YUSON CHIROPRACTIC
15355 Sherman Way Ste Q, Van Nuys, CA 91406
818.627.6956 ph 818.627.1404 fax drj@yusondc.com

PATIENT INFORMATION

Date ______________________________

Name ______________________________
Last

____
First *Middle*

Address ______________________________

City ______________________________

State __________ Zip ______________________

Email ______________________________

Sex ☐ M ☐ F Age ______________________

Birth Date ______________________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ______________________________

Hours at work ______________________________

Employer/School ______________________________

____

Employer/School Address ______________________________

____

Employer/School Phone ______________________________

Spouse's/Partner's Name ______________________________

____

Whom may we thank for referring you? ____________________

INSURANCE

Who is responsible for this account? ____________________

Relationship to patient ______________________________

Insurance Co. ______________________________

ID #______________________________

Is patient covered by additional insurance (2nd)? ☐Yes ☐No

Subscriber's Name ______________________________

Relationship to patient ______________________________

Insurance Co. ______________________________

ID # ______________________________

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

____
Name of Insurance Company(ies)

and assign directly to *Jesse Yuson, D.C. (Clinic)*, 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-mentioned *clinic* 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 payable for related services. This consent will end when my current treatment plan is completed or one year from date signed below.

____
Signature of patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian, or Personal Representative

__________________ ______________________________
Date *Relationship to Patient*

PHONE NUMBERS

Home Phone ______________________________

Cell Phone ______________________________

Best time to reach you ________________ ☐ Home ☐ Cell

EMERGENCY CONTACT PERSON

Name ______________________________

Relationship ______________________________

Home Phone ______________________________

Work Phone ______________________________

Other Phone ______________________________

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date of Accident ______________________________

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other
If other, explain ______________________________

To who have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ Other
If other, explain ______________________________

Adjuster/Attorney Name & Phone (if applicable):

____

PATIENT CONDITION

Reason for visit ______________________________

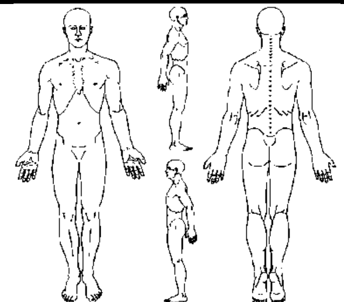
When did your symptoms start? ______________________________

Is the condition getting worse? ☐ Yes ☐ No ☐ Other, explain ____________________

Please mark an X on the picture on the right to the area(s) of complaint(s).

Rate the severity of your pain on a scale of 1 (minor pain) to 10 (severe pain): ________________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting ☐ Numbness
☐ Burning ☐ Tingling ☐ Cramp ☐ Stiffness ☐ Swelling ☐ Other



- O V E R -

HEALTH HISTORY

What treatments have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other ________________________

Name and address of other Doctor(S) who have treated you for your condition: ____

____

____

Date of last: Physical Exam ____________________ Spinal X-Ray ____________________ Blood Test ____________________

Spinal Exam ____________________ Chest X-Ray ____________________ Urine Test ____________________

Dental X-Ray ____________________ MRI, CT, Bone Scan ____

Place a mark on "Yes" or "No" to indicate if you have or have had any of the following:

HIV/AIDS	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other ____________________	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	________________________	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	________________________	
				Rheum. Arthritis	☐ Yes ☐ No		

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ____________________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ____________________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/Day ____________________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason ____________________

Are you pregnant? ☐ Yes ☐ No Due Date ____

Injuries/Surgeries you have had:

	Description	Date
Falls	____________________	__________
Head Injuries	____________________	__________
Broken Bones	____________________	__________
Dislocations	____________________	__________
Surgeries	____________________	__________

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

YUSON CHIROPRACTIC
PHYSIOTHERAPY & REHAB

15355 Sherman Way Ste Q, Van Nuys, CA 91406
(818) 627-6956 phone • (818) 627-1404 fax • drj@yusondc.com

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

_______ (Initial)	I hereby give authorization for payment of insurance benefits be made directly to Yuson Chiropractic / Jesse Yuson, D.C for services rendered.
_______ (Initial)	I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all collection costs and attorney fees.
_______ (Initial)	I acknowledge that insurance 'co-payment' charges are my responsibility and due at time of rendered service(s).
_______ (Initial)	I acknowledge that insurance 'co-insurance' charges are my responsibility and due once claim for my date of service is processed.
_______ (Initial)	Invoices sent to me by this facility/doctor are due 30 days after the date of invoice. I may be charged a 1.5% late fee per month on the unpaid balances. Failure to keep my account current may result in denial of services.
_______ (Initial)	If my current policy prohibits direct payment to the facility and/or treating physician, I hereby instruct and direct my insurance company to make the check out to me and mail it to: Yuson Chiropractic 15355 Sherman Way Ste Q, Van Nuys, CA 91406
_______ (Initial)	I authorize this healthcare provider to release all information necessary to secure payment from my health insurance policy. I further agree that a photocopy of this agreement shall be valid as the original.

By providing your initials above, you hereby agree to accompanying statements.

Name (Printed): ____

Signature: ____ Date: __________________________

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physiotherapy 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 while 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 other office or clinic personnel the nature and purpose of Chiropractic adjustments and procedures. 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 and sprains. 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 which the Doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition 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.

CHIROPRACTOR Name:

PATIENT Signature **X** *Date:*

(Or Patient Parent/Guardian/Representative) (Provide name & relationship if signing for patient)

ALSO **SIGN** THE **ARBITRATION AGREEMENT** ON **REVERSE** SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

***Article 1:* Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any 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 and federal 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 health care provider including any heirs 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 the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptor interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's 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 health care 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, 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 a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel 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 damage 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 shall 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 judgment for future damages conformed to 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 of 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 UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT Signature **X**	*Date:*
(Or Patient Parent/Guardian/Representative)	(Provide name & relationship if signing for patient)

OFFICE Signature **X**	*Date:*