ResponseCare Chiropractic

11562 Knott Street #17
Garden Grove, CA 92841
Phone: 714.209.7602 Fax 714.209.7465
drtom@theathletesadvantage.com

Financial Agreement for Patients Paying CASH

WELCOME to our Clinic!

We'll do our best to provide you with the best care we are capable of, and our office staff will help you with anything else you need to take care of.

If we do not live up to our objectives, please feel free to let the following people know, in person, by phone, or in writing:

Drs. **Iwashita, Halverson, Mai,** or **Negro** Regarding Chiropractic Management and **Sandy Tomooka** Regarding the Office Support Functions.

Your health care bills will be handled in this manner:

Since charges for treatment are normally due at the time you are treated, you will be asked to make payment before leaving. We can take your cash or check over the counter. For your convenience, we also accept PayPal and Zelle electronic payments. Please use drtom@theathletesadvantage.com for these types of payments. Posting of payments may be delayed due to the nature of the electronic transfer systems.

In exceptional cases, we will try to accommodate patients who are in positions of undue hardship. In such cases, we ask you to make payments on a previously agreed upon monthly/quarterly basis. We do not charge Interest on any outstanding balances. Additionally, when such arrangements are made, any default in payment will bring the entire balance due and payable.

Notwithstanding any other arrangements, if you should suspend or terminate treatments, your outstanding fees and balance will become due and payable immediately.

We are pleased you've chosen our office, and we anticipate you will be, too. We'll do our best to make sure you are.

Chiropractically Yours,

_____ _____ _____

Dr. Thomas Iwashita Dr. Roni Negro Sandy Tomooka

I have read and agree to the aforementioned billing policies/procedures Financial Agreement.

_____ _____

Patient Signature Date

ResponseCare Chiropractic

Dr. Tom Iwashita DC
Dr. Roni Matsumoto DC, DACBSP
Dr. David Halverson DC
Dr. Thai Mai DC
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Financial Hardship Agreement

Patient Name: _____ Birthdate: _____

My finances do not allow for me to procure care at this office for the listed/billed rate. I ask for a discount so I may receive this care.

Patient Signature _____Date _____

Approved by: _____Date _____

ResponseCare Chiropractic

The Athlete's Advantage

Dr. Tom Iwashita DC
Dr. Roni Matsumoto-Negro DC DACBSP
Dr. David Halverson DC
Dr. Thai Mai DC

Cancellation of Appointment Policy/No Show Policy

When our office books your appointment, we are setting aside a dedicated amount of time for you and we consider this a contract between you and us. To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time.

1. Cancellation/Missed Appointment/No Show Policy

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. Please call/text to cancel an appointment at least 24 hours prior to your appointment.

There is a charge of $80 for not showing up for scheduled appointments OR for a late cancel.
Note: this fee will not be covered by your insurance company

- If you do happen to cancel late, but we are able to fill the slot, you will not be charged.
- The first offense will be considered a "warning"
- Repeated cancellations or missed appointments will result in loss of future appointment privileges and/or potential dismissal from the practice.

2. Scheduling/Scheduled Appointments

For your convenience we accept appointments via text, email, and Facebook.

Please call or text to let us know that you will be late. Please understand that with a late arrival treatment may be cut short and kept within the allotted time frame of your scheduled appointment.

You may receive a text asking to change your appointment time. You have the right to say "no", but realize this system exists to help everyone get the care they need. If it's not an inconvenience for you and you can switch, please do.

I have read and understand ResponseCare Chiropractic's Cancellation/Missed Appointment/No Show Policy and understand my responsibility to plan appointments accordingly and notify Dr. Tom or Dr. Roni appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____

Patient Name | Date of Birth | Date

_____ _____

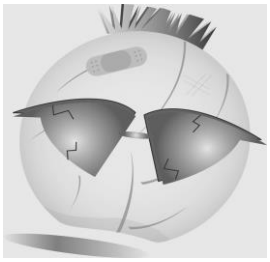
Patient Signature or Parent/Guardian if minor | Relationship to Patient

