

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

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

Patient: _____

Employer: _____

Claim/Group #: _____

SS/ID#: _____

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

Dr. Thomas Iwashita DC
11562 Knott Street #17
Garden Grove, CA 92841

Or

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

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 RIGHTS 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 or facsimile 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 _____, CA this _____ day of _____ 201_____.

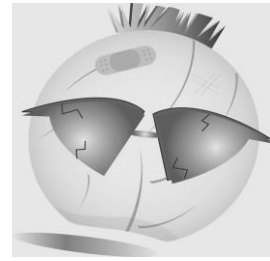
Signature of Policy Holder

Witness

Signature of Claimant, if other than Policyholder

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: for Present Complaints

Please indicate: for Past Complaints

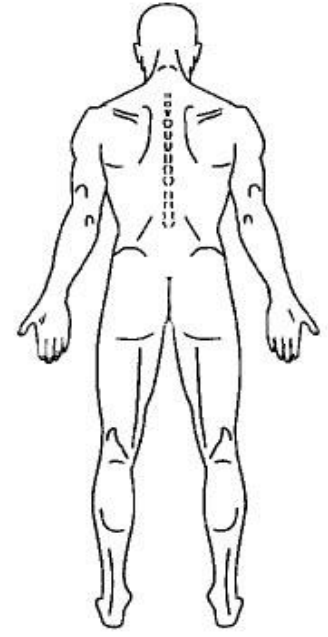
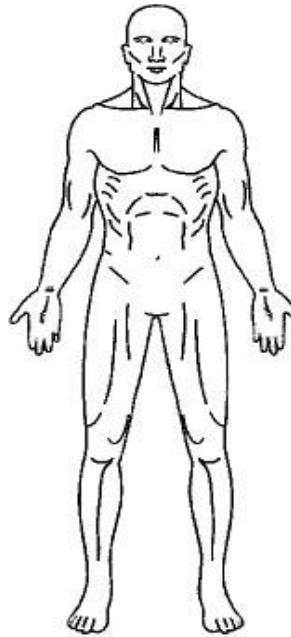
Musculoskeletal

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

Nervous System

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

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



Gastro-Intestinal

- Poor appetite
- Excessive hunger
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Bloody stool
- Hemorrhoids
- Liver trouble

- Gall bladder problems
- Weight trouble
- Stomach upset

Genito-Urinary

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

Female

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

Are You Pregnant?

- Yes No

Cardiovascular

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

Eyes, Ears, Nose, Throat

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

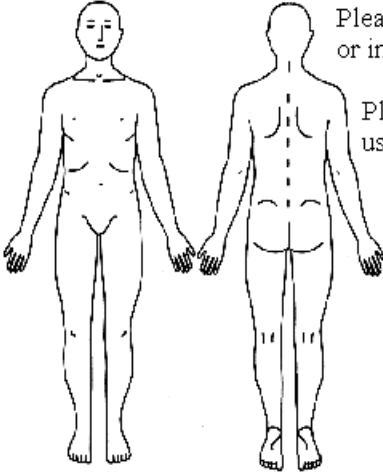
Name: _____ Age: _____ Date: _____ Sex: M F

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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Thomas Iwashita, D.C.

Roni Negro, DC DACBSP

David Halverson, DC

Thai Mai, DC

11562 Knott Street #17

Garden Grove, CA 92841

714.209.7602

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

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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

Dr. Tom Iwashita DC

Dr. Roni Matsumoto DC, DACBSP

Dr. David Halverson DC

Dr. Thai Mai DC

11562 Knott Street #17

Garden Grove, CA 92841

Phone: 714.209.7602 | Fax: 714.209.7465

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