PRECISION SPORTS MEDICINE & CHIROPRACTIC

Date_____/____/_____ Dr. Christopher Matock D.C., C.C.S.P. Dr. Sergio Perry D.C.

PATIENT INFORMATION					
LAST NAME	FIRST	MIDDLE		WHAT DO YOU PREFER TO BE CALLED	
HOME ADDRESS		CITY	STATE	ZIP CODE	
CELL PHONE	HOME PHONE		SOC. SEC NO.		GENDER: M / F
EMAIL ADDRESS		DRIVERS LICENSE		REFERRED BY:	
PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE FRONT DESK					

INSURANCE INFORMAITON					
COMPANY NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO.
INSURED'S NAME	GROUP NO.	POLICY NO.	SOC SEC. NO		RELATION: ( ) SELF ( ) SPOUSE ( ) OTHER

SECONDARY INSURANCE INFORMATION					
COMPANY NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO.
INSURED'S NAME	GROUP NO.	POLICY NO.	SOC SEC. NO		RELATION: ( ) SELF ( ) SPOUSE ( ) OTHER

IN THE EVENT OF AN EMERGENCY			
WHO SHOULD WE CONTACT	RELATION	CELL PHONE	WORK PHONE

ACCOUNT INFORMATION		
PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT	RELATION: ( ) SELF ( ) SPOUSE ( ) OTHER	PHONE
BILLING ADDRESS ( ) CHECK IF SAME AS HOME ADDRESS CITY STATE ZIP CODE		DRIVERS LIC. ( ) SAME AS ABOVE

I understand the above information and guarantee this entire page form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to my medical status.

I authorize payment of medical benefits to Precision Sports Medicine for services provided.
I authorize release of any medical or other information necessary to process claims.

_____ _____

Patient's or Responsible Party's signature Date

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK OR CREDIT CARDS

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INSURANCE POLICY

We bill insurance as a courtesy only. You are ultimately responsible for your account. If your insurance does not pay within 45 days payment in full is immediatley due and expected by you. Please be aware some and perhaps all of the services provided may be considered " non covered services" and /or not reasonable and necessary under your insurance plan. You will need to contact your insurance provider to find out if the service are covered.

INITIALS:

WORKERS COMPENSATION

Workers Compensation pays in full for chiropractic care. Patient must report the injury to their employer within 30 days of its occurance. Patient must have prior authorization from your employers Workers Compensation company prior beginning care. If the claim is denied as a Workers Compenation injury the patient will be responsible for payment.

INITIALS:

MEDICARE

Medicare only pays for spinal manipulation ONLY. All other servcies are DISALLOWED. We are a NON-PAR provider. Payment will be sent directly to the patient.

INITIALS:

PERSONAL INJURY

As a courtesy to you, we will submit your charges to your insurance company(ies) and/ or your attorney; however, all services rendered by this office are charged directly to you, and, ultimately, you are responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive. If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. If your bill remains unpaid beyond 60 days of conclusion of care or termination of care you will begin accruing interest at 1% per month.

INITIALS:

CANCELLATION POLICY

Cancellations without 24 business hours notice, or a "no-show" constitue a missed appointment (MA). Patients must take full responsibilty for any reason they cannot make their appointment

Cancellation must be made during our regular business hours. Monday appointments must be cancelled by the previous Friday. It is impreative to be on time to obtain the full benefit of treatment. Late arrivals may receive an abbreviated service. A MA minimum $25.00

INITIALS:

Signature _____ Date _____

PRECISION SPORTS MEDICINE CHIROPRACTIC

Date_____/____/_____ Dr. Christopher Matock D.C., C.C.S.P. Dr. Sergio Perry D.C.

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic manipulation(s) and other chiropractic procedures, including examination tests and various physical therapy techniques on me (or the patient named above, for whom I am legally responsible) by Dr. Christopher Matock D.C., C.C.S.P., Dr. Sergio Perry D.C. and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serve as back-up for Dr. Christopher Matock D.C., C.C.S.P. and/or Dr. Sergio Perry D.C.

Dr. Matock and Dr. Perry prefer to perform soft tissue therapy (STT) and/or GRASTON Technique (GT) prior to manipulation because it assures a smoother, less forceful, more effective manipulation. STT/GT are extremely safe and non-invasive procedures which relieve muscle spasm, increase range of motion, releases painful adhesions due to the build up of scar tissue, and re-educates faulty movement patterns established by injury. Manipulation increases range of motion of joint structures and is effective in relieving musculoskeletal, non-surgical back pain.

I understand and am informed that, as in practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fracture, disc injury, strokes, dislocation, sprains, muscle strains Horner's syndrome, cervical myelopathy and rarely death. Risks associated with STT/GT include, but are not limited to, soreness, bruising, and release of pre-existing blood clots or embolisms. I do not expect the doctor to be able to anticipate and explain all risks and complications and I which to rely on the doctors 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 interest.

