Patient Information

Today's Date: ______________________________

Last Name: ________________________________

First Name: ____________________ M.I ________

Address ____________________________________

City ________________ State_____ Zip __________

Email ______________________________________

Sex ☐ Male ☐ Female Age _________

Birthday: __________________________________

Patients SS#: ______________________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: ________________________________

Employer/School: ___________________________

Employers Address: _________________________

City ___________ State_________ Zip ___________

Employer/School Phone: ____________________

Whom may we thank for referring you? __________

Phone Numbers

Home Phone (_____) _________________

Cell Phone (____) ______________________

Appointment Reminder- **Email, Text or Phone Call**?

Cell Phone Carrier – **VZW- Sprint- ATT- Metro- T-Mobile**

Other _______________________________

IN CASE OF EMERGENCY, CONTACT

Name _______________________________

Relationship __________________________

Home Phone (____) ____________________

Accident Information

Is condition due to an accident? ☐ Yes ☐ NO

Date __________________________________

Type of accident ☐ Auto ☐ Work ☐ Home

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ Other

Attorney Name (if applicable) ______________________

List of Medications/Vitamins

____

____

____

____

____

Exercise

☐ None

☐ Moderate

☐ Heavy

☐ Daily

Work Activity

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

Habits

☐ Smoking — Packs/Day__________

☐ Alcohol — Drinks/Week________

☐ Coffee/Caffeine Drinks — Cups/Day___________

☐ High Stress Level — Reason______________

Are you pregnant? ☐ Yes ☐ No Due Date________________

Allergies

--Latex --Rubber -- KT tape --NSAID --Soaps --None --Other______________________

Surgeries

--Abdominal	--Ablation	--Achilles	--Ankle	--Appendix
--Arm	--Back	--Brian/Tumor	--Breast	--Carpal tunnel
--Cataracts	--Cervical Disc	--Chest	--Colon	--Cornea
Transplant				
--C-section	--Disc	--Diverticulitis	-- Ectopic Pregnancy	--EENT
--Elbow	--Endometriosis	--Femur	--Foot	--Gallbladder
--Gastrointestinal	--Gynecological	--Hand	--Heart	--Heart Bypass
--Hemorectomy	--Hernia	--Hip	--Hip Replacement	--Hysterectomy
--Knee	--Intestine	--Jaw/Orthodontic	--Kidney	--Kidney Stones
--Knee Replacement				
--Lumbar Disc	--Lasik	--Liposuction	--Laparoscopy	--Lithotripsy
--Miscarriage	--Lumpectomy	-- Lymphedema	--Lipoma	--Mastectomy
--Nose	--Mole	--Neck	--Neurological	--NONE
--Prostate	--Obstetrical	--Other	-- Ovary	--Podiatric
--Sinus/Jaw	-- Prostatectomy	--Rhinoplasty	--Scar Revision	--Shoulder
thoracic	--Sleep Apnea	-- Spinal fusion cervical	--Spinal fusion	--Spinal fusion
--Stent			lumbar	
Removal	--Thoracic Disc	--Throat	-- Tonsil/s	--Varicose Vein
--Wrist				
	--Wrist/Hand			

--Other ____________________

Medical History

--Alcoholism	--Allergy Shots	--Anemia	--Ankle Pain
--Appendicitis	--Arm Pain	--Arrhythmia	--Arthritis
--Asthma	--Back Pain	--Brachialplexus Palsy	--Breast Lump
--Broken Bones	--Bronchitis	--Cancer	--Carpal Tunnel
--Chemical Dependency	--Chest Pain	--Chicken Pox	--Colon
--Concussion	--Congestive Heart Failure	--Depression/Other disorder	--Diabetes
--Dislocations	--Dizziness	--Elbow Pain	--Emphysema
--Epilepsy	--Eye/Vision Problems	--Fainting	--Falls/Concussion
--Fatigue	--Foot Pain	--Fracture	--Genetic Spinal Disorder
--Goiter	--Gout	--Hand Pain	--Headaches
--Hearing Problems	--Heart Disease	--Hemochromatosis	--Hepatitis
--Hernia	--Herniated Disc	--Herpes	--High Blood Pressure
--High Cholesterol	--Hip Pain	--Jaw Pain	--Join Stiffness
--Kidney Disease	--Kidney Stones	--Knee Pain	--Leg Pain
--Liver Disease	--Low Back Pain	--Lupus	--Measles
--Menstrual Problems	--Mid Back Pain	--Migraines	--Minor Heart Trouble
--Miscarriage	--Mononucleosis	--Multiple Sclerosis	--Mumps
--Neck Pain	--Neurological Disorder	--Neuropathy	--NONE
--Osteoporosis	--Ovarian Cysts	--Pacemaker	--Parkinson’s disease
--Pinched Nerve	--Plantar Faciitis	--Pneumonia	--Polio
--Prostate Problems	--Psychiatric Care	--Pulmonary Embolism	--Rheumatic Fever
--Rheumatoid Arthritis	--Scoliosis	--Shingles	--Shoulder Pain
--Significant weight change	--Spinal Cord Injury	--Spondylolistheisis	--Sprain/Strain
--Stomach Problems	--Stroke/Heart Attack	--Thyroid	--Tonsillitis
--Tumor/Growths	--Ulcer/s	--Vaginal Infections	--Vertigo
--Whooping Cough	--Wrist Pain		

