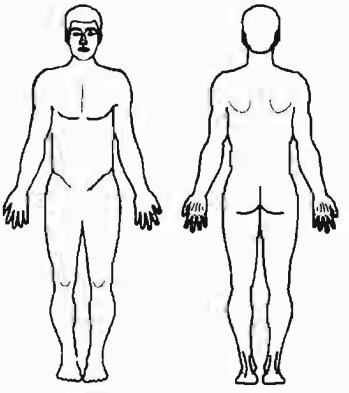
American Specialty Health Plans (ASHP)
P.O. Box 509002, San Diego, CA 92150-9002

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

E-Mail _____

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

_____
_____
_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

DATE PROBLEM BEGAN: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%
Can you perform your daily activities? ☐ Yes ☐ No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____
WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Pregnancy, # of births _____
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Stroke (date) _____	☐	☐	History of Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Surgeries/Medications: _____
☐	☐	Cancer/Tumor			_____
☐	☐	Osteoporosis			_____
☐	☐	Recent Trauma			

Your WEIGHT _____ Height _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____

American Specialty Health Plans (ASHP)
8989 Rio San Diego Drive, Suite 250, San Diego, CA 92108
Fax: 619-297-1717

ELIGIBILITY GUARANTEE/ ASSIGNMENT OF BENEFITS FORM

For questions, please call ASHP at 800-972-4226

Bryan A. Kolozsi, D.C. (ASHP Chiropractor) 681 Oak Grove Ave #c (Address) Menlo Park, CA 94025

Eligibility Guarantee:

I, _____ (Name of Patient/Member/Guardian) hereby certify that I am eligible for chiropractic benefits offered by _____ (Name of Health Plan) through my employer, _____ (Name of Employer Group) as of _____ (Today's Date).

I understand that if the above is not true, or if I am not eligible under the terms of my employer's Medical and Hospital Subscriber Agreement or Insurance Policy, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from the above chiropractor or health plan.

Assignment of Benefits:

I authorize the release of any health information necessary to process this claim. A photo copy of this authorization shall be as effective and valid as the original.

I authorize payment of medical benefits to the chiropractor listed above who accepts assignment through his/her contract with ASHP and/or ASHP's Health Plans.

I understand that the ASHP Chiropractor will not bill me for any charges over and above the insurance payment, other than the applicable copayments, coinsurance or deductibles, since the ASHP Chiropractor has agreed in his/her contract with ASHP and/or ASHP's Health Plans to waive all un-paid fees.

_____ (Date) _____ (Signature of Member (Or Subscriber))

Note to Chiropractor's Office Personnel:

Please keep the original copy of the completed Eligibility Guarantee/Assignment of Benefits Form in the patient's file. If you need to submit this form to ASHP, please send it to ASHP at the address above. If you have any questions, call ASHP Provider Services at 800/972-4226.

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-rays 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 backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, 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, Horner's 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 procedures 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 for which I seek treatment.

671 Oak Grove Ave. #O
Menlo Park, CA 94025

Bryan Kolozsi, D.C.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient _____ Date _____

Signature of Patient _____ Date _____

Signature of Patient's Representative _____ Date _____

Witness to Patient's Signature _____ Date _____

Translated by _____ Date _____

INTAKE FORM/ OFFICE POLICIES / FINANCIAL AGREEMENT

Name_____Referred to the office by: _____

****Please read & initial items 1-6:**

_____1. In order to respect and not interfere with other patient's treatment and therapy, treatments are provided BY APPOINTMENT ONLY. Failure to arrive by your appointment time may result in an inability to provide service to you. Emergency visits can be arranged. Please call to arrange an emergency visit.

_____2. Cancellation of or changing an appointment requires a two (2) hour notice prior to your appointment. A FEE OF $30.00 WILL BE CHARGED TO YOU, NOT TO YOUR INSURANCE COMPANY, FOR LATE CANCELLATIONS OR NO-SHOWS.

_____3. There is a $20 fee on all returned checks. Payment is due upon receipt.

_____4. I understand that the Bryan A. Kolozsi,DC is not responsible for quotations of benefits or payments of claims by my insurance company. I understand that it is recommended to me by this office to verify my benefits, as this is my method of payment.

_____5. I understand that this office does not carry accounts. Payment is due at the time services are rendered. Accounts aged over 30 days will be subject to a 1.5% finance charge.

_____6. I understand that I am responsible to provide current insurance information to to this office. I know that if my insurance changes it is my responsibility to provide my new card and information regarding that insurance upon the first visit of my new coverage. If this information is not given I understand that I am responsible for all charges that would not be covered.

FINANCIAL AGREEMENT

****Initial the 1 insurance option that applies to you:**

_____1. CASH- I do not have chiropractic benefits. I will pay for services at the time they are rendered.

_____2. Out of Network Insurance-Please bill my insurance and have them pay the doctor directly. I understand that I am responsible for any deductible amounts and co-pay amounts at the time services are rendered.

_____3. In Network Insurance/ American Specialty Network-I agree to pay all co-payments and deductible amounts at the time services are rendered.

_____4. Medicare-I understand that Medicare only pays for manipulations and does not reimburse for x-rays. I will pay for each visit at the time services are rendered and Medicare will reimburse me directly. I understand that Medicare will only reimburse me for 12 visits per year after my deductible is met.

I have read and understand the above office policies and agree to the financial option that I have chosen. I do understand that x-rays remain the property of the Bryan A. Kolozsi DC

Patient or Guardian Signature_____Date_____

Print Name_____

Bryan A. Kolozsi, DC CCSP
681 Oak Grove Ave
Menlo Park, CA 94025
650-322-6080

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient of Bryan A. Kolozsi, DC CCSP we may use or disclose personal and health related information about you in the following ways:

*Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of services provided to you.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.
We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

If you would like further information about our privacy policies and practices please contact: Bryan A. Kolozsi, DC CCSP

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____

Personal Representative Printed Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient.