Health EDGE
FAMILY SPINAL CARE

Name:
Address:
City, State, Zip:
Home Phone: Cell:
Social Security Number: Male or Female
Birth date: Age:
Occupation: Employer:
Work Number: E-mail:
Emergency Contact: Phone Number:
Spouse: Children/ages:
Whom may we thank for referring you to our office?
Have you ever been to a Chiropractor?

What is the purpose of your visit today?

- ☐ I have no complaints. I am here for a wellness checkup.
- ☐ Current health concerns:

Do you presently (or in the past) experience any of the following health problems?

- ☐ Acid Reflux
- ☐ Asthma
- ☐ Allergies/Sinus Troubles
- ☐ Tremors
- ☐ Loss of Balance
- ☐ Dizziness/Vertigo
- ☐ Shortness of Breath
- ☐ Sleeping Problems
- ☐ Emotional Stress
- ☐ Depression
- ☐ Hearing Loss/Ringing in Ears
- ☐ Menstrual Irregularities/Pain
- ☐ Fatigue/Loss of Energy
- ☐ Frequent Colds/Flus
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Headaches/Migraines
- ☐ Neck Pain
- ☐ Hip/ Leg Pain
- ☐ Low Back Pain
- ☐ Sciatica
- ☐ Numbness/Pins & Needles
- ☐ Shoulder Tension
- ☐ Scoliosis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bladder Problems

Current list of medications:

Any surgeries or hospitalizations:

Any accidents or injuries:

Methods you have tested:

- ☐ Exercise
- ☐ Physical therapy
- ☐ Prescription drugs
- ☐ Massage
- ☐ Acupuncture
- ☐ Nothing

My conditions interrupt the following:

- ☐ Career
- ☐ Sleep
- ☐ Social life
- ☐ Family life
- ☐ Ability to exercise

What results would you want for yourself?

- ☐ Reduce symptoms
- ☐ Restore health
- ☐ Maintain health

Print Name:
Signature: Date:
Witness Signature (Office Staff): Date:

Financial Policy

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care. We have prepared this material to acquaint you with some of our financial policies and to provide you information regarding our appointments and treatments.

Insurance: As a courtesy to you, we will complete and file insurance forms relative to your treatment. Deductibles, co-pays, or other amounts deemed "Patient Responsibility" is expected to be paid at the time of the appointment.

Medicare: Dr. Armen Manoucherian is a "nonparticipating" Medicare provider. Therefore, we require that you pay at the time of your appointment. We will submit the forms relative to your treatment. Medicare will send any portion of your reimbursement to you directly.

Personal Injury:
We accept:
-Cash, Check or Credit card (There is a $35.00 charge for returned checks.)
-Med Pay
-Liens - Health Edge will only accept liens with lawyers we have worked with previously. New lawyers may be considered, but only on a case by case basis and at our sole discretion.

Cancellation Policy: In order for us to better accommodate our patients we require a 24 hour cancelation notice for all appointments. A $40 charge will be made for all broken appointments; i.e. appointments missed without notice, late cancellations, and late reschedules.

By signing below, I am acknowledging that I have read and understand the information above regarding the financial policy of this office and I take full responsibility for any balance that is due at the time of services. I also agree to keep my appointments as recommended by the doctor. I am responsible for costs required to enforce collection of my account including, but not limited to, collection fees, attorney fees and court costs. Once again, we welcome you to our office, and will be glad to answer any further questions that you might have.

Patient
Name:_____

Patient
Signature:_____Date:_____

Informed Consent for Upper Cervical NUCCA Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care in general include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic adjustments and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. There have been no reports of any such injuries occurring in association with the gentle upper cervical correction that we perform in this office.

Prior to receiving care in this office, a health history and examination will be completed. We will assess your specific condition, your overall health, and, in particular, your spinal health. This will assist us in determining if NUCCA care is needed, or if any further examinations or studies are needed before initiating care. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a program of care prior to any treatment.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the upper cervical chiropractic care including upper cervical spinal corrections, as reported following my assessment.

Patient
Name:_____

Patient
Signature:_____Date:_____

Health Care Provider-Patient 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 law, and not by a lawsuit or resort to court process except as California 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 the intention of the parties that this agreement bind all parties whose claims may arise out of or relate 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 preceptorship 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 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 or punitive damages. Filing of any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the health care provider, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

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 the 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 Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one processing. 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 California 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.

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 below.
Effective as of the date of first professional services.

_____
Patient's Initials

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.

_____ _____
Healthcare Provider's Signature Date

_____ _____
Healthcare Provider's Duly Authorized Rep. Date

_____
Translated by: Date

_____
Print Patient's Name

_____
Signature of Patient, Patient's Agent, Representative or Parent Date

As:_____
Relationship to Patient

837 N. Glendale Ave., Glendale, CA 91206, (818) 724-4352

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices provided by Health Edge Family Spinal Care and that I read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

Patient Name: _____Date:_____

Parent, Guardian or Patient's legal representative: _____

Signature: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Do not write below this line

***For Office Use Only*:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____

Signed form received by:_____Date:_____