--Other___________

PATIENT: ____ DATE: _________________

What body part are you being seen for today:

____

Is it: Bilateral Left Right

When did condition start?____

How did it start?____

Do you have any recent imaging (X-ray, MRI, CT, etc.) ? If so please list date and name of facility.

____

ON A SCALE OF 0-10, WITH 10 BEING UNBEARABLE PAIN, PLEASE RATE YOUR SYMPTOMS:

1 2 3 4 5 6 7 8 9 10

INTENSITY: Minimum Mild Moderate Severe unbearable

NATURE: Dull ache Numbness Radiating pain Sharp Shooting Stabbing Tightness Tingling Throbbing

WHAT HELPS: Acupuncture Chiropractic Heat ICE Massage Nothing Pain Meds Therapy Sleep/rest Stretching other:____________

FREQUENCY: Intermittent 0-25% of the day Occasional 26-50% of the day Frequent 51-75% of the day Constant 76-100% of the day

ANY ADDITIONAL COMMENTS:

Activities of Daily Living

Circle each of the activities which you have a difficulty performing and or can perform only with pain.

Bending	Gardening	Personal hygiene/Grooming
Care of others/Pets	General Mobility	Pushing/Pulling with legs/feet
Carrying Objects	Holding onto objects	Pushing/Pulling with hands/arms
Climbing Stairs	Jogging	Reaching out/up/down
Concentrating	Keeping balance	Sitting
Cooking/Cleaning	Housework	Standing
Crouching/ Squatting	Lifting	Turning
Dressing	Lying Down	Twisting
Driving	Moving Joint/s	Walking
Eating	Exercise/Sports	Yard Work

Other Explain:____________

Please initial:

____________ Please arrive ten minutes before your scheduled appointment time to ensure a full session.

__________We pride ourselves in not having patients wait and as such need all patients to arrive 10 minutes before their appointment time and no later than their scheduled appointment time. We may have to reschedule your appointment if you are running late.

___________You may cancel your appointment without charge up to 24 hours preceding your appointment. Same day cancellations will be charged 50% of the scheduled service price. If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service.

___________Your next ____________________ visits are for treatment only. In the event that your condition deteriorates, there is re-injury, or new areas need to be addressed please call our office prior to your appointment so we can allow the necessary time for a re-examination by the doctor.

___________When you arrive at the office we have to first check you into our system before you can sign the sign-in pad.

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENT 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 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 the 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 or clinic personnel the nature and purpose of chiropractic adjustments and other 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, dislocation 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 judgement 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 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.

To be completed by patient

____
Print Patient's Name

____

Signature of Patient

____
Date Signed

*To be completed by patient's R*epresentative, if necessary, e.g., if patient is a minor or is physically *or legally incapacitated:*

____
Print Name of Patient

____

Print Name of Patient's Representative

____
Signature of Patient's Representative

To be completed by doctor or staff

Anthony B. Morovati, D.C. and / or
Janine Abramian, D.C. and / or

Morovati Chiropractic Corp
Anthony B. Morovati, D.C.
Janine Abramian-Morovati, D.C.
3515 North Verdugo Rd.
Glendale, CA 91208

Print Name(s) of doctor(s) treating this patient:

Staff Signature: __________________________________ Date: _______________
Witness to Patient's________________________________ Date:________________
This Signed original is to be filed in patient's file and a copy is to be given to the patient.