I have had the opportunity to discuss with the doctor(s) the nature and purpose of chiropractic adjustments, soft tissue therapy, GRASTON Technique, and other procedures. I have been told I can expect the above mentioned benefits from the proposed procedure(s), but that no results can be guaranteed or assured. I also understand that the condition for which this procedure(s) is being done may not be cured or significantly improved, and in rare cases, may even become worse.

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

GRASTON TECHNIQUE INFOMRED CONSENT

Grasont Technique is a unique, evidence-based form of instrument-assisted soft tissue mobilization that enables clinicians to effectively and efficiently address soft tissue lesions and fascial restrictions resulting in improved patient outcomes.

GT uses specially-designed stainless steel instruments with unique treatment edges and angles to deliver an effective means of manual therapy. The use of GT instruments, when combined with appropriate therapeutic exercise, leads to the restoration of pain-free movement and function.

The Graston Technique protocol has several basic components. Your clinician will determine the protocol best for you.

All components of Graston Technique have been explained to me. I understand the risks of the procedure and I give my full consent for treatment.

Print Name _____ Signature _____ Date _____

PRECISION SPORTS MEDICINE & CHIROPRACTIC

Date_____/____/_____ Dr. Christopher Matock D.C., C.C.S.P. Dr. Sergio Perry D.C.

GRASTION TECHNIQUE INFORMED CONSENT

Grasont Technique is a unique, evidence-based form of instrument-assisted soft tissue mobilization that enables clinicians to effectively and efficiently address soft tissue lesions and fascial restrictions resulting in improved patient outcomes.

GT uses specially-designed stainless steel instruments with unique treatment edges and angles to deliver an effective means of manual therapy. The use of GT instruments, when combined with appropriate therapeutic exercise, leads to the restoration of pain-free movement and function.

GRASTON TECHNIQUE QUESTIONNAIRE

Please answer the following questions.

1) Do you bruise easily?	Yes	No
2) Do you bleed for a long gime after you cut yourself?	Yes	No
3) Are you taking blood thinners or anticoagulants?	Yes	No
4) Do you take asprin on a regular basis	Yes	No
5) Do you take cortisone on a regular basis?	Yes	No
6) Have you ever had inflamed veins or blood clots?	Yes	No
7) Do you have surgical implants in your body?	Yes	No
8) Do you have diabetes or kidney disease?	Yes	No
9) Do you currently have any infections?	Yes	No
10) Do you have uncontrolled high blood pressure?	Yes	No

GRASTON TECHNIQUE PROTOCOL

The Graston Technique protocol has several basic components. Your clinician will determine the protocol that is best for you.

1) Warm up of the treatment area
2) Graston Technique Treatment
3) High repetition, low load exercise
4) One to three 30-second stretches
5) Low repetition, high weight exercises
6) Ice therapy
7) Stretching/rehabilitation exercises

All components of Graston Technique have been explained to me. I understand the risk of the procedure and I have my full consent for treatment.

_____ _____

Print Name Date

_____

Signature

Mar-17

PRECISION SPORTS MEDICINE CHIROPRACTIC

Date_____/____/_____ Dr. Christopher Matock D.C., C.C.S.P. Dr. Sergio Perry D.C.

HEALTH CARE PROVIDER-PATIENT ARBITRATION AGREEMENT

ARTICLE I: AGREEMENT TO ARBITRATE

It is understood that any dispute as to medical malpractice, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE II: ALL CLAIMS MUST BE ARBITRATED

It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provide by the health are provider including and heirs or past, present, or future spouse(s) of the patient in relation to all claims, including loss on consortium. This agreement is also intended to bind any children of patient whether born or unborn at the time of the occurrence giving rise to any claim. All health care providers, health care associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for a loss consortium, wrongful death, emotional distress or punitive damages. Filing any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following that assertion of any claim against the health care provider, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

ARTICLE III: PROCEDURES AND APPLICABLE LAW

A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neural arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) days thereafter. The neutral arbitrator shall then be the sold arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party to such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that the provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this Arbitration Agreement including but not limited to sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1) the limitation on recovery for non-economic losses (Civil Code 3333.2) and the right to have a judgement for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the America Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

ARTICLE IV: GENERAL PROVISIONS

All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one processing. A claim shall be waived and forever barred if (1) on the date of notice thereof is received, the claim, of assured in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration conducted pursuant to this Arbitration Agreement.

PRECISION SPORTS MEDICINE CHIROPRACTIC

ARTICLE V: REVOCATION

This agreement may be revised by written notice delivered to the health care providers within thirty (30) days of signature and if not revoked will govern all professional services received by the patient

ARTICLE VI: RETROACTIVE EFFECTIVE

If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial below

Effective as of first professional services. Patient Initials: _____

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions. I understand that I have the right to receive a copy of the arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DEDCIDIED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE I OF THIS CONTRACT.

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient/Legal Guardian Relationship to Patient

_____ _____

Doctor Signature Date