

# WELCOME TO OUR OFFICE

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**Philip S. Rosen, D.C.**  
18399 Ventura Blvd., Suite 241, Tarzana, California 91356  
(818) 943-6140

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PATIENT'S NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_  
ZIP \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Drivers License \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marriage Status: M \_\_\_ S \_\_\_ W \_\_\_ D \_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_  
Referred by: \_\_\_\_\_

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## **Patient Statement:**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the doctor's 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 the Doctor's office will be credited to my account on 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 that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

## **Authorization to release x-rays & information:**

I authorize and request \_\_\_\_\_  
and any and all physicians who attended me while I was a patient to furnish to \_\_\_\_\_ the below  
noted information concerning my medical care. I understand that I have a right to have these records sent for review upon my  
authorized request.       X-rays       Reports       Records       Other  
\_\_\_\_\_.

## **Assignment of Benefits**

I hereby authorize payment directly to the provider of services named on this form of the benefits otherwise payable to me under the terms and conditions of my insurance company. I understand that I am financially responsible to the provider for services for charges not covered by my policy.

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

Relationship (if other than patient) \_\_\_\_\_ Date: \_\_\_\_\_

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

The purpose of our chiropractic center is to support each individual in achieving their optimum health and to educate them so that they may understand their health and chiropractic and in turn educate others. We encourage any and all questions that you may have.

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**Consent to Treatment:**

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 patient below, for whom I am legally responsible) which are recommended by \_\_\_\_\_ D.C., and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named above.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to; fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedures(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named above and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

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 future condition(s) for which I seek treatment.

**Medicare Explanation:**

Medicare only pays a doctor of chiropractic for manipulation. Medicare does not pay for examinations or x-rays (which they require annually) when performed by a chiropractor. Both of these services are offered at a reduced rate to Medicare patients. Medicare also does not cover the cost of additional services rendered at this office such as physiotherapy modalities. These additional services are often a vital part of your care at this office. We charge our patients additional \$20.00 copay for these services.

**Massage Agreement**

Should massage therapy be included in my care, I agree to pay an additional copay of \$20.00 for massage treatments rendered at this clinic. I understand that this amount is reasonable and not a violation of any contract my doctor has with my insurance company as this amount falls under non-payable services. I further agree to pay this amount at the time of service And will be responsible for payment if I do not keep the appointment and fail to call and cancel my appointment with a 24-hour notice (you MUST speak with someone in the office to cancel, a message on our voice mail may not be retrieved in time).

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

Relationship (if other than patient) \_\_\_\_\_ Date: \_\_\_\_\_

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