

**Patient Information**

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I: \_\_\_\_\_ Last Name: \_\_\_\_\_

E- Mail Address: \_\_\_\_\_

Home Number ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone number: \_\_\_\_\_

**General Health:** Allergies: \_\_\_\_\_

Hospitalizations/ Surgeries: \_\_\_\_\_

Drugs you now take: \_\_\_\_\_

Woman Last Menstrual Period: \_\_\_\_\_

Chiropractor consulted in the past: YES - NO Name: \_\_\_\_\_

Date: \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Is this condition due to an (A) Auto Accident (B) Work Injury (C) Other accident  
(D) Unknown cause (E) Illness

Date of injury: \_\_\_\_\_

Are the symptoms? (A) Improving (B) Getting worse (C) About the same (D) Intermittent  
Date symptoms appeared? \_\_\_\_\_

Circle any activities which aggravate your condition: (A) Standing (B) Walking (C) Sitting  
(D) Laying (E) Bending (F) Lifting (G) Twisting (H) Coughing

Have you had these symptoms before? YES NO If so when? \_\_\_\_\_

Have you seen another doctor for this condition? YES NO (A) M.D (B) Chiropractor  
(C) Osteopath (D) Acupuncturist (E) Dentist (F) Podiatrist

Doctor's Name: \_\_\_\_\_ Date of consulted \_\_\_\_\_

**Insurance information:** Insurance company: \_\_\_\_\_

Phone Number: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of insured: \_\_\_\_\_

If spouse please give birth date: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me and charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment that fees for professional services rendered me will be immediately due and payable in the event of default. I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collections.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

"Dr. Dollase is an independent Chiropractic practice and is not a partner or affiliated with any other health care professional at this location."



# Sharon Dollase, D.C., C.C.S.P., R.N.

3180 Willow Lane, Suite 122 • Thousand Oaks, CA 91361 • (805) 495-2127 • Fax (805) 495-4946

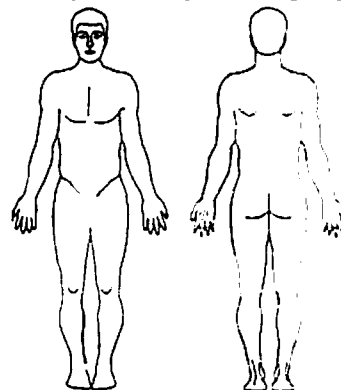
Patient Name: \_\_\_\_\_

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.  
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

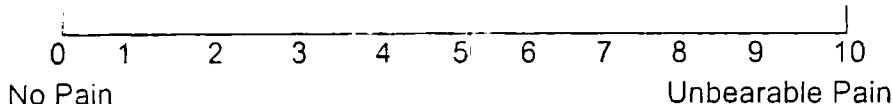
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this?  Work Related  Auto Related  N/A

DATE PROBLEM BEGAN: \_\_\_\_\_



Current complaint (how you feel today):



How often are your symptoms present?  0 - 25%  26 - 50%  51 - 75%  76 - 100%

Can you perform your daily activities?  Yes  No (Describe) \_\_\_\_\_

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN?  No  Yes Date(s) taken: \_\_\_\_\_

WHAT AREAS WERE TAKEN? \_\_\_\_\_

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

- | No                       | Yes                      | Condition                   |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use          |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttacks  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma               |

- | No                       | Yes                      | Condition   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures   |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use  |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____  |

Family History:  Cancer  Diabetes  High Blood Pressure  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.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PATIENT HEALTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Patient ID# \_\_\_\_\_

If you have ever had a listed symptom in the \_\_\_\_\_, please check that symptom in the *Past Column*. If you are presently troubled by a particular symptom, check that symptom in the *Present column*. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT AND THERAPY YOU RECEIVE.

