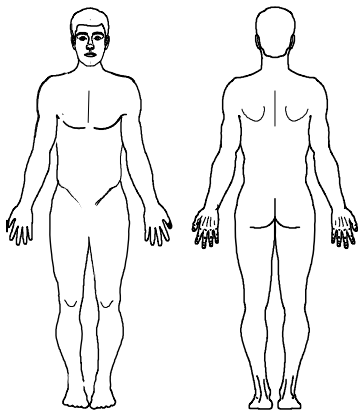
American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name _____ Birthdate _____ Sex M / F
Address _____ City _____
State _____ Zip _____ Telephone (____) _____ E-mail Address _____
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):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

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:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) _____
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) _____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) _____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
☐ 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** _____

Jason A. Edwards, DC
940 W. San Marcos Blvd., Ste. B
San Marcos, CA 92078
Phone: (760) 744-1881 Fax: (760) 744-2103
www.jasonedwardschiropractic.com

Financial Policies

Welcome you to our office. Be assured that you will be receiving the very best care we can offer. With you help, we are confident that we can assist you in your recovery in an effective and cost efficient manner. To avoid confusion, the following is an explanation of how your chiropractic bills will be handled at this office.

Insurance Coverage

Your insurance policy is an agreement between you and your insurer. Coverage for chiropractic services varies depending on your individual plan. Our office participates or is contracted with a number of insurance companies. As a courtesy to you, we will make every reasonable effort to verify your insurance benefits. This office will rely upon this provided information in processing your claims, but please note that v*erification of benefits is not a guarantee of payment by your insurance company*. **You are ultimately responsible for any services rendered at this office, including payment of any non-covered services, deductibles, co-pays, or co-insurance. All copays will be collected at the time services are rendered. Payment for non-covered services, deductibles, and co-insurance expenses are due within 30 days of the billing statement being mailed to you from this office.**

Cash Discount Rates

For those with no chiropractic coverage, we offer a special cash discount rate. We charge $100 for a new patient office visit, which includes: a consultation, limited exam, and treatment. The cost for follow-up visits for the same problem is $60. These special rates do NOT include x-rays, supplements, supports, or special procedures. Limited re-exams within 3 years of the last office visit are $35. When more than 3 years have passed since the office visit, the new patient rate of $100 will apply to that visit. We also offer a discount price on a *pre-paid* 10 visit package for $550, available after the first visit. **All of these special rates only apply when the patient has no other source of payment AND the visit is paid in full at the time service is rendered.**

Student Rates

If you are a full-time student (12 units or more per semester), you may qualify for a special student rate. Valid school I.D. is required for verification. Inquire with the front office staff.

For your convenience we accept cash, check, Visa, MasterCard, Discover, or AMEX.

My signature below signifies that I have read and understand the office policies detailed above.

Print Name: _____ Date: _____

Signature: _____

NOTICE OF PRIVACY PRACTICES

WELLNESS CHIROPRACTIC
940 W. SAN MARCOS BLVD. #B
SAN MARCOS, CA 92078

The Office of
Gary N. Lewkovich, DC, QME, Chiropractic Orthopedist, DAAPM
and Jason A. Edwards, DC

Wendy Lewkovich, Office Manager and Privacy Compliance Officer
760-744-1881
fax: 760-744-2103
wendyitzel@aol.com

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your healthcare information. We make a record of the healthcare we provide and may receive such records from others. We use these records to provide or enable other health care provider(s) to provide quality healthcare, to obtain payment for services provided to you as allowed by your health plan, and to enable us to meet our professional and legal obligations to operate this healthcare practice properly. We are required by law to maintain the privacy of protected health information (PHI), to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your healthcare information. It also describes your rights and our legal obligations with respect to your healthcare information. If you have any questions about this Notice, please contact our Privacy Compliance Officer listed above.

