# JOINT REHABILITATION & SPORTS MEDICAL CENTER, INC.

Name_______________________________________________________________
(LAST) (FIRST)

Address_____________________________________________________________

City ___________________________State ________ Zip _____Height:__________Weight:______

Drivers License # _______________________Birth Date:_____________________Age ________

Home Phone ( ) ____________________Work Phone ( )___________________________

Emergency Contact____________________________________Phone ( )_______________

Health Insurance Co ___________________________Social Security # _________________

E-Mail address __________________________________________________for weekly newsletter

Employer________________________________________Family Physician _______________

Business Address________________________________Physician Address_______________

________________________________________________Physician's #___________________

What is your chief complaint?______________________________________________________

Other complaints?_________________________________________________________________

How long have you had this condition?_______________________________________________

How long has it been since you felt really good?______________________________________

What aggravates your condition?____________________________________________________

List any doctors previously treating this condition:______________________________________

Have you had Nutritional Therapies, Chiropractic or Physical Therapy? Yes No

Do you want to use nutritional therapy instead of drugs? Yes No

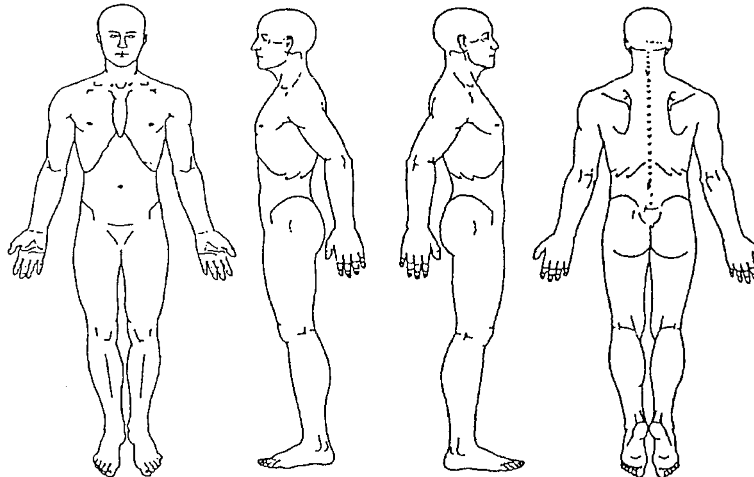
Were X-Rays taken? Other Diagnostics? Yes No If yes, when? _______Where?____________

List any surgeries or medications: ____________________________________________________

_______________________________________________________________________________

Use the picture below to illustrate your areas of pain, spasm, tingling, or concern.

Make an **X** where you have pain, **N** where there is numbness or tingling.



**CIRCLE THE SYMPTOMS YOU HAVE NOW AND "X" FOR PAST SYMTPOMS.**

**1.** Headaches Muscle Cramps Blood in stool Jaw Pops Leg cramps at night
Hernia Swollen Joints Use Antacids Arthritis Pain in Fingers
**2.** Hypoglycemia Dizziness upon rising Family history of Diabetes Need coffee
**3.** Rose colored urine Frequent urination Difficulty urinating High Cholesterol
**4.** Headaches after eating Hepatitis/jaundice Less than 1 bowel movement daily
Intolerant to greasy foods Fatigue after eating
**5.** Can't tolerate exercise Sensitive to bright lights Nervousness Lack of mental alertness
**6.** Tingling pain sensation Loss of grip strength Accident prone Shingles
**7.** Eczema/psoriasis Migraine Headaches Use Cortisone Aspirin or Tylenol regularly
**8.** Pain around ribs Smoke ? How much ____________ Bronchitis
**9.** Shortness of breath Pain in the left arm Heart attack Chest pains
Ringing in ears
**10.** Pains while walking Blood pressure problems Stroke
**11. FOR WOMEN ONLY :**
Tender breasts Mood Swings Insomnia Hysterectomy Hot flashes Abortion
Missed periods Weight Gain Fibroids Painful Intercourse Difficult / painful urination
Night Sweats Cysts Number of children?____Type of delivery_____Heavy bleeding
**12. FOR MEN ONLY:**
Weight Gain Difficult/painful urination Painful Intercourse Decreased Libido
Memory Loss Erectile Dysfunction Joint Pains
**13.** Fatigue Dry skin Cold hands and feet Depression Cry easily Hair Loss
**14.** Recent weight gain Bowel/bladder incontinence Recent extremity weakness
**15.** Chronic cough Allergies Ear disorder Sinus trouble Hay fever
**16.** Gastritis/ulcers Diarrhea Stomach pains Constipation Reflux
Nausea/vomiting
**17.** Recurrent infections Bladder or kidney infections Vaginal or yeast infections

**X-RAY CONFIRMATION:** This is to confirm that I have been advised by the doctor that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to having x-rays taken.

