PATIENT INFORMATION

Patient Name: ____________________________________ **Social Security No:** _______________________

Address: ____

City: ____ **State:** ___________ **Zip:** __________________

Phone No: _______________________________________ **Marital Status:** __________________________

Occupation: ______________________________________ **Birth Date:** ___________ **Age:** ____ **Sex:** ____

Employer: _______________________________________ **Work Phone No:** ________________________

Employers Address: ____

Nearest Relative: ____
(Full Name) **(Address)** **(Phone No)**

INSURANCE INFORMATION

Medical Insurance: _______________________________ **Group No:** ______________________________

Policy or ID No: __________________________________ **Driver's License No:** _____________________

Insurance Address: ____

Responsible Party for Bill: ____

Address If Different From Above: ____

Is This Condition Due to An Auto Accident? ___________________________ **Date of Accident:** _______

Is This Condition Work Related? ____________________________________ **Date of Injury:** _________

Do You Have An Attorney For This Case? ___________ **(If Yes) Name** ___________________________

Address of Attorney: ____ **Phone No:** ___________________

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED WHILE BEING TREATED AT THIS FACILITY.

Signature: _____________________________________ **Date:** _____________________________

I AUTHORIZE PAYMENT TO GO DIRECTLY TO:

DR.____ **Signature:** _________________________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-ray, on me (or on the patient named below, for whom I am Legally responsible) By the doctor of chiropractic named below and/or other Licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or saving 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.

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 other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but on 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 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 from to cover the entire course of treatment for my present condition and for any future condition(s) for which I seed treatment.

To be completed by patient:

____
Print Patient's Name

____
Signature of Patient

____
Date Signed

To be completed by patient's representative, if necessary, e.g. if patient is a minor or physically or legally incapacitated:

____
Print Name of Patient

____
Print Name of Patient Representative

____
Signature of Patient's Representative

As: ______________________________________
Relationship or authority of Patient's Representative

____
Date Signed

Name and Address of Clinic/Office

Dr. Hagop Alajajian, D.C.
815 E. Colorado St. Suite 250
Glendale, CA 91205
Phone: (818) 246-3600
Fax: (818) 246-3604

Print name(s) of doctor(s) treating this patient:

____
____
____
____
____

Witness to Patient's Signature: ____ **Date** ____________

Translated by: ____ **Date** ____________

The signed original is to be filed in patient's file and a copy is to be given to the patient.

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 binds all parties whose claims may arise out of or relate to treatment or services provided by the health care provider and his or her successors and assigns 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 oat 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 ship 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 clinic or office listed below or any other office or clinic, 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 Association, corporation, partnership, employees, agent and estate, must be arbitrated including, without limitation, claims for loss of Consortium, wrongful death, emotional distress or punitive damages. Filling 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 exiting court action, shell 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.

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 joiner 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 joiner any existing court action against such additional person or entity shall be stayed Pending arbitration.

The parties agree that the provision of the Californian 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) the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: **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 5: **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.

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.

____

Print Patient's Name

____

Health Care Provider's Signature Date

____

Patient's Signature Date

By____

Health Care Provider's Duty Authorized Representative

____

Patient's Agent's or Representative's Signature Date

____

Translated by

As ____

DOCTOR'S LIEN & INSTRUCTION TO COUNSEL

I, the undersigned, understand that all past, present and future bills incurred at the Doctors/Clinic noted below, are my responsibility for payment. I hereby ratify my agreement to pay all bills incurred during my health care at this Clinic.

In consideration for the below named Doctor/Clinic have agreed to treat me without payment at this time of service and enabling me to obtain treatment for my accident/injury/illness, without financial hardship, I give you a lien on any settlement, claim, judgment, verdict or result of said accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claim or judgment related to this accident/injury/illness.

I also understand that if the settlement does not cover my entire bill at this Clinic, I am still responsible for the remainder and the payment by me of this bill is not contingent on any settlement, claim or judgment, which I may eventually recover.

Furthermore, in consideration for the below named Doctor/Clinic refraining from attempting to collect immediate Payment for services rendered for my accident/injury/illness, I do hereby waive and toll any applicable statute of limitations on the collection of my account until I notify the Doctor/Clinic of the conclusion of my efforts to obtain a settlement or judgment through the assistance of my attorney and for a period of three (3) months thereafter.

Dr. Hagop Alajajian, D.C.
815 E. Colorado St. Suite 250
Glendale, CA 91205
Phone: (818) 246-3600
Fax: (818) 246-3604

Doctor/Clinic Name and Address

____
Patient Name (Please Print)

____
Patient Signature

____
Date

INSTRUCTIONS TO COUNSEL

I do hereby irrevocably instruct you, my Attorney, named below, to pay Doctor/Clinic named above for services to me for my accident/injury/illness from any proceeds of settlement, claim or judgment regarding said accident/injury/illness. You are to pay the Doctor/Clinic prior to distributing any proceeds to me which I have agreed to pay in full.

____
Firm Name

____
Patient Signature

____
Attorney Name

____
Date

ATTORNEY'S ACCEPTANCE OF LIEN

Being the attorney of record or authorized representative, I acknowledge receipt of my client's instructions to Counsel and Lien and agree to honor the same.

____
Attorney's Name

____
Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name ____

Employer ____

Claim / Group #: ____

S.S.N. / ID #: ____

I hereby instruct and direct the _________________________________ **Insurance Company to pay by check made out and mailed directly to:**

Dr. Hagop Alajajian, D.C.
815 E. Colorado St. Suite 250
Glendale, CA 91205
Phone: (818) 246-3600
Fax: (818) 246-3604

OR

If my current policy prohibits direct payment to doctor, then I also instruct and direct you to make out the check to me and mail it as follows:

C/O

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHT 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 balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at ____________________ **this** ______________ **day of** _____________ **20**_______

__________________________________ __________________________________
Signature of Policyholder **Witness**

__________________________________ __________________________________
Signature of Claimant, If other than Policyholder

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign this Acknowledgement"

I _________________________ have received a copy of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Date

-------------------------------- 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.**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**.
- ☐ **An emergency situation prevented us from obtaining acknowledgement.**
- ☐ **Other (Please Specify)**

____
____
____
____
____

PATIENT CONSENT FORM

The department of health and human service has established "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we fill are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories that only in interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health are operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to provide treatment if you should choose to refuse disclosing your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request all or part of your PHI. You may not revoke actions that have already been taken which rely on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our Privacy Notice.

Print Name: ______________________________ **Signature:** ______________________________ **Date:** ______________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We would like you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with the government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethical and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper Disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believed will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any penalty if they feel that an event in any way compromises our policy of integrity. More so we, welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you,

Dr. Hagop Alajajian, D.C.