yes ☐ No When _____

Type of Surgery _____

Other Treatment _____

Previous X-Rays for this condition? ☐ Yes ☐ No Where _____ When _____

Previous MRI for this condition? ☐ Yes ☐ No Where _____ When _____

List all chronic illnesses _____

List current medications being taken _____

List all allergies _____

Patient's Signature _____

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ACKNOWLEGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

This notice is effective as of _____/_____/_____

HIPPA

I have read the Notice of Privacy Practices and understand my rights contained in the notice.

By way of my signature, I provide Neck and back Medical Center, Inc with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Notice of Privacy Practices.

Video Surveillance

The waiting area, therapy area and common area of our office are equipped with video cameras. These allow the doctors and staff to see how many patients are in each area. This information helps us to manage the healthcare operations of our office. We store the last 7-10 day video in electronic format, but we do not make or keep videotapes of these areas. The only cameras in this office are the waiting area, therapy area and common areas.

By way of my signature, I acknowledge the use of video surveillance.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date

_____ _____
Authorized Signature of Witness for Facility Date

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ASSIGNMENT, RECORDS RELEASE AND PAYMENT AGREEMENT

THIS AGREEMENT, entered into this date by and between _____ Hereinafter called "Patient", and NECK & BACK MEDICAL CENTER, INC., hereinafter called "Provider". WHEREAS Patient desires to receive healthcare services from Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for the payment of such benefits, it is hereby agreed:

1. Patient assigns to provider any and all benefits payable by Patient's insurance or healthcare plan(s) as a result of charges incurred by Patient for healthcare services and supplies furnished by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, healthcare benefit plan or any other party contractually liable to Patient for payment of healthcare costs incurred by Patient as a result of services rendered by Provider.

This assignment of benefits and contractual rights to those benefits shall not exceed the total amount of charges incurred by Patient for Services rendered by Provider. The total amount paid to Provider from all sources shall not exceed the total amount of Provider's billing for services. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and Provider's acceptance of Patient's assignment of benefits is a convenience to Patient, and that Provider may revoke this assignment if Patient breaches this Agreement.

2. Patient hereby directs all insurers and other persons responsible for Patient's healthcare costs to make all payments for healthcare services rendered by Provider directly to Provider.

3. Patient agrees to waive any applicable statute of limitations, which may at any time interfere with Provider's right to collect for services rendered to Patient.

4. Patient agrees that in the event Patient receives any check, draft or other payment subject to this Agreement, Patient will act as fiduciary agent for Provider and will immediately deliver said check, draft or payment to Provider. Provider agrees to apply the proceeds from the check, draft or payment to Patient's debt for services rendered.

5. Patient hereby authorizes Provider to release and permit the examination and / or copying of any of Patient's medical records, x-rays, laboratory reports and the results of all tests of any type or character to such persons as Provider deems appropriate.

6. A photocopy or facsimile of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient/insured at any time or will, upon request by Patient/Insured, be mailed to a designated address.

7. Patient agrees to be responsible for any deductibles or co-payments required by the terms or any applicable insurance or healthcare plan. Patient further agrees to pay for any services not covered by Patient's insurance or healthcare plan. In the event Patient's Insurance carrier or healthcare plan requests reimbursement of any amounts paid to Provider, Patient shall be solely responsible for any such reimbursement and agrees to hold harmless and indemnify the Provider from any such claim for reimbursement.

8. In the event that any Section or provision of this Agreement is legally void, invalid or unenforceable, all other Sections and provisions of their Agreement shall remain in full force and effect.

9. The assignments and agreements contained in this document may not be revoked by Patient without the express written consent of the Provider.

10. In the event of any default in the performance of this Assignment, all amounts due Provider shall become immediately due and payable and Patient agrees to pay all costs of collection and attorney fees incurred by Provider in any arbitration or litigation which shall arise there from. From and after the date of any such breach, the amount due Provider shall bear Interest at the rate of 10% per annum.

IN WITNESS WHEREOF, this Agreement has been entered into the day and year set forth below.

_____ _____
Patient (Parent if Patient is a minor) Date

_____ _____
Insured (if different from Patient) Witness

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CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize:

Dr. _____ and whomever he or she may designate as assistants to administer medical care

as deemed necessary to my _____ (Indicate relationship of child),

_____
(Name of child)

Dated at _____, _____ this _____ day of _____, 20 _____.
(City) (State) (Month)

Signed: _____
(Parent or Guardian)

Witnessed: _____