<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (R _____ L _____)	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (R _____ L _____)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R _____ L _____)	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (R _____ L _____)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip (R _____ L _____)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (R _____ L _____)	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (R _____ L _____)	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Liver / Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon
		<input type="checkbox"/> Gain <input type="checkbox"/> Loss	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	If a family member has had any of the following, please mark the appropriate box:		
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue			
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow			
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow			
<input type="checkbox"/>	<input type="checkbox"/>	Breast <input type="checkbox"/> Soreness <input type="checkbox"/> Lump			
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis			
<input type="checkbox"/>	<input type="checkbox"/>	PMS			
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control			
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination			
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination			
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing			
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion			
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash			
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Cancer
			<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Back Problems
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Headaches
			<input type="checkbox"/>	<input type="checkbox"/>	Lupus
			<input type="checkbox"/>	<input type="checkbox"/>	Other _____
			<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure

Present Weight \_\_\_\_\_ pounds      Height \_\_\_\_\_ feet \_\_\_\_\_ inches

Please check any of the following that apply to you

<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # births _____	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills, type _____	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere) _____	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
		_____	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffinated Soft drinks: _____
		_____			cups/cans per day _____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures (list if not described elsewhere) _____			

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my condition or health plan coverages in the future.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONFIDENTIAL HEALTH QUESTIONNAIRE**

Name  
Address  
Phone  
email

Date \_\_\_\_\_

Have you ever stayed at a hospital overnight?

Reason ----- Year (list)

---

---

---

Injuries body part ----- year (list)

---

---

---

Illness and disease

Current -----

---

---

---

Past (list, with year)

Drug history (prescription or recreational)

Current

---

---

---

Past ----- (year)

What health supplements are you taking on a regular basis?

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---

How much confidence do you have in your family MD, 1-10, with 10 being highest? \_\_\_\_\_

How much confidence do you have in your body's ability to heal itself, 1-10? \_\_\_\_\_

Do you want to lose weight? \_\_\_\_\_

How much? \_\_\_\_\_

Check which of these are **MORE** IMPORTANT to you than you health (honestly)

\_\_ looking good

\_\_ being normal weight

\_\_ money

\_\_ cars

\_\_ fame

\_\_ travel

\_\_ bowling

\_\_ animals

\_\_ being thin

\_\_ family

\_\_ success

\_\_ house

\_\_ love

\_\_ music

\_\_ sports

\_\_ art

\_\_ none

\_\_ motorcycles

\_\_ fencing

\_\_ alcohol

\_\_ other \_\_\_\_\_

Which best describes your diet??

- the worst
- never think about it
- moderately indulgent
- see-food diet (whatever you see, you eat)
- fairly reasonable
- No dairy
- occasional binges
- Nothing exceeds like excess
- fairly bad
- no alcohol before noon
- vegetarian
- raw foods
- all ethnic
- some McDonald's
- Spartan
- totally healthful
- bad
- Karen Carpenter
- Vegan
- cosmically organic
- coffee, Coke, chocolate
- meat, milk, potatoes
- TV dinners
- Keith Richard

Specific Health Goals (what do you really want?) \_\_\_\_\_

How much money do you spend per month on your health, out of pocket? \_\_\_\_\_

How far are you willing to commit to achieve your health goals?

- not much
- a little
- a reasonable amount
- as much as I can
- whatever it takes
- don't want to change lifestyle

Symptoms: Which have you had in the past 3 months? Write # of times per week

- headache \_\_
- neck pain \_\_
- upper back pain \_\_
- low back pain \_\_
- leg pain \_\_
- stomach pain; indigestion \_\_
- shoulder pain \_\_
- leg numbness \_\_
- arm pain \_\_
- arm numbness \_\_
- heart pain \_\_
- fatigue \_\_
- can't breathe well! \_\_
- feeling of impending doom
- jaundice
- tremors
- shortness of breath
- other \_\_\_\_\_

## Our Insurance and Financial Policy

We will gladly bill your insurance in lieu of payment from you for your care in our office. The following policy prevails:

1. If your insurance has been verified by our office, we will gladly accept ½ of your initial examination procedures charge as partial payment. The remaining ½ can be billed directly. Completed and signed insurance claim forms must accompany your partial payment.
2. The ½ you pay will go toward satisfying your deductible and the percentage (known as coinsurance) not usually paid by insurance. PLEASE DO NOT SEND IN ANY RECEIPTS YOURSELF WHEN YOU DESIRE US TO DIRECT BILL FOR YOU.
3. Once the Doctor has determined the nature of your problem, she will discuss her recommendations with you. At this time we will advise you of the estimated costs and the percentage that will not be covered by your insurance. This balance may be paid all at once or in installments within 60 day period without finance charges.
4. If you were unable to bring a completed and signed claim form with you on your first visit, please do so by your second visit if you desire us to either direct bill your insurance or complete forms for you.

