Welcome to our office

Youdeem Chiropractic, Inc.
Dr. Gilbert Youdeem, D.C., CCSP
9922 Walker St, Suite G
Cypress, CA 90630
(714) 527-7463

1 Please tell us about you!

Today's Date: ___/___/___ Driver's License #: _____ Male ☐ Female ☐

Name: _____ What do you prefer to be called? _____

Birthdate: ___/___/_____ Age: _____ SSN: ___-___-_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: (___) _____ Cell phone: (___) _____ Other: (___) _____

Email address: _____

Whom can we thank for referring you? _____

Employer: _____ How long? _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Work phone: (___) _____ Ext: _____

Marital Status: *Single* ☐ *Married* ☐ *Divorced* ☐ *Seperated* ☐ *Widowed* ☐ Spouse's name: _____

Children? No ☐ Yes ☐ How many? _____

2 In event of an emergency

Who should we contact? _____ Relationship: _____

Homephone: (___) _____ Workphone: (___) _____ Cell: (___) _____

Who is your Medical Doctor? _____ Phone: (___) _____

May we contact him/her regarding your condition? Yes ☐ No ☐

3 Account

Person ultimately responsible for account: ☐ Self ☐ Other (If other, Please compelete below)

What form of payment would you prefer? cash ☐ check ☐ credit card ☐

Name _____ Relationship: _____

Billing Address: _____

_____

Driver's License #: _____ SSN: ___-___-_____

Workphone: (___) _____ Cell: (___) _____

4 Previous Chiropractic care

Have you been treated by a Chiropractor before? Yes ☐ No ☐ Date of last visit: _____

Reason for last treatment: _____

_____

_____

How long were you treated? _____ Type of treatment given: _____

5 Reason for your visit?

The reason for this visit is the result of (please circle): work, sports, auto(describe accident below), trauma or chronic.
Explain what happened: _____

6 More about your visit? (If Accident Related Skip To Section) 7

Please describe your pain and its location: _____

When did the condition begin? ___/___/___ Is this condition getting worse? *yes* ☐ *no* ☐ *constant* ☐ *comes and goes* ☐

Is this condition interferring with your (please circle): Work, sleep, or daily routine?
If so, please explain: _____

Have you had this or similiar condition in the past? Yes☐ No☐ Explain: _____

Have you been treated by a Medical Physician for this condition? Yes☐ No☐
If yes, where and by whom? _____

Type of treatment given: _____

7 Auto related accident (If Not Accident Related Skip To Section) 9

Date and time of Accident: _____ a.m. p.m. (please circle)
Were you the: Driver ☐ Front passenger ☐ Rear passenger ☐ Number of people in accident vehicle: _____
If a traffic violation was issued, to whom was it issued? _____
Did the police come to the accident site? Yes☐ No☐
Was a police report filed? Yes☐ No☐
Were there any witnesses? Yes☐ No☐
Were you wearing your seat belt? Yes☐ No☐
Was this vehicle equipped with airbags? Yes☐ No☐
If yes, did it/they inflate? Yes☐ No☐
In relation to the base of your skull, where was the headrest?
Above ☐ *Below* ☐ *At base of skull* ☐

What did your vehicle impact? Another vehicle☐ Other ☐ If other, explain: _____

Did any part of your body strike anything in the vehicle? Yes☐ No☐ If yes, please describe: _____

Make and model of the vehicle you were occupying? _____
Name of the location/street on which you were traveling? _____

In which direction were you headed? *North* ☐ *South* ☐ *East* ☐ *West* ☐
What was the approx. speed of your vehicle? _____ I was stopped: ☐
Did the impact to your vehicle come from the: *Front* ☐ *Rear* ☐ *Right side* ☐ *Left side* ☐ *Other* ☐
During the impact, were you facing: *Right* ☐ *Left* ☐ *Forward* ☐ Were you: Aware☐ or Suprised by the impact? ☐
If accident vehicle made impact with another vehicle, make & model of that other _____

Direction other vehicle was headed? *North* ☐ *South* ☐ *East* ☐ *West* ☐ Speed of other vehicle? _____

8 After injury

Did the accident render you unconscious? Yes ☐ No ☐ If Yes, how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen another doctor? Yes ☐ No ☐

When did you go? Just after the accident ☐ The next day ☐ 2days plus ☐

How did you go? Ambulance ☐ or Private transportation ☐

Name of hospital and/or attending doctor: _____

Was he/she a: D.C. ☐ M.D. ☐ D.O. ☐ D.D.S. ☐

Describe any treatment you received: _____

Were X-rays taken? [Y N] On what body part was X-ray taken? _____

By whom? _____

Was medication prescribed? [Y N] Have you been able to work since this injury? [Y N]

Are your work activities restricted as a result of this injury? [Y N]

Indicate the symptoms that are a result of this accident:

Is your condition getting worse? [Y N] Constant ☐ Comes and goes ☐

Have you retained an attorney? Yes ☐ No ☐

If yes, please give name & phone #: _____

9 Health history

Are you taking any medications?

