

DR. STEVEN M. GILLIS

CHIROPRACTOR

8281 Melrose Avenue, Suite #201, Los Angeles, CA 90046

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WELCOME TO OUR OFFICE

Welcome to the Chiropractic office of Dr. Steven M. Gillis. You have taken the first step in the process of better health.

FREQUENTLY ASKED QUESTIONS ABOUT CHIROPRACTIC CARE

Q: What can I expect on my first visit?

A: First and foremost, you can expect to be treated with kindness and compassion at our offices at all times.

Dr. Gillis will ask you about your present health complaints and offer suggestions on possible treatment remedies.

A physical examination will be performed, which may include x-rays and other diagnostic procedures. In addition, a careful spinal examination will be performed to detect any structural abnormalities which may be affecting or causing your condition and to determine if an "adjustment" is necessary.

An "adjustment" means the specific manipulation of vertebrae (bones of spine), which have abnormal movement patterns or fail to function normally.

Q: Will it hurt?

A: Under normal circumstances adjustments don't hurt. Patients may experience a minor amount of discomfort during the adjustment, which lasts only seconds. Most patients have a sensation of relief.

Modern Chiropractic techniques are gentle enough for newborns and the elderly. Each adjustment is specific for the individual.

Q: Is it safe?

A: Adjustments or manipulations are extremely safe. The risk factor of complications is estimated to be approximately a million to 1.

Chiropractors have the lowest cost for malpractice insurance than any other health care provider. Chiropractors do not prescribe drugs or perform surgery that have much greater risks associated.

Q: How long does it take?

A: There are (3) main types of care. Relief care, correction care and maintenance care. Relief care approaches the symptoms (pain) and although effective, is usually temporary. This can take days to weeks. Correction care goes beyond relief care (symptoms) to correct the cause of the spinal malfunction. It takes longer (months) but is more permanent in results. Maintenance care is an approach to maintaining health with periodic spinal adjustments after correction and before a problem begins. Everyone has their own personal rate of response depending on many health factors. You will always have a choice in the type of care you choose.

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FINANCIAL AGREEMENT

Insurance companies will quote your Chiropractic benefits but **will not guarantee** payment until your claim is reviewed. As a courtesy, we will help you verify your benefits, submit your claim and provide any necessary documentation needed to support the claim.

You are responsible for any deductibles, co-payments or denied services by your insurance company.

Since we are contracted with many insurance companies, we will accept the contracted rate for services provided.

However, we are not required to accept insurance company contracted rates in the event your treatment is related to a personal injury claim. Upon us being informed of a personal injury claim a lien will be issued for unpaid monies.

In the event that you do not have Chiropractic insurance coverage or we are unable to verify your coverage prior to your visit, the following fee schedule will apply and will be credited appropriately:

\$89 Initial Visit (including exam and treatment)

\$60 Established patient limited visit (non complex)

Extended/complex visits, supports and supplements are not included in this fee.

We respect your time and will do our best to honor your scheduled appointment time. In order to maintain this unique courtesy, we must charge for missed appointments and late cancellations.

\$30 for missed office visit or late cancellation (less than 3 hour notification)

\$70 for missed or late cancellation of 1 Hour Massage Therapy appointment (less than 8 hour notification).

Note: The late fee is not covered by insurance. It is your responsibility.

Thank you for your courtesy and understanding of this agreement.

I have read the above financial agreement and agree to the terms above.

(Signature) _____

(Date) _____

INITIAL HEALTH STATUS

Email Address _____
Patient Name _____ Birthdate _____ Sex M / F
Address _____ City _____
State _____ Zip _____ Telephone (____) _____ Patient Primary Language _____
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.

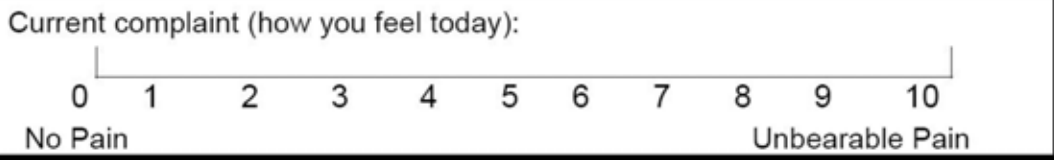
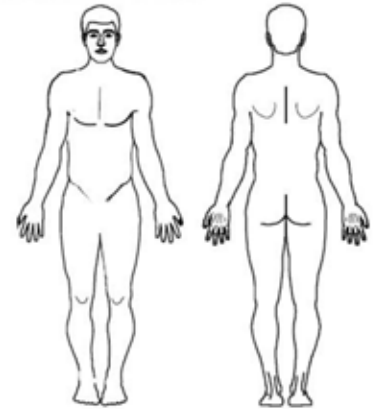
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache
- Neck Pain
- Mid-back Pain
- Low Back Pain
- Other _____

Is this? Work Related Auto Related N/A

Date Problem Began: _____

How Problem Began: _____



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 _____