IF YOU HAVE ANY QUESTIONS CONCERNING OUR FINANCIAL OR  
INSURANCE POLICY, PLEASE DO NOT HESISTATE TO SPEAK WITH US.

### OTHER METHODS OF PAYMENT

1. For those patients who do not have insurance coverage for our services you may pat at time of services are rendered by: CASH CHECK, MASTERCARD, VISA or AMERICAN EXPRESS. ALL FEES FOR SERVICES RENDERED ARE EXPECTED TO BE PAID AT TIME OF SERVICE. Any fees not paid will be subject to 1.5% interest rate per month or 18% per year.
2. If your health problem is the result of an AUTO ACCIDENT, we will gladly direct bill all charges when your policy provider for direct payment to the doctor. You must present all auto insurance information and major medical policy information prior to when our direct billing begins. We file all refunded to the patients. If you do not have auto med-pay or major medical coverage then payment in full is requested at time of service, unless attorney lien is signed and an attorney represents you.
3. If your health problem is the result of a WORK-RELATED INJURY please speak with the insurance administrator prior to any consultation with the doctor. State law is specific on how we must direct bill our charges if we are to direct bill 100% of your services.

If you have massage done there will be a \$15.00 charge for a half hour and \$30.00 charge for a full hour if missed without prior notice. PLEASE NOTE THAT THIS FEE CANNOT BE BILLED TO YOR INSURANCE CARRIER.

An addition an exam will be performed so that we can better understand your health problem, and make the proper recommendations should you need further examinations or treatment. All fees are explained prior to services rendered.

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Patient's Signature  
(Parent/Guardian if a minor)

Date

Witness

“Dr. Dollase, is an independent Chiropractic practice and is not a partner or affiliated with any o  
heath care professional at this location.:

## Chiropractic Informed Consent to Treat

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 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, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and 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, 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, 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, and is in my best interests.

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.

**Patients Signature:**

**Date:**

**Dr. Sharon Dollase D.C.,  
3180 Willow Lane, Suite # 122  
Thousand Oaks, CA 91361**

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

\_\_\_\_\_ hereby states that by signing this Consent, I acknowledge and agree as follows:

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 also 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 in the future 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 the applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a.) a postcard mailed to me at the address provided by me; and b.) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
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 for the Practice to treat me and obtain payment for that 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 healthcare 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 treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my satisfaction in a way that I can understand.

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative  
(E.g. Attorney, Guardian, Parent if minor)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness

“Dr. Dollase, is an independent Chiropractic practice and is not a partner or affiliated with any other health care professional at this location.”

# PATIENT - DOCTOR AGREEMENTS

The purpose of this agreement is to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that those patients who follow through with these agreements get the best results.

## SIGNING IN

When you arrive, sign in. You will be called and assigned a treatment area in the order you signed in for the Doctor. On each visit, pick up your card at the front desk, go to the assigned treatment area, and lie face down. Rest and relax, the Doctor will be in as soon as possible.

## NEW PATIENT ORIENTATION

It is the policy of this office that you, the patient, participate in your recovery. It is mandatory that all patients attend our Patient Orientation as soon as possible after starting care. This class explains how the body functions, how Chiropractic works, and how results are produced. Family and friends are always welcome. There is no charge for the class. While children are welcome in the office during our regular treatment times, child care is not available during our evening classes, so it is important that other arrangements are made for children under the age of 12 during the Patient Orientation.

## MISSING OR CHANGING APPOINTMENTS

The Doctor has set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required to get the results we both desire. Thus, if you need to change the time of your appointment plan to come another time the same day or, if the same day is not possible, it is important that you make up the missed appointment within one week. If you want to be here and have your spine corrected, you will be expected to follow the Doctor's treatment recommendations. There will be no exceptions to this. If you are not ready to make your health a priority by making a commitment to your treatment, then do not waste your time and money now and plan to have your spine corrected at a later date. **SCHEDULE YOUR LIFE AROUND YOUR HEALTH, NOT YOUR HEALTH AROUND YOUR LIFE.**

## APPOINTMENT TIMES

We will set a specific time for your adjustment. Try to be prompt as the Doctor has set this time aside to detect and correct vertebral subluxations and during this time that is all he will do. If you come at another time, you may have to wait a few minutes, as the Doctor also sets aside specific times to see new patients and conduct extended consultations. We value your time and do not want you to wait needlessly. If you wish to sit down with the Doctor to discuss your case, a specific Doctor/Patient conference can be arranged at no additional charge.

