F.I.R.S.T. HEALTH

NAME _____ HOME PHONE _____

ADDRESS _____ BUSINESS PHONE _____

CITY _____ ZIP _____ CELL PHONE _____

BIRTH DATE _____ AGE _____ REFERRED BY _____

E-MAIL _____@_____ MARITAL STATUS: M D W S

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY _____ ZIP _____

SPOUSE'S NAME _____ BUSINESS PHONE _____

SPOUSE'S EMPLOYER _____ SPOUSE'S SS# _____

PATIENT'S NEAREST RELATIVE _____ RELATIONSHIP _____

HOME PHONE _____ BUSINESS PHONE _____

OTHER DOCTOR'S SEEN FOR THIS CONDITION _____

DATE OF LAST PHYSICAL EXAM _____

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that no shows or cancellations without a 24-hours notice are charged for the office visit. Furthermore, I understand that F.I.R.S.T. HEALTH will prepare any necessary reports and forms to assist me in making collection from the insurance company and that the amount authorized to be paid directly to F.I.R.S.T. HEALTH will be credited to my account on receipt. However, I understand that, except where legally or contractually prohibited, any charges for professional services rendered will be immediately due and payable if I suspend or terminate my care and treatment. Furthermore, I understand that a $20.00 collection fee is charged to all delinquent (90 days past due) accounts.

I agree to allow F.I.R.S.T. HEALTH to forward health-related material to my personal E-Mail address.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN/SPOUSE
SIGNATURE AUTHORIZING CARE _____

DRIVERS
LICENSE# _____ SS# _____

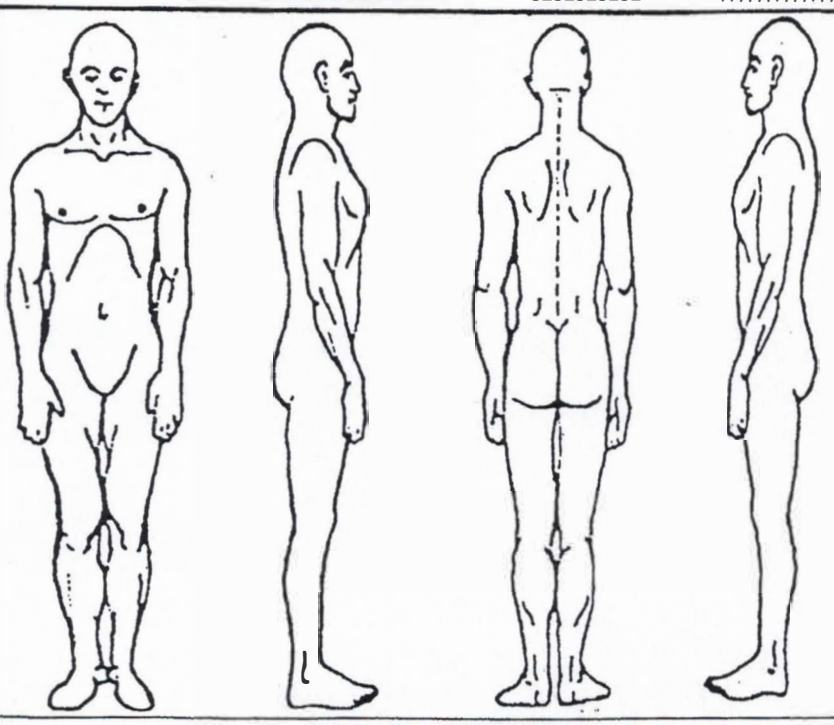
INFORMATION TAKEN BY _____ DATE _____

F.I.R.S.T. HEALTH

NAME: _____ DATE: _____

Draw location of your pain on the body outlines using the symbols below to describe your complaint.

Aching	Numbness	Pins & Needles	Burning	Stabbing & Sharp
∧∧∧∧	++++++++	0000000000000	XXXXX	//////////////////////////



Instructions: Please choose the number which best describes your pain.

What is your pain RIGHT NOW?

