Birch Pain & Spine Group
227 E. Eleventh Street
Tracy, CA 95376
Tel: 209 -830 -1799

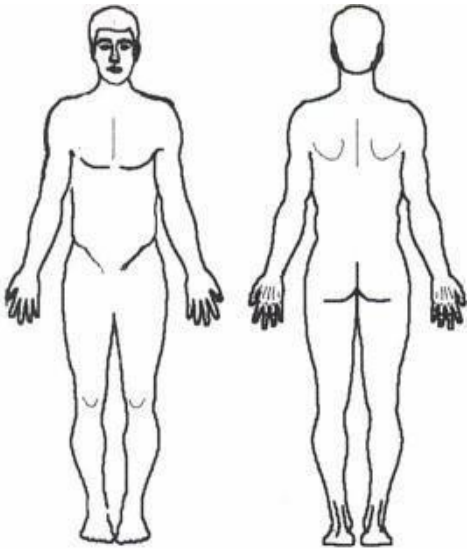
What services are you interested in:

O IV Nutrition/ Vitamin Therapy O Ozone Therapy O PRP/ Regenerative Therapy
O Botox O Fillers O Weight Loss
O Knee pain O Chiropractic care O Physical Therapy

How did you find us: O Facebook O Website O Friend O Other _____

Patient Name:_____ **Birthdate**:_____Sex: F / M
Address:_____City:_____State:____Zip:_____
Telephone:_____Social Security:_____
Email:_____
Occupation:_____**Employer**:_____Work phone:_____
Address:_____City:_____State:_____Zip:_____
Subscriber Name:_____Date of Birth:_____
Subscriber ID:_____Group#:_____
Emergency Contact:_____Phone:_____
Primary Care Physician:_____Phone:_____

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



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

O Headache O Neck Pain O Mid-back Pain O Low Back Pain

O Other _____

Is this? O Work Related O Auto Accident Related O N/A
Date of Injury_____ Date of Injury_____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 1 0

No Pain Unbearable Pain

DATE PROBLEM BEGAN:

How often are your symptoms present?

O 0-25% O 26-50% O 51-75% O 76-100%
Intermittent Constant

Can you perform your daily activities? O Yes O No

Describe if no_____

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

0____1____2____3____4____5____6____7____8____9____10

No interference Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? O Yes O No

If Yes, Date(s) taken: _____ **WHAT AREAS WERE TAKEN?**_____

Please check all of the following that apply to you: O None Apply

YES	NO	Condition	YES	NO	Condition
O	O	History of Recent Infection	O	O	Prostate Problems
O	O	Recent Fever	O	O	Frequent Urination
O	O	HIV/AIDS	O	O	Pregnancy, # of births_____
O	O	Diabetes	O	O	Abnormal Weight O Gain O Loss
O	O	Corticosteroid Use	O	O	Epilepsy/Seizures
O	O	Birth Control Pills	O	O	Visual Disturbances
O	O	High Blood Pressure	O	O	History of Low/Mid Back Pain
O	O	Stroke (date) _____	O	O	History of Neck Pain
O	O	Dizziness/Fainting	O	O	Arthritis
O	O	Numbness in Groin/Buttocks	O	O	History of Alcohol Use
O	O	Urinary Retention	O	O	History of Tobacco Use
O	O	Aortic Aneurysm	O	O	Osteoporosis
O	O	Cancer/Tumor (type) _____	O	O	Recent Trauma
O	O	Surgeries/Medications:_____			

Family History: O Cancer O Diabetes O High Blood Pressure O Cardiovascular Problems/Stroke

I certify that 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. Therefore I give authorization to my chiropractor and/or Insurance to contact my physician, if necessary.

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Birch Pain & Spine Group as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(s). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entided, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Patient Signature: _____ **Date:** _____

