"Dr. Zuckerman is an independent Chiropractic practice and is not a partner or affiliated with any other health care professional at this location."

First Name: _____ MI: _____ Last Name: _____

Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Marital Status: S M W D Spouse: _____

DOB: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ email: _____

Emergency Contact: _____

Whom may we thank for referring you to our office? _____

Occupation: _____ Employer: _____

Employer Address: _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: _____

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Name(s) and Address(es) of Office or Clinic Print Name(s) of Doctor(s) Treating this Patient

Robert M. Zuckerman, D.C.
3180 Willow Lane
Suite 112
Thousand Oaks, CA 91361

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Printed name of Patient

Signature of Patient Date

Signature of Patients' Representative (if minor or physically incapacitated) Date

Witness to Patients' Signature Date

Translated By Date

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

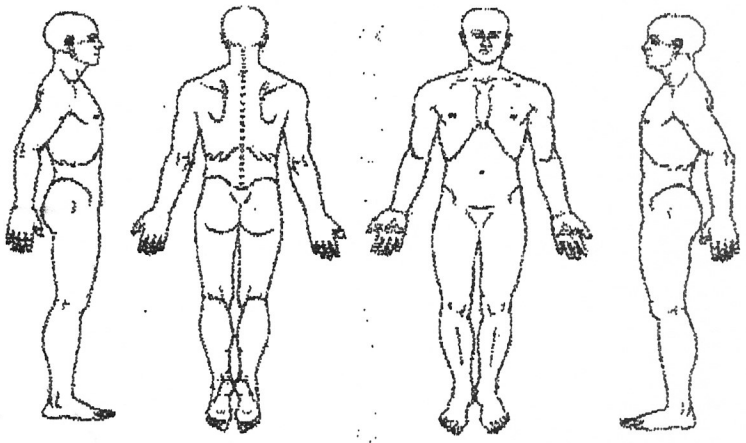
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? *(like visiting with friends, relatives, etc)*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

10. What is your occupation? _____

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

Consent To Treat A Minor

Parent or Guardian:

Name: _____

Address: _____

_____
City, State & Zip

_____
Home Phone #

Minor's Name: _____

Age: _____ Sex: _____

I being the parent or guardian of the above said minor do hereby consent, authorize and request Dr. Robert Zuckerman to administer such CHIROPRACTIC treatment, as he deems necessary on the above named minor.

I understand that the above named Doctor's recommendations and instructions for care and treatment must be complied with; otherwise the Doctor cannot be held responsible or liable.

I understand that there will be certain specific recommendations and procedures to follow for the care and treatment of the above minor. I therefore agree to comply with the Doctor's instructions for the total amount for care necessary until the Doctor releases the patient.

Parent/Guardian Signature:_____

Date: _____

OUR INSURANCE AND FINANCIAL POLICY

We will gladly bill your insurance in lieu of payment from you for your care in our office. The following policy prevails:

1. If your insurance has been verified by our office, we will gladly accept ½ of your initial examination procedures charge as partial payment. The remaining ½ can be billed directly. Completed and signed insurance claim forms must accompany your partial payment.
2. The ½ you pay will go toward satisfying your deductible and the percentage (known as co-insurance) not usually paid by insurance. PLEASE DO NOT SEND IN ANY RECEIPTS YOURSELF WHEN YOU DESIRE US TO DIRECT BILL FOR YOU.
3. Once the Doctor has determined the nature of your problem, he will discuss his recommendations with you. At this time we will advise you of the estimated costs and the percentage that will not be covered by your insurance. This balance may be paid all at once or in installments within a 60 day period without finance charges.
4. If you were unable to bring a completed and signed claim form with you on your first visit, please do so by your second visit if you desire us to either direct bill your insurance or complete forms for you.

IF YOU HAVE ANY QUESTIONS CONCERNING OUR FINANCIAL OR INSURANCE POLICY, PLEASE DO NOT HESISTATE TO SPEAK WITH US.

OTHER METHODS OF PAYMENT

1. For those patients who do not have insurance coverage for our services you may pay at time services are rendered by: CASH, CHECK, MASTERCARD, VISA or AMERICAN EXPRESS. ALL FEES FOR SERVICES RENDERED ARE EXPECTED TO BE PAID AT TIME OF SERVICE. Any fees not paid will be subject to 1.5% interest rate per month or 18% per year.
2. If your health problem is the result of an AUTO ACCIDENT, we will gladly direct bill all charges when your policy provides for direct payment to the doctor. You must present all auto insurance information and major medical policy information prior to when our direct billing begins. We file all AUTO and MAJOR MEDICAL POLICIES simultaneously. Any overpayment at the end of care is refunded to the patient. If you do not have auto med-pay or major medical coverage, then you will be required to make a minimum payment of $100.00 per month toward you care until final settlement/payment has been received. If full payment has not been received within 6 months of dismissal from active care, then the entire balance will be due at that time. An attorney lien must be signed if an attorney represents you.
3. If your health problem is the result of a WORK-RELATED INJURY please speak with the insurance administrator prior to any consultation with the doctor. State law is specific on how we must direct bill our charges if we are to direct bill 100% of your services.

There will be a $25.00 fee charged for appointments missed with the doctor without prior notice. If you have massages done there will be a $15.00 charge for a half hour and $30.00 charge for a full hour if missed without prior notice. PLEASE NOTE THAT THIS FEE CANNOT BE BILLED TO YOUR INSURANCE CARRIER.

IT IS THE POLICY OF THIS OFFICE TO CONDUCT A NO CHARGE CONSULTATION AND HEALTH HISTORY ON ALL NEW PATIENTS TO DETERMINE IF POSSIBLE SPINAL OR NERVE RELATED CONDITIONS EXIST CAUSING YOUR ILL HEALTH. IN ADDITION, AN EXAM WILL BE PERFORMED SO THAT WE CAN BETTER UNDERSTAND YOUR HEALTH PROBLEM, AND MAKE THE PROPER RECOMMENDATIONS SHOULD YOU NEED FURTHER EXAMINATIONS OR TREATMENT. ALL FEES ARE EXPLAINED PRIOR TO SERVICES RENDERED.

Patient's Signature (Parent/Guardian if a minor) Date Witness

"Dr. Zuckerman is an independent Chiropractic practice and is not a partner or affiliated with any other health care professional at this location."

I have read and understand the foregoing notice, and all of my questions have been answered to my satisfaction in a way that I can understand.

Name of Individual (Printed)	Signature of Individual
Signature of Legal Representative (E.g. Attorney, Guardian, Parent if minor)	Relationship
Date Signed	Witness

"Dr. Zuckerman is an independent Chiropractic practice and is not a partner or affiliated with any other health care professional at this location."