I hereby request and consent to the performance of medical care, procedures, injections, electrodiagnostics, physical therapy, acupuncture, chiropractic care and MedX spinal rehabilitation.

I understand that neither the practice of medicine nor chiropractic is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results has been made to nor relied upon by me.

I further authorize Joint Rehab to release my name and medical information to my insurance carrier for purposes of obtaining payment for services rendered. I authorize disclosure and release of any and all confidential healthcare information, inclusive of alcohol and/or drug abuse, HIV testing/treatment psychiatric notes and/or venereal disease.

Patient's Name ______________________________ Signature ______________________________

Witnesses________________________________________________________Date_______________

Relationship or authority if not signed by patient ______________________________________________

I understand that all examinations, treatments, x-rays and lab work are to be paid for as they are rendered or definite financial arrangements made in advance. There is a charge for missed appointments without a 24 hour notification.

SIGNATURE ________________________________________DATE_______________________

**Joint Rehabilitation & Sports Medical Center, Inc.**

## Office Policy and Procedure

Our goal at Joint Rehabilitation & Sports Medical Center, Inc. is to provide you with the most effective care possible in a relaxed manner.

**SIGNING IN:** You will be asked to sign your chart each time you arrive.

**Going to the treatment rooms:** When it's your turn you will be asked or escorted to a specific room. Please remove all heavy garments, jewelry and especially earrings. Please stay in the appropriate room as you may lose that room if someone thinks it is not occupied.

**If you miss an appointment** try to make that visit up in the same week so as not to delay your progress. We will work hard to get you out of pain fast. You must do your part and stay on track with your appointments.

**24 Hour cancellation policy:** To prevent being personally charged for a missed visit you must give us 24 hour notification of cancellation. We understand life's emergencies. Please call us as soon as you know you are not going to be able to make your appointment so that we may schedule another patient who really needs us. There is an $85 cancellation fee when seeing more than one practitioner and $50 for just one.

**All supplies and supplements** are to be paid for at the time they are dispensed. These items are typically not billable to your insurance company. They are also not part of any lien.

After reading the above policies and going over them with a member of the doctor's staff, I agree and accept full responsibility for all of these policies.

Signed_________________________________________Date_____________

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO JOINT REHABILITATION & SPORTS MEDICAL CENTER, INC.BILLING SERVICE PRIVATE AND GROUP ACCIDENT HEALTH INSURANCE**

**PATIENT:** ______________________________________________________________

**EMPLOYER:** ____________________________________________________________

**CLAIM/GROUP:** ______________________________ **SS#/ID#**______________________________

**I HEREBY INSTRUCT AND DIRECT THAT** _____________________________________________

INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED TO:

**Joint Rehabilitation & Sports Medical Center, Inc.**
**11645 Wilshire Blvd. #120, LA CA 90025**

**OR**

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEREBY ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

**C/O Joint Rehabilitation & Sports Medical Center, Inc.**
**11645 Wilshire Blvd #120, LA CA 90025**

THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD THE TOTAL CHARGES FOR THE PROFESSIONAL SERVICES RENDERED. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO THE ABOVE MENTIONED ASSIGNEE, AND I HAVE AGREED TO PAY, IN A CURRENT MANNER, ANY BALANCES OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSDURANCE PAYMENT.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ALSO AUTHORIZE THE RELEASE OF INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTOR, OR ATORNEY INVOLVEO IN THIS CASE.

**DATED AT L.A. COUNTY THIS**______________________**DAY OF**______________________________
(Day) (Month/Year)

_____________________________________________ ____________________________

**SIGNATURE OF POLICY HOLDER** **WITNESS**

___________________________________________________________________________

**SIGNATURE OF CLAIMANT, IF OTHER THAN POLICYHOLDER**

## Joint Rehabilitation & Sports Medical Center, Inc.

We'd like to thank the person who **referred** you to our practice, please take a minute and complete the information below.

________________________________________
Your Name

________________________________________
Who referred you

________________________________________
Their Address

________________________________________
City, State Zip

________________________________________
Telephone Number