

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M / F  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ 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.

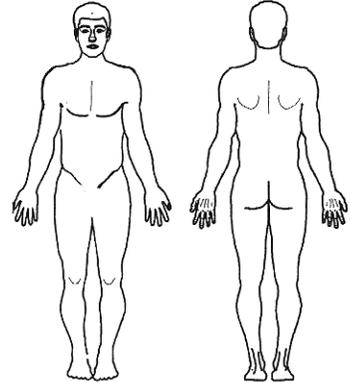
**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

- Headache    Neck Pain    Mid-back Pain    Low Back Pain  
 Other \_\_\_\_\_

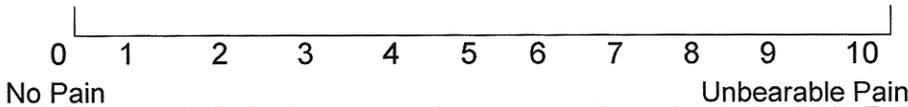
Is this?    Work Related    Auto Related    N/A

Date Problem Began: \_\_\_\_\_

How Problem Began: \_\_\_\_\_



Current complaint (how you feel today):



How often are your symptoms present?

- (Intermittent)    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

**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:

- |   |  |
|---|--|
| <input type="checkbox"/> Recent Fever   | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Menstrual Problems  |
| <input type="checkbox"/> High Blood Pressure                                    | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> Stroke (date) _____                                    | <input type="checkbox"/> Currently Pregnant, # weeks _____   |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.) _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking Birth Control Pills                             | <input type="checkbox"/> Marked Morning Pain/Stiffness   |
| <input type="checkbox"/> Dizziness/Fainting                                     | <input type="checkbox"/> Pain Unrelieved by Position or Rest   |
| <input type="checkbox"/> Numbness in Groin/Buttocks                             | <input type="checkbox"/> Pain at Night   |
| <input type="checkbox"/> Cancer/Tumor (explain) _____                           | <input type="checkbox"/> Visual Disturbances   |
| _____   | <input type="checkbox"/> Surgeries _____   |
| <input type="checkbox"/> Osteoporosis   | _____  |
| <input type="checkbox"/> Epilepsy/Seizures                                      | _____  |
| <input type="checkbox"/> Other Health Problems (explain) _____                  | <input type="checkbox"/> 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 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. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEMBER BILLING ACKNOWLEDGMENT (Chiropractic)

For questions, please call ASH Plans at 800/972-4226

I, \_\_\_\_\_, a member being treated by Dr. \_\_\_\_\_,  
(Name of Patient/Member/Subscriber) (Chiropractor Name)  
do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with \_\_\_\_\_. I understand and agree to be responsible to self-pay for the following services: \_\_\_\_\_  
(Name of Health Plan)

### LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Date:	Procedure:	Charge:
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Separately list each date of service on which non-covered services will be rendered and have the Member initial the charge. Please attach additional Member Billing Acknowledgment form(s) for additional services.

This form is only to be used if an ASH Plans Member desires to self-pay for non-covered services. Non-covered services include services that are not covered by the Member's payor. Non-covered services may also include services determined by ASH Plans to be maintenance-type services.

The ASH Plans Contracted Chiropractor may not bill the member during the course of an ASH Plans approved treatment program unless there is a copayment, deductible, coinsurance, or the Member is receiving non-covered services.

The ASH Plans Contracted Chiropractor may not bill the member for the difference between what the ASH Plans Contracted Chiropractor bills and what the ASH Plans Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH Plans Contracted Chiropractor agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill Members for any services not reimbursed by ASH Plans. Such use will render this agreement "void" and non-binding on the Member. This agreement may only be used to allow the Member to agree to "self pay" for specific services **in advance**.

I acknowledge that I have been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my chiropractor, Dr. \_\_\_\_\_,  
(Chiropractor Name)  
to pay for these services myself.

Dated at \_\_\_\_\_, California this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(city) (date) (month) (year)

\_\_\_\_\_  
Member Signature  
(Guardian must sign for all members 17 years or younger)

\_\_\_\_\_  
Member Health Plan ID#

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date