American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
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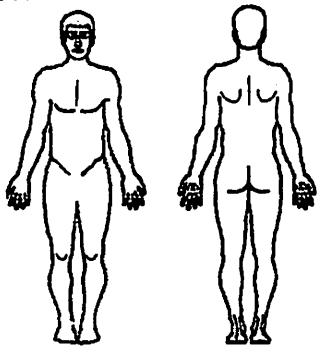
INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

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



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began_____
How 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?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, 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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

WINDWARD FAMILY WELLNESS CENTER
PAYMENT POLICY FORM

Directions: Please initial next to the plan you will be using, then sign and date on the bottom

_____ **PRIMARY INSURANCE:** We will bill your primary insurance as a courtesy to you. We assume payment of insurance benefits not forthcoming on charges older than 60 days. Charges outstanding for more than 60 days will be due in full from you regardless of the type of insurance involved, any remaining balance after your copay and your primary coverage has been paid, including items classified asm"above usual and customary", is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. We will verify your insurance benefits, be aware that verification of benefits is not a guarantee of payment by your insurance carrier.

_____ **SELF PAY/ CASH:** Please pay the balance in full at the time of service. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that Windward Family Wellness Center is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Payment may be made through cash, check, or credit card.

_____ **WORKERS' COMP/ MOTOR VEHICLE ACCIDENT/ PERSONAL INJURY:** We will bill your Insurance carrier for your charges. Please note that you will remain financially responsible for all your charges if your carrier denies coverage.

_____ **LEGAL SUIT:** We will accept a legal letter of protection if you meet each of the following criteria:

1. Do not qualify for benefits under any insurance policy (medical or auto), and
2. Are indigent and cannot pay for charges using cash or credit card, and
3. Are awaiting settlement and subsequent payment of damages from a related legal case, and
4. Return our lien, signed by both you and your attorney.

Prior to your settlement, payment on your account will not be required unless your charges remain outstanding for more than 90 days from the date of last treatment. Upon settlement of your legal case, your balance in full is due within 30m days. Please be aware that you remain financially responsible for services rendered regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting adult will be responsible for the principal amount owing, and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees. attorney fees, and all court costs and additional legal expenses associated with the recovery of this debt.

We reserve the right to charge interest on balances over 30 days old and charge return check fees as allowed by the State of Hawaii.

_____ _____

PRINT NAME **DATE**

_____

AUTHORIZED SIGNATURE

CHIROPRACTIC INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatures to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise of cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms 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 exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and non refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded upon written request.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest, medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers, physical therapy, steroid injections, bracing , and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

Doctor of Chiropractic's Name: **Dr. Shayne M. Guthrie, D.C., LMT, etal.**
_____ **Dr. Scott Horwitz, D.C.**

I have read, or have had read to me, the informed 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 to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

_____	_____	_____
Patient's Name (Please Print)	Signature of Patient	Date
_____	_____	_____
Parent/Guardian Name if Minor (Please Print)	Signature of Parent/Guardian	Date