_____ _____

Staff Signature | Date

RESPONSECARE CHIROPRACTIC

DR. TOM IWASHITA



PATIENT INFORMATION			
Date			
Last Name:	First Name:	Initial:	
Address			
City	Zip Code		
Home Phone#			
Cell Phone #			
Email:			
Birthdate:	Age:	School:	
Married	Single	Divorced	Widowed
SS#			

PRIMARY INSURANCE	
Carrier:	
Group #	
Employer	
Occupation:	
Insured Name:	
Birthdate:	Relationship to Pt:
Insured ID#	
Insured SS#	

SECONDARY INSURANCE	
Carrier:	
Group #	
Employer	
Occupation:	
Insured Name:	
Birthdate:	Relationship to Pt:
Insured ID#	
Insured SS#	

GETTING TO KNOW YOU			
You were referred by:			
What is your condition related to?	Accident	Employment	Other
Have you been to a chiropractor before?	Yes	No	
Phone #:			
Emergency Contact Person:			
Closest relative not living with you:			
Phone #:			

ACCOUNT INFORMATION	
Person Financially Responsible For Account:	
Name:	
Relationship to pt	
SS#	
Address:	
City:	Zip
Phone #	

Name: **HEALTH QUESTIONNAIRE** **Revised 09-2016**

Date:

Purpose of your visit: _____

Date of accident / illness: _____/_____/_____ Time: _____am/pm Location: _____

How did it occur? ☐ Auto Collision, ☐ Work ☐ Other: _____

Have you lost time from work? ☐ Yes ☐ No

Have you seen any other doctors for this condition? ☐ Yes ☐ No If yes, who and when: _____

Have you had any other significant accidents or injuries? ☐ Yes ☐ No

Please describe the circumstances: _____

List Medications or supplements: _____

Previous broken bones: _____

Previous Hospitalizations or Surgeries _____

_____

Have you or any immediate family members had any major disease? Please explain: _____

_____

On the following scale, please indicate the severity of your complaint:

0	1	2	3	4	5	6	7	8	9	10

No Pain Severe Pain

Please indicate: O for Present Complaints

Please indicate: ☐ for Past Complaints

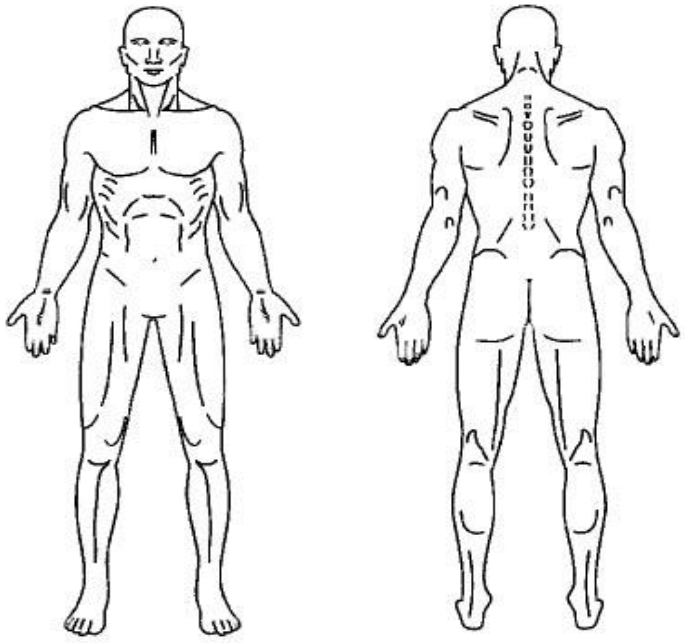
Musculoskeletal

- O ☐ Headaches
- O ☐ Neck problems
- O ☐ Jaw pain or stiffness
- O ☐ Jaw clicking
- O ☐ Shoulder problems
- O ☐ Arm problems
- O ☐ Pain between shoulders
- O ☐ Chest pain
- O ☐ Lower back problems
- O ☐ Leg problems
- O ☐ Swollen joints
- O ☐ Painful joints
- O ☐ Stiff joints
- O ☐ Sore muscles
- O ☐ Weak muscles
- O ☐ Walking problems
- O ☐ Tendon ruptures
- O ☐ Osteoporosis