	Medication Name:	*Dose:*	*Reason:*	*Prescribed By:*
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				

Have you ever had any of the following disease/medical conditions? Please circle Y for yes or N for no

[Y N] Heart attack/stroke	[Y N] Fainting	[Y N] Emphysema	[Y N] Heart Murmur
[Y N] Congenital Heart Defect	[Y N] Asthma	[Y N] Psychiatric Problems	[Y N] Venereal Disease
[Y N] Hepititis	[Y N] Lower Back Pain	[Y N] Kidney Problems	[Y N] Shingles
[Y N] Cancer / tumor	[Y N] Heart Surg/Pacemaker	[Y N] Seizures/Epilipsy	[Y N] Anemia
[Y N] Frequent Neck Pain	[Y N] Alcohol/Drug Abuse	[Y N] Diabetes	[Y N] Rheumatic Fever
[Y N] Severe Frequent Headaches	[Y N] HIV / Aids	[Y N] Artificial Bones/Joints	[Y N] Ulcers
[Y N] High Blood Pressure	[Y N] Difficulty Breathing	[Y N] Spinal Surgery	[Y N] Corticosteroid Use

Please list any other serious medical condition(s) you have ever had (including surgeries):

	Condition:	*Date:*	*Treatment Received:*	*Treated By:*
N/A☐				
N/A☐				
N/A☐				
N/A☐				
N/A☐				

9 Health history continued

Please list any previous accidents, falls or sports injuries you have ever had:

	Condition:	Date:	Treatment Received:	Treated By:
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				
N/A ☐				

Please list family health history such as Cancer/Diabetes/High blood pressure/Heart disease/Rheumatoid Arthritis:

Do you smoke? Yes☐ No☐ If Yes, how much?_____ How long?_____

Do you drink alcohol? Yes☐ No☐ If Yes, how often? _____

For women: Are you taking Birth Control Pills? Yes☐ No☐

Are you, or is there a chance you are pregnant? Yes☐ No☐ How long? _____

10 Please read completely:

I here by authorize assignment of my insurance right and benefits directly to Dr. Gilbert Youdeem, D.C. for services rendered.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED EFFECTIVE AND VALID AS THE ORIGINAL.

I authorize Dr. Gilbert Youdeem, D.C. and his staff to perform any necessary services needed during diagnosis and treatment.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, attorney or other health care professional involved in the case.

In the event other responsible parties fail to pay in full for services rendered, I understand I am ultimately and fully responsible for my account. I also understand that I am responsible for my deductible and co-payments at each office visit.

initial: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

initial: _____

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

initial: _____

I agree to the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health or insurance status.

Signature: _____ Please print your name: _____ Today's Date: ___/___/___

Dr. Gilbert Youdeem, D.C.
Certified Chiropractic Sports Physician

9922 Walker St. Suite G, Cypress, CA 90630
Phone: (714) 527-7463 E-Mail DrYoudeem@aol.com

EXPLANATION OF MEDICARE BENEFITS FOR CHIROPRACTIC SERVICES

DEDUCTIBLE:

Medicare requires that yo pay a yearly deductible of $203 towards your Part B medical expenses before they will begin paying for covered services. If you have seen other medical providers this year, all or part of your deductible may have been satisfited.

MEDICARE COVERAGE:

Medicare in a Chiropractic office only covers manual manipulation for the spine (commonly referred to as a spinal adjustment or CMT) Medicare pays 80% of the services and you are liable to 20% after deductible is met. If you have a secondary insurance they cover some of your out of pocket expense. All services and treatments (I.e. upper and lower extremity conditions) other than spinal manipulation are patient responsibility as outlined below.

EXAMINATIONS:

In order to determine the extent of your conditions, as well as the type of treatment you will need, the doctor will examine you prior to the initiation of treatment, and periodically thereafter. Medicare will not reimburse for examination charges; and therefore, payment must be made by you.

X-RAYS:

Medicare does not require X-rays in order to be reimbursed for chiropractic treatment. Dr. Youdeem may determine x-rays are necessary to assess your condition. If x-rays are taken or ordered by Dr. Youdeem, they are not covered by Medicare and therefore you are fully liable for the charges for x-rays.

PHYSICAL MEDICINE, SUPPLEMENTS, AND SUPPORTS

During the course of your treatment in this office, the doctor may determine that certain physical therapy modalities (Ultrasound, Muscle Stimulation, Cold laser therapy, massage etc.) vitamin supplements or orthopedic support may be necessary to assist in the treatment of your condition. The costs associated for these modalities are between $10 and $35. Medicare will not reimburse for any of these services, and therefore, payment must be made by you.

I understand that although the Chiropractic services listed above may be required for treatment of my condition, these charges are not covered by Medicare and I will personally responsible for payment of these charges.

Patient Name _____ Patient Signature _____ Date _____

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Office Policy & Procedures

Insurance verification - The benefits we have quoted to you are an estimate of your coverage, based on information we received from your insurance company. Your actual coverage is determined when claims are received & processed by your insurance company.

Please check your EOB (Explanation of Benefits) for your coverage determination by your insurance company when you receive it.

Our office is a zero balance office. All deductibles/copays/co-insurances are due at the time services are rendered.

Patient's Name _____ Signature of Patient/Guardian _____ Date _____

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HIPAA PRIVACY REGULATIONS

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that Youdeem Chiropractic, Inc. (Dr. Gilbert Youdeem, D.C., CCSP) will not reveal to anybody personal information about you or your family member (i.e. name, address, social security number as well as other health information) without your permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation, or fund raising.

It is, however, understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, billing (paper and wire), include fax transmissions, insurance company follow-up and interaction with billing services relating to patient care
- Hospital workers, nurses, aids, and medical records department
- Emergency officials, Paramedics, fire personnel, emergency room physicians, nurses or technicians. Personal religious designate.
- Our office staff
- Pharmacists, drug program personnel/workers
- Completions of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

My signature below authorizes the release of any necessary information listed above.

Patient's Name _____ Signature of Patient/Guardian _____ Date _____