Patient Name: ______________________________

Financial Policy

Thank you choosing Morovati Wellness Center as your Chiropractic Providers. We are committed to your successful treatment. We request you read, agree to, and sign the following statement of Financial Policy prior to starting treatment.

1. It is your responsibility to verify with your insurance plan/carrier as to your coverage with them. Although we verify your insurance we cannot be held responsible for the information given as insurance companies read a disclaimer that states that verification of benefits is not a guarantee of payment. Please note that Dr Anthony Morovati is not a contracted provider with any insurance company other than Lakeside Medical Group IPA. Please note that Dr Janine Morovati is not a contracted provider with any insurance company. Please verify that service such as office visits, X-Rays and in-office procedures do not require pre-authorization. Some plans require pre-authorization or referrals from the patient's primary care physician. .

2. Payment is due at the time services are rendered, including co-payment and deductibles. Your insurance is billed as a courtesy but it is not a guarantee of payment. We accept cash, check, Visa and MasterCard.

3. Written or verbal authorizations from insurance plans or management groups are not guarantee of payment. All claims are reviewed by the insurance carriers after services are rendered and authorizations can be denied at the time of review. Denied claims become the patient's responsibility. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances of certain procedures or limit the length of the sessions. Ultimately all charges are your responsibility. Please note that acuscope treatments are time based and are billed in increments of 15 minutes. Furthermore, there is two ways the acuscope can be applied, attended and unattended. When we apply the acuscope attended, we bill for the electric current being applied as well as myofascial release of the trigger points in increments of 15 minutes. When the acuscope is being applied unattended we only bill for the electrical current in increments of 15 minutes. However, keep in mind that the length of time the acuscope is applied is dependent on medical necessity. All supplies, which are not billable to your insurance carrier, must be paid for at the time they are dispensed.

4. Statements are mailed after the insurance company has paid their portion. The account is then payable within 30 days. Overdue accounts are subject to a $15.00 rebilling fee each 30 days it goes unpaid. Accounts 90 days in rear will be subject to collection and/or interest by and external agency unless financial arrangements are made with our office.

5. APPOINTMENTS THAT ARE NOT CANCELLED WITHIN 24 HOURS TO THE SCHEDULED APPOINTMENT TIME WILL BE CHARGED $45.00 MISSED APPOINTMENT FEE. PLEASE BE SURE TO ADVISE THIS OFFICE 24 HOURS IN ADVANCE OF CANCELLATION. **We ask that you arrive 10 minutes prior to your appointment time to insure you receive your full session.**

6. Whenever our office refers you to outside laboratories, hospitals, physical therapy or tests, be sure to verify that pre-authorization is not required and that your insurance participates with their facility.

7. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Private Insurance, and other health plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

8. I also acknowledge receipt of the notice of Privacy Practices.

I HAVE READ THE ABOVE AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS AS SET FORTH.

Print name of the financially responsible party____

SIGNATURE____ DATE _______________

Authorization to Release Medical Records

To:____

Address____

____
_

I, ___________________________________hereby authorize and request you to release to:

Anthony B. Morovati, D.C.
Janine Abramian –Morovati, D.C.
3515 North Verdugo Rd.
Glendale, CA 91208
818-500-8484
818-369-7459 Fax

Any and all records and/or reports in your possession; including history, x-ray results, diagnosis, and treatment concerning my illness of injury of _____/_____/_____.

Patient's Signature:____ Date_____________

Social Security #____

Birth Date:____

CONSENT FOR TREATMENT OF A MINOR

Date:______________________

(I) (We) the undersigned, parent (s) or legal guardian (s) of ____, a minor, do hereby authorize, **Anthony B. Morovati, D.C. and/or Janine Abramian, D.C.,** as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent (s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until ____________________, unless sooner revoked in writing delivered to said agent (s).

Father:______________________________ Witness:____________________________

Mother:______________________________ Witness:____________________________

Legal Guardian:____________________________ Witness:____________________________

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. ________
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could including receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. ________
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. ________
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell ________
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. ________
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. ________
- I have been offered a copy of this consent form. ________

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	________	Parent / Guardian Signature	________	Witness Signature	________
Name	________	Name	________	Name:	________
Date	________	Date	________	Date:	________