0	0	0	0	0	0	0	0	0	0
1	2	3	4	5	6	7	8	9	10

No Pain **Unbearable Pain**

PURPOSE OF THIS APPOINTMENT: Please mark "1" if present condition, "2" if past history of.

___Headaches/Migraines
___Neck pain
___Pain between shoulders
___Low back pain/Sciatica
___Spinal check-up for child
___Sports injury
___Auto accident/Whiplash
___Wellness/Prevention care
___Digestive disorder
___Dizziness
___Other_____

___Sinuses/Allergy
___Asthma/Allergy
___Ankle/Foot pain
___Wrist/Hand pain
___Nutritional imbalance
___Arthritis
___Numbness
___Rheumatic fever
___Cancer
___Heart trouble

ARE YOU PREGNANT? ___YES ___NO DATE OF LAST MENSTRUAL PERIOD_____

SIGNATURE: _____

F.I.R.S.T. HEALTH

HEALTH HISTORY

Who is your primary care physician? _____ Phone #: _____

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Arm/Hand Pain	☐ Cold Sweats	☐ Hip Pain	☐ Nausea	☐ Pins/Needles in Legs
☐ Back Pain/Stiffness	☐ Dizziness	☐ Jaw Problems	☐ Neck pain/Stiffness	☐ Sleeping Difficulties
☐ Blurred Vision	☐ Fainting	☐ Leg/Knee Pain	☐ Nervousness	☐ Shoulder Pain
☐ Bowel /Bladder changes	☐ Fever	☐ Light Bothers Eyes	☐ Night Pain	☐ Shortness of breath
☐ Chest Pain	☐ Foot/ Ankle Pain	☐ Loss of Memory	☐ Palpitations	☐ Stomach Problems
☐ Cold Feet	☐ Headaches	☐ Loss of Smell/Taste	☐ Pins/ Needles in Arms	☐ Sudden Weight Loss

Please check to indicate if you have ever had any of the following:

☐ Allergies	☐ Breast Lump(s)	☐ Fractures	☐ Migraines	☐ Psychiatric Care
☐ Allergy Shots	☐ Cancer	☐ Gout	☐ Miscarriage	☐ Sports Injuries
☐ Anorexia/ Bulimia	☐ Chemical Dependency	☐ Heart Disease	☐ Multiple Sclerosis	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Osteoporosis	☐ Tension
☐ Arthritis	☐ Depression	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Asthma	☐ Dysmenohrrea	☐ Herniated Disc	☐ Pinched Nerve	☐ Tuberculosis
☐ Auto Accident Injury	☐ Emphysema	☐ Herpes	☐ Polio	☐ Tumors/Growths
☐ Balance Problems	☐ Epilepsy	☐ Hypertension	☐ Postural Problems	☐ Ulcers
☐ Bleeding Disorder	☐ Fatigue	☐ Kidney Disease	☐ Prostate Problems	☐ Urinary Incontinence
☐ Bowl Disorder	☐ Fibrocystic Breasts	☐ Liver Disease	☐ Prosthesis	☐ Vaginal Infections

☐ Other: _____

Are you currently under medical care? ☐ Yes ☐ No if yes, Explain _____

Please list any medications you are currently taking: _____

_____

Please list any surgeries and / or hospitalizations you have had (type & date): _____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

☐ Heart Disease _____ ☐ Diabetes _____

☐ Cancer _____ ☐ Arthritis _____ ☐ Other _____

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a orthopedic pillow? ☐ Yes ☐ No

What is your daily/weekly intake of the following:

Caffeine/Coffee _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

*I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____ DATE: _____

PERSONAL INJURY QUESTIONNAIRE

Name _____ Date of Injury _____ Time of Day _____

Your Ins. Co. _____ Policy # _____ Agent's Name _____

Driver/Other Vehicle _____ Ins. Co. _____ Policy # _____

Have you retained an attorney? ( ) Yes ( ) No Name _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

Nature of Accident:

1. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
2. Number of people in your vehicle? _____ Other vehicle? _____
3. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____ City _____
4. What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____ City _____
5. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
6. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
7. Were police notified? ( ) Yes ( ) No
8. In your own words, please describe the accident: _____