Date _____ **Patient Name** _____ **Date of Birth** _____

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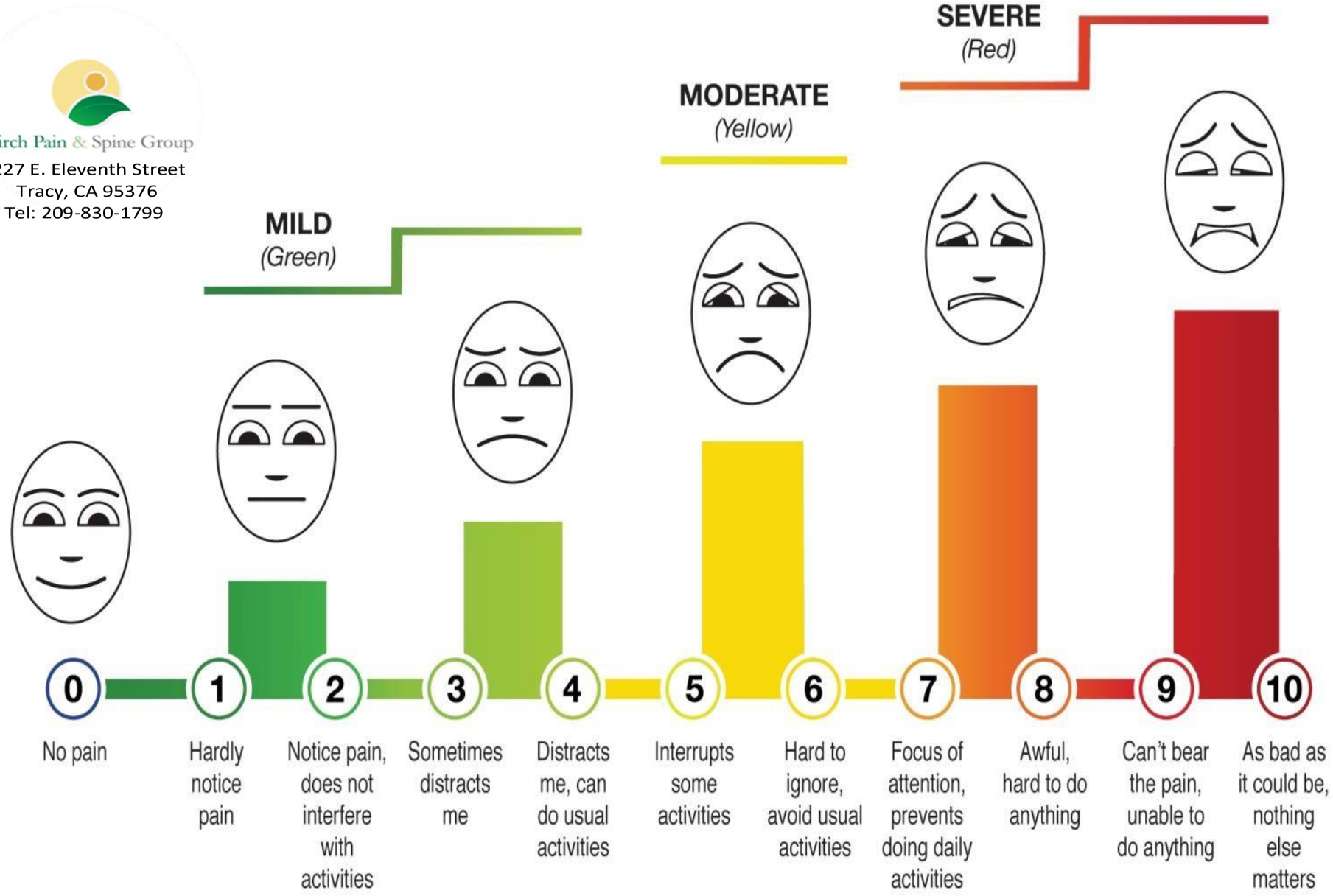

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1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:

Does not interfere — Completely interferes

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:

Does not interfere — Completely interferes

3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:

Does not affect — Completely affects

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:

Does not contribute — Contributes a great deal

**Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.*

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CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by Lina Yousofi, D.C. and/or other licensed Doctor of Chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the Doctor Yousofi the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I have had an opportunity to discuss with Megan Pope MSN FNP-BC or Joseph A. Sclafani MD the purpose of exam and treatment 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 and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

Lina Yousofi, D.C @ Birch Pain & Spine Group 227 E. 11th Street Tracy, CA 95376

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PATIENT MISSED APPOINTMENT POLICY

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. You'll be sent a text or voice reminder regarding your appointment 24 hours prior.

Apart from serious emergencies, it is expected that you keep all your appointments. If you need to reschedule an appointment, we require **24-hour notice**. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

ALL PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDULED APPOINTMENTS OR WHO CANCEL WITH LESS THAN 24 HOURS ADVANCE NOTICE WILL BE CHARGED A MISSED APPOINTMENT **FEE $95.00**

I have read and understood the above policy:

Signature: _____ Date:_____

Print: _____

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PATIENT POLICY: DOCTOR -PATIENT AGREEMENTS

Welcome to Birch Pain and Spine Group. The purpose of these agreements is to allow us to more completely serve you and get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements, get the best results.

PAYMENT OF BILLS:

We will expect you to honor your financial agreement with our office. If you find you cannot fulfill the agreement you`ve made, please advise our stuff so we can make other agreements. We do not bill patients so payment at the time of service is appreciated. Insurance companies will be billed, services that are not covered will be your responsibility. Any outstanding balance over 120 days will be turned over to a collection agency and accessed a 40% late fee.

PROGRESS EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, progress evaluations and check-ups may take place. The fee for these services may not be covered by insurance so they will become your responsibility.

DIETS AND SUPPLEMENTS

Diets should be followed, and food supplements taken if recommended. We do not prescribe but will make recommendations to help speed your recovery. You are expected to pay for supplements at the time of purchase.

CELL PHONES/WAITING ROOM

Please be courteous to others in the waiting room by turning off your cellphone. If you are visiting with another patient, please keep conversations as quit as possible.

We are here to serve you. Please speak with your doctor about any upsetting matter. We see your comment as helping us to help you and others.

I HAVE READ ABOVE AND I UNDERSTAND AND ACCEPT THESE POLICIES.

_____ _____

Patient`s signature Todays Date