Nervous System

- O ☐ Numbness or tingling
- O ☐ Loss of feeling
- O ☐ Paralysis
- O ☐ Dizziness
- O ☐ Fainting
- O ☐ Headaches
- O ☐ Muscle jerking
- O ☐ Convulsions
- O ☐ Forgetfulness
- O ☐ Confusion
- O ☐ Depression
- O ☐ Sleeping problems
- O ☐ Nervousness
- O ☐ Tension or stress
- O ☐ Loss of memory
- O ☐ Loss of balance
- O ☐ Cold hands or feet
- O ☐ Cold sweats

Please mark the areas of complaint and indicate their priority: (eg: 1,2,3…)



Gastro-Intestinal

- O ☐ Poor appetite
- O ☐ Excessive hunger
- O ☐ Difficult swallowing
- O ☐ Excessive thirst
- O ☐ Nausea
- O ☐ Vomiting food
- O ☐ Vomiting blood
- O ☐ Abdominal pain
- O ☐ Diarrhea
- O ☐ Constipation
- O ☐ Bloody stool
- O ☐ Hemorrhoids
- O ☐ Liver trouble
- O ☐ Gall bladder problems
- O ☐ Weight trouble
- O ☐ Stomach upset

Genito-Urinary

- O ☐ Bowel/bladder trouble
- O ☐ Excessive urination
- O ☐ Painful urination
- O ☐ Discolored urine

Female

- O ☐ Vaginal discharge
- O ☐ Vaginal bleeding
- O ☐ Vaginal pain
- O ☐ Breast pain
- O ☐ Lumps on breast

Are You Pregnant?

☐ Yes ☐ No

Cardiovascular

- O ☐ Chest pain
- O ☐ Difficulty breathing
- O ☐ Persistent cough
- O ☐ Coughing phlegm
- O ☐ Coughing blood
- O ☐ Rapid heartbeat
- O ☐ Blood pressure condition
- O ☐ Heart problems
- O ☐ Lung problems
- O ☐ Varicose veins

Eyes, Ears, Nose, Throat

- O ☐ Eye strain
- O ☐ Vision problems
- O ☐ Ear pain
- O ☐ Ringing in ears
- O ☐ Hearing loss
- O ☐ Vertigo
- O ☐ Nose pain
- O ☐ Nose bleeding
- O ☐ Sinus problems
- O ☐ Seasonal allergies
- O ☐ Dental problems
- O ☐ Fever
- O ☐ Loss of smell or taste

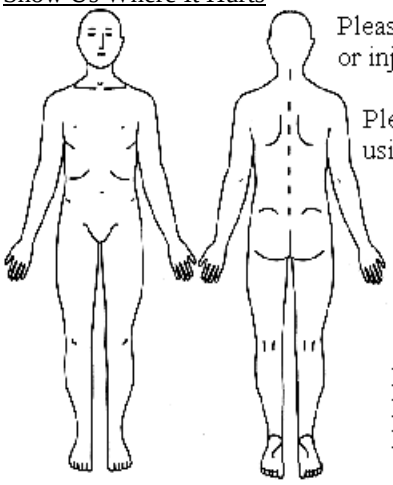
Name:_____ Age:_____ Date:_____ Sex: M F

Street Address: _____Phone #_____

City/State/Zip:_____ B-Day _____ Have you been to a chiropractor before? Y N

Employer_____ Employer's Address_____ City/State/Zip _____

Show Us Where It Hurts



Please mark the area(s) of pain or injury on the drawing.

Please note the type of pain by using the symbols below.

Sharp/stabbing >>>
Dull/Achy ###
Numb/Pins+needles OOO
Burning ***

On a scale of 1-10, 10 being the worst pain you have ever had, how would you rate your pain at this time?_____
How would you rate it when it first started?_____
MOI:_____
Prov:_____
Pall:_____
Other Notes:_____
_____
_____
_____
_____
_____
_____
_____
_____

Tell Us About What Hurts

What is your main complaint?_____

When did it start? _____ Is it better or worse now? _____ What % of the day is it present? _____

Have you ever injured this area before? Y N If yes when and how? _____

Medical Information

Have you or any of your immediate family had any of the following? (circle all that apply)
stroke, cancer, hypertension, diabetes, heart attack, arthritis, other_____
Condition? _____ who? _____ Age? _____
Condition? _____ who? _____ Age? _____