_____

_____

9. Please describe how you felt:
   A. IMMEDIATELY AFTER the accident: _____
   B: LATER THAT DAY: _____
   C: THE NEXT DAY: _____
10. Number the symptoms below, which you have noticed since the accident:

1 = constant 2 = frequent 3 = comes and goes 4 = occasionally 5 = rarely 6 = never

____ Headache	____ Dizziness	____ Lights Bother Eyes	____ Diarrhea
____ Neck Pain	____ Head Seems Too Heavy	____ Loss of Memory	____ Feet Cold
____ Neck Stiff	____ Pins/Needles in Arms	____ Ears Ring	____ Hands Cold
____ Mid Back Pain	____ Pins/Needles in Legs	____ Face Flushed	____ Stomach Upset
____ Low Back Pain	____ Numbness in Fingers	____ Buzzing in Ears	____ Constipation
____ Nervousness	____ Numbness in Toes	____ Loss of Balance	____ Cold Sweats
____ Tension	____ Shortness of Breath	____ Fainting	____ Fever
____ Irritability	____ Fatigue	____ Loss of Smell	____ Sleeping Problems
____ Chest Pain	____ Arm/Leg Pain	____ Loss of Taste	____ Depression

11. Please describe any other present complaints, in detail: _____

_____

_____

12. Where were you taken after the accident? _____

13. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctor's name and address: _____

What type of treatement did you receive? _____

14. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

15. Have you lost time from work as a result of this accident? ( ) Yes ( ) No

If yes, please answer the following:

A. Last Day Worked: _____

B. Type of Employment: _____

C. Present Salary: _____

D. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving? _____

16. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in detail: _____

17. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No

If yes, please describe: _____

18. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe: _____

19. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received?

20. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No

If yes, please describe in detail: _____

21. Other pertinent information: _____

_____ Date

_____ Patient's Signature

DOCTOR'S LIEN

To: Attorney/ Insurance Carrier

_____

_____

_____

Doctor:

CRAIG E. MORRIS, D.C.

19000 HAWTHORNE BL.SUITE 302

TORRANCE, CA 90503

RE: Patient records and doctor's lien

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/ insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Dated:_____ Patient's signature:_____

The undersigned, being attorney of record or authorized representative insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated:_____ Authorized signature:_____

NOTICE: Please date, sign, and return one copy to doctor's office at once.

Keep one copy for your records.
Reply envelope attached.

F.I.R.S.T. HEALTH

CRAIG E. MORRIS, DC
Chiropractic Rehabilitation

THEODORE GEORGIS, MD
Orthopedic Surgery

19000 Hawthorne Blvd. Suite 302
Torrance CA 90503
Phone: (310) 793-9400
Fax: (310) 793-0200

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____
Name of Doctor, Clinic, Hospital, etc.

_____
Address

I_____ request the following information to be released to F.I.R.S.T. HEALTH for the purpose of review:

X-rays _____ History _____ Treatment Records _____ MRI/CT Scan(S) _____ Reports _____

A photocopy of facsimile copy of this form with your signature shall be considered as authentic as the original.

I understand the California Health and Safety Code Section 1795.12 requires the patient records be transmitted within 15 days after receiving this request.

Signed: _____ Date: _____

_____
Translator/ Witness

***CONFIDENTIALLY NOTICE**
THIS FORM IS PRIVILEGED AND CONFIDENTIAL AND IS INTENDED ONLY FOR THE REVIEW OF THE PARTY TO WHOM IT IS ADRESSED. IF YOU HAVE RECEIVED THIS FORM IN ERROR, PLEASE IMMEDIATELY RETURN IT TO THE SENDER.

F.I.R.S.T. HEALTH

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the _____

Insurance Company to make checks payable and mailed directly to:

F.I.R.S.T. HEALTH
Craig E. Morris, D.C., A.P.C.C.
19000 Hawthorne Blvd.,
Suite # 302
Torrance CA, 90503

The professional or medical expense benefits allowable and otherwise be payable to me under my insurance policy payment toward charges for Professional Services rendered by F.I.R.S.T. HEALTH. I agree to pay the above mentioned signed, in the current manner, any balance of said Professional Service charges over the insurance payment.