A. HOW THIS HEALTHCARE PRACTICE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

This healthcare practice collects health information about you and stores it in a chart and a computer and in an electronic health record/personal health record. This is your healthcare record. The healthcare record is the property of this healthcare practice, but the information in the healthcare record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment: We use healthcare information about you to provide your healthcare. We disclose healthcare information to our employees and others who are involved in providing the care you need. For example, we may share your healthcare information with other healthcare providers who will provide services that we do not provide. Or we may share this information with a laboratory or special testing facility that performs a study or test. We may also disclose healthcare information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment: We use and disclose healthcare information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations: We may use and disclose healthcare information about you to operate this healthcare practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your healthcare information with certain "business associates," such as a billing or accounting service, that perform administrative services for us. As required by law, we have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with the following: their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care coordination activities, their review of competence, qualifications and/or performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders: We may use and disclose healthcare information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet: We may use and disclose healthcare information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable, or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing: Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, tell you about government sponsored health programs or encourage you to purchase a product or service. We will not otherwise use or disclose your healthcare information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information: We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirements concerning those activities as set forth below:

10. Public Health: We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities: We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement: We may be required by law to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners: We may be required by law to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation: We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues if you have granted prior permission for their use.

16. Public Safety: We may be required by law to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Specialized Government Functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

18. Workers' Compensation: We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

19. Change of Ownership: In the event that this healthcare practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another healthcare provider or healthcare group.

20. Breach Notification: In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances, our business associate(s) may provide the notification. We may also provide notification by other methods, as appropriate. (Caution: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example, an email address should not contain information that directly identifies a patient and his/her condition.)

21. Research: We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law. Personal identifying information is not disclosed for the purpose of research.

B. When This Healthcare Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this healthcare practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this healthcare practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy: You have the right to inspect and copy your health information, with limited exceptions. To access your healthcare information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing, it must be because we believe allowing such access would be reasonably likely to cause substantial harm to the patient. If such a denial occurs, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to a mental health professional.

4. Right to Amend or Supplement: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this healthcare practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information made by this healthcare practice, except that this healthcare practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 17 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this healthcare practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice: You have a right to notice of our privacy practices, which includes our legal duties and your rights, with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Compliance Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. These amendments, if and when they occur, are typically mandated by the federal and/or state government. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we

maintain, regardless of when it was created or received. We will keep a copy of the current notice available in our reception area and a written copy will be available to keep by all patients and/or their designees.

E. COMPLAINTS

Complaints about your Privacy rights or the handling of your PHI should be directed to this office's Privacy Compliance Officer noted above. If necessary, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which the Practice handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509 F HHH Building
Washington, DC 20201

Your complaints may also be filed at OCRMail@hhs.gov. The complaint form may be found at: www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

This is the current version (effective: 9/23/13) of this office's Notice of Privacy Practices. This version is subject to modification as new government regulations are mandated or recommended. We apologize for any inconvenience that this compliance process requires on your part.

Please sign and date this form to comply with Federal regulations regarding patient privacy.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that the following appointment reminders and other notifications may be used by the Practice: a) a postcard and/or letter mailed to me at the address provided by me; b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; or c) emailing me at the email address provided to this office.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order to obtain payment for my treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent. 7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not be in a legal position to treat me under federal law.

I have read, understand, and agree to the above information, and will accept full responsibility for asking any questions I may have.

_____	_____
Printed Name of Individual	Signature of Individual
_____	_____
Signature of Legal Representative (e.g., Guardian, Parent, if a minor)	Relationship to Patient
Date Signed:_____	Witness:_____

INFORMED CONSENT TO
CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks that have been associated with treatment, including, but not limited to, fractures, disc injuries, strokes, TIAs, cardiac arrest, dislocations and sprains. It should be noted that the more severe risks are extremely remote. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand and am informed that possible alternatives to chiropractic treatment include, but are not necessarily limited to rest, physical therapy, acupuncture, massage, over the counter medication, and osteopathic/medical care involving prescription drugs and/or surgery.

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.

Signature of Patient

_____

Print Patient's Name

_____

Date Signed _____

Signature of patient's representative, if necessary, (e.g., if patient is a minor or physically/legally incapacitated)

_____

Print Name of Patient's Representative

_____

Date Signed _____

Translated by (if applicable)

_____

Date Signed _____

--- Below is for Office Use Only ---

This form was verbally explained to the patient or to his/her representative by _____

on _____ **. Initial here as evidence of having personally performed this duty:** _____

Adapted from the CCA's Fact Sheet #800 on Informed Consent