Have you ever seen another doctor for this condition? MD_____ DO_____ DC_____ DDS_____ Dr's Name_____

Have you ever experienced any of the following? Unexplained weight loss, night pain, or pain at rest, bowel or bladder problems, dizziness, chest pain, weakness in arms or legs, difficulty breathing, fractures, or any other injury/illness requiring medical attention: _____

Have you had any x-rays? Why were they taken? _____

Have you had surgery? Y N If Yes, when and why? _____

Please list any medications you are taking: _____
What are they for? _____
Have you ever used prescription contraceptives? Y N When? _____ How long? _____

Have you had or do you presently have cancer? Y N If yes, when was the initial diagnosis made? _____

What type of cancer?_____ What type of treatment? _____ Date of last bone scan: _____

Date of last mammogram? _____ Pelvic exam? _____ Breast exam? _____

What were the results of the above tests ? _____
Are you postmenopausal? Y N Approximate date of onset? _____ Are you on hormone replacement? Y N

Vitals:

Pulse: _____ BPM Temp: _____ Resp: _____ RPM BP L: _____/_____ BP R: _____/_____ Georges: + --

Ht_____ Wt._____ Pulse ox%_____

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Thai Mai, DC
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INFORMED CONSENT FOR EVALUATION AND EXAMINATION OF ALL PATIENTS

By signing this form, you are consenting to an examination by Dr. Thomas Iwashita, or Dr. Roni Negro, or another staff doctor. ResponseCare Chiropractic employs standard chiropractic examination methods including the following:

1. Observation: General assessment/appraisal in all positions;
2. Inspection: This involves viewing your body parts, and includes general body viewing in a standing position; front, back, and side. All symptomatic (painful) body parts may be viewed. Women will ALWAYS continue wearing their undergarments in the course of the examination unless it obscures the viewing of injured/abnormal body parts. Women may request a female observer at any time during the examination.
3. Auscultation: This is a procedure in which a stethoscope will be used to listen for blood pressure and other bodily produced sounds.
4. Palpation: This means the doctor will touch you. The doctor can feel for tenderness, heat, swelling, nodularity, laxity of tissues, integrity, and abnormality.
5. Percussion: This is a procedure in which the doctor uses a rubber hammer to tap on bones or tendons.
6. Orthopedic/Neurological Testing: These are standard tests performed to assess your neuromusculoskeletal system.

NOTE: You do not have to accede to any examination/procedures. We ask you to comply to the best of your ability and report changes in the pain and/or symptoms so we may best understand your complaints and reach a definitive diagnosis. If any procedure is too uncomfortable, please let us know so we may utilize alternative procedures that may be more accommodating to you.

I, _____, understand the above statement and agree to submit to any of the above evaluation and examination procedures the doctors deems necessary, and I accept the risks and consequences of their application.

_____ _____
Signature of Patient or Guardian (If patient is under 18) Date

ResponseCare Chiropractic

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David L. Halverson, DC
Thai Mai, DC
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CONSENT TO EXAMINATION AND TREATMENT

I have been informed that the doctor providing my treatment in this office has been certified as Associated Faculty within the Clinical Education Division of the Los Angeles College of Chiropractic, and that this office serves as a teaching as well as a treating facility. I understand that a clinical student, under the direct supervision of the doctor, may provide some of the treatment that I receive in this office. I understand that a clinical student will be identified as such prior to their involvement in any treatment that I receive.

I hereby request and consent to examination and the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor, or by a clinical student under the direct supervision of the doctor.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor or clinical student, affiliated with the Los Angeles College of Chiropractic to perform such. I intend this consent form 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) **Date**

_____

Patient or Guardian's Signature

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with ResponseCare Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not 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. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with ResponseCare Chiropractic to perform such. I intend this consent form 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) **Date**

_____

Patient or Guardian's Signature

ResponseCare Chiropractic

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Dr. Roni Matsumoto DC, DACBSP
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

We do not share your information with anyone. You do not have to opt in to receive these protections. Opting Out to share your information with someone requires your reading and signing an additional form. Please ask us to provide this to you if you think you need to.

A copy of the *Notice of Information Practices* is on the clipboard you sign in on.

_____ _____

Patient Signature Date