## PAYMENT OF BILLS

We will expect you to honor the financial agreement you make with our office. In order to serve you better, please plan to make any payments at the front desk before you go to the back office for your adjustment. Upon being released from care, a three-month time period is allowed for settlement of your account. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your Doctor's approval, payment for services is due immediately.

## PROGRESS EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, re-examinations and progress reports will be done on a regular basis.

**COMMUNICATION**

Please communicate directly to your Doctor any upsetting matter such as waiting too long, rudeness by any staff member, failure to understand treatment, need for extended consultation, etc. We are here to serve you. Your criticism will help us to help you as well as others.

**CASH PATIENT FINANCIAL POLICY**

We request that 100% of the first visit be paid at the time of the first visit. For your convenience, future payments may be arranged at the first visit of each week. We are happy to accept your check or credit/debit card.

**MAJOR MEDICAL/GROUP INSURANCE**

You are expected to make a payment toward your services on the first day in this office. Complete the information on the "Chiropractic Insurance Policy" sheet. Bring it with you to your next visit. Also, all checks sent to your home by the insurance company must be brought or sent to our office within three days.

**AUTO ACCIDENT/PERSONAL INJURY**

You are usually covered 100% for these injuries. You are responsible for obtaining an insurance form, the address to which we send statements for your care. You are also responsible for reporting your accident to the insurance company and your insurance agent.

**WORKER'S COMPENSATION**

If your care is related to Worker's Compensation, you must obtain written consent from your employer allowing you to receive care at our office. Also, you must request that your employer notify his insurance companies that you are under care at our office and have them send the appropriate forms to our office immediately.

**MEDICAID**

Medicaid will cover 100% of your chiropractic care for the first 50 treatments each year. Once that limit has been reached, ask your insurance coordinate about special payment plans for which you might be eligible.

**MEDICARE**

Medicare will cover a portion of your visits after your deductible is met. Medicare does not pay for examinations or x-rays. Once Medicare benefits are exhausted, you are responsible for payment. Once that limit has been reached, you are responsible for payment. Don't hesitate to ask your insurance coordinator about special payment plans for which you might be eligible.

I, \_\_\_\_\_ understand the above policy and agree to  
(PRINT NAME)

Abide by it. \_\_\_\_\_  
SIGNATURE DATE

Dr. Sharon Dollase D.C.,  
3180 Willow Lane, Suite # 122  
Thousand Oaks, CA 91361

\*Dr. Dollase, is an independent Chiropractic practice and is not a partner or affiliated with any o health care professionals at this location.:

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

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check and mailed directly to:

Sharon E. Dollase D.C.  
3180 Willow Lane, Suite 122  
Thousand Oaks, CA 91361

For the Professional or Medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward charges for professional Services rendered by Dr. Sharon Dollase, D.C. The payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in the current manner, any balance of said professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to the Doctor, then I hereby also instruct you to make the check out to me, and mail it to me in Care OF Sharon Dollase, D.C.

A photocopy of this assignment shall be considered as valid as the original.

I also authorize Sharon Dollase, D.C. to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this case, and hereby release her of any consequences thereof.

I am aware that it is my contractual obligation with my insurance carrier and that I am required to pay for any deductibles and co-insurance. I am financially responsible for any unpaid balance by my insurance carrier to the Doctor.

\_\_\_\_\_  
Patient's Signature/Parent or Guardian if patient is a Minor

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

Explanation of Payment Responsibility

My Chiropractic Insurance benefits have been explained to me:

I fully understand my responsibilities with regards to co-pays, and / or any services rendered that exceed, or are not included in my insurance coverage.

I understand that this office is billing my insurance as a courtesy to me, and that any uncollected balances and / or disputes with my insurance company are my responsibility.

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Patient signature

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Date

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Office Manager

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Date

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Attending Doctor

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