A photocopy of facsimile copy of this agreement shall be considered as effective and valid as the original.

I also authorized Craig E. Morris, D.C. to release information pertinent to my case to any insurance company, adjuster, and attorney involved in this case; I hereby release him of any consequences thereof.

Dated at Torrance, California this _____ day of _____, 20_____

_____
SIGNATURE OF POLICY HOLDER

_____
SIGNATURE OF CLAIMANT (IF OTHER THAN POLICY HOLDER)

_____
SIGNATURE OF WITNESS

F.I.R.S.T. HEALTH

Notice of Privacy Practices

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACESS TO THIS INFORMATION
***PLEASE REVIEW CAREFULLY**

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your doctor(s), our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the doctor's practice and any other care required by law

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, we would disclose your protected health information or, as necessary, to a home health agency that provides care to you rand/ or we may share information with hospital staff and other physician or therapist to whom you have been referred to ensure that necessary information is available to diagnose or treat you.

Payment: Your protected health information may be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a diagnostic procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operation: We may use or disclose as-needed, your protected health information in order to support the business activities of F.I.R.S.T. HEALTH. These activities include, but are not limited to, quality assessment activities, employee review activities, training of clinical staff, licensing, and conducting or arranging for other business activities. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room or back office when the doctor or staff is ready to see you. We may use or disclose protected health information, as necessary, to contact you or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directions and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the Law (and when required by the Secretary of the Department of Health and Human Services) we must disclose to you any investigations that may involve you to determine our compliance with the requirements of section 164.500

Other Permitted and Required Uses and Disclosure Will Be Made Only With Your Consent, Authorization or Agreement unless require by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosures indicated in the authorization. If, in our judgment, the breadth or extension of revoked uses is such that we can no longer adequately provide health care, get paid for our

F.I.R.S.T. HEALTH

services rendered, or conduct our business operations, we may be unable to continue proving Medical/Chiropractic care to you. You do have the right to use another Healthcare Provider.

You have the right to request and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in a reasonable anticipation of, a criminal or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice alternatively (i.e electronically)

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us notifying our privacy officer of your complaint. **We will not retaliate against you for filing a complaint.**

The notice was published and become effective on/or before April 14, 2003

We may require by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this notice of our Privacy Practice:

Print Name	Signature	Date

F.I.R.S.T HEALTH
19000 Hawthorne Blvd. Suite 302, Torrance CA, 90503
* Phone (310) 793- 9400 * Fax (310) 793-0200

F.I.R.S.T. HEALTH

PRIVACY POLICIES AND PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

F.I.R.S.T. HEALTH has INFORMATION

F.I.R.S.T. HEALTH has adopted policies to comply with state and federal law and safeguard your personal information. During the course of treatment in this office non-public personal information is collected about you from various sources:

- Information received from you on health questionnaire or other forms;
- Information received from other health providers;
- Information received from insurance Carriers;

To protect the privacy of all patients in the course of conducting business, even if information is not shielded from disclosure by law, information will be maintained in the strictest confidence. Protected Health information will not be sold, transferred, copied, distributed or shared with any other person or companies without express consent. Access to your personal account information is restricted to the doctor and staff members. Physical, electronic and procedural safeguard and maintained that comply with federal standards to safeguard your nonpublic personal information. Your Protected Health Information is shared with outside billing service, health plans, authorized emergency personnel, and governmental agencies in accordance with applicable law or under court subpoena.

- Inspect and copy their records
- Amend health records
- Designate with whom Protected Health Information is shared
- Request restrictions on disclosure of Protected Health Information
- File a privacy violation complaint with practice's Privacy Officer

Any privacy violation complaint should be presented in writing to a staff member and will be given to the Privacy Officer. You will be advised of the outcome of your complaint and the steps taken to correct the issue

Print name: _____ Date: _____

Signature: _____

F.I.R.S.T. HEALTH • 19000 Hawthorne Blvd., #302 • TORRANCE, CA 90503
TELEPHONE (310) 793-9400 • FAX (310) 793-0200