Gregory M. Berkoff, D.C.
La Jolla Village Family Medical Group
4520 Executive Drive
Suite 105
San Diego, CA 92121
(858) 622-9459 Telephone
(858) 622-9458 Fax

PATIENT INFORMATION

Name _____ Date _____

Phone (M) _____ (H) _____ (W) _____

Email Address _____

Address _____

City _____ State _____ Zip _____

Sex _____ Age _____ D.O.B. _____ S.S. # _____

Referred by _____

Phone (In Case of Emergency) _____ Name/Relationship_____

Please Describe Your Work

What is the name of your business/company? _____

What is your job title? _____

How much of the following do you do (hrs/day)?

Sitting _____ Standing _____ Driving _____ Telephone _____ Computer _____ Walking ____

Does your work require you to perform repetitive tasks with your hands? Y N

Does your work involve lifting? Y N If yes, how heavy? _____ Lbs.

Please describe the Nature of your Problem

What are your symptoms and where do you feel them (pain, numbness, weakness, etc. ?)
_____

For how long have your had this problem? _____

Have you had this problem in the past (if so, when)? _____

How did the current problem begin? _____

Please list all medicines you are taking for any condition _____

_____

_____

Please rate your general daily stress level: 0 1 2 3 4 5 6 7 8 9 10

Do you have any of the following sleeping problems?

Sleep less than 8 hrs/night	Y	N
Difficulty falling asleep	Y	N
Difficulty staying asleep through the night	Y	N
Stressful dreams (more than 1/month)	Y	N
Wake up feeling groggy and unrefreshed	Y	N

Do you exercise? Y N If so, what do you do and how many times per week?

_____

Have your seen any other doctors for your current problem? Y N
If so, please list them below:
Doctors' name: Approximate dates:

Do you follow a particular dietary regimen? Y N If so, please describe: _____

_____

What things make the problem better? (Ice, heat, rest, activity, NSAIDs, etc.) _____

_____

Please check **the closest reason** for today's appointment:

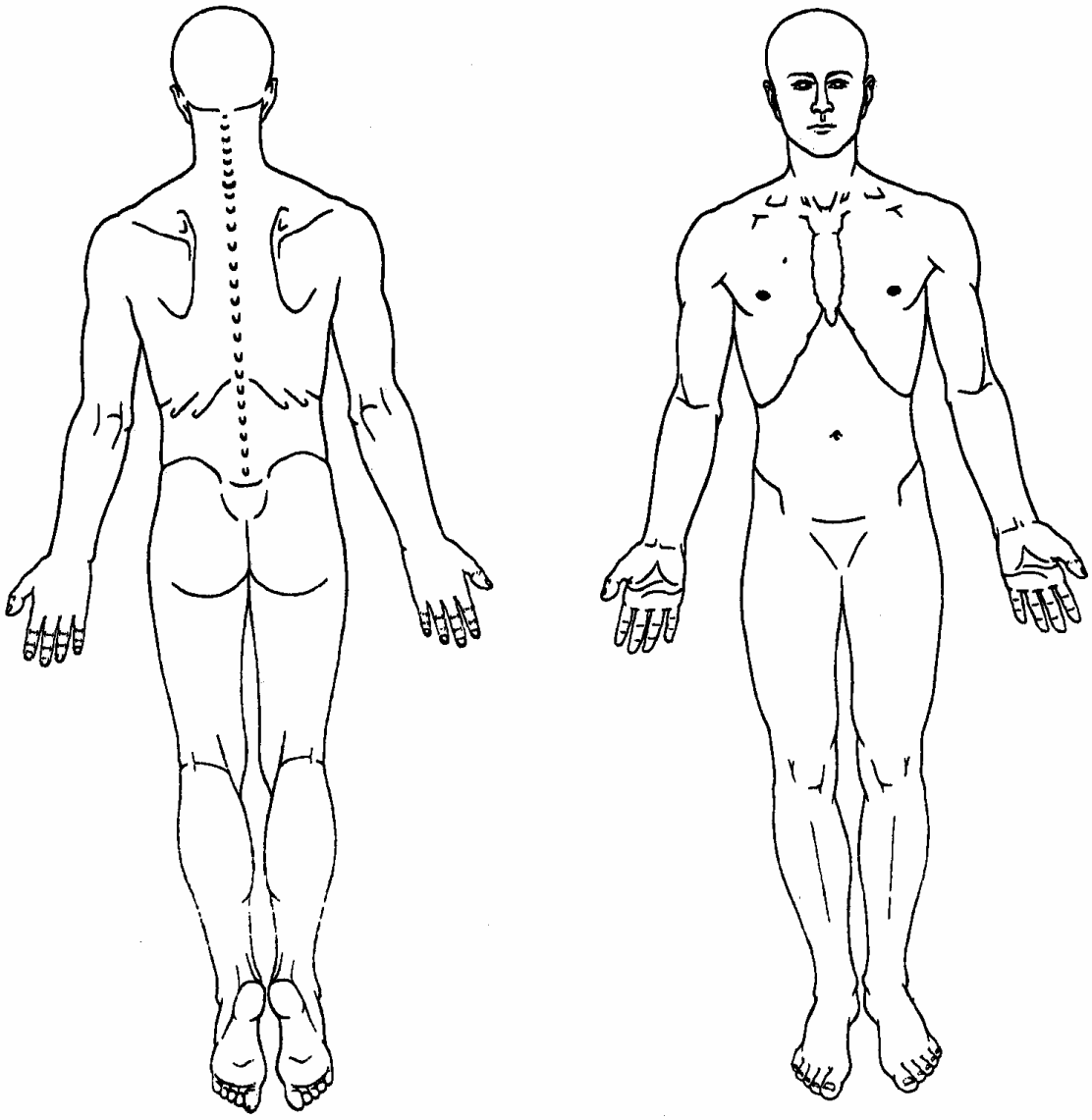
_____ I have a problem that I want resolved and am willing to participate in a course of care that will help me achieve this goal.

_____ I am having pain and am looking for immediate relief from a chiropractor.

_____ I have a chronic condition and wish to enter into a long-term relationship with a chiropractic doctor who can help me to manage better.

_____ I am here for an evaluation and expert opinion only; I do not wish to receive any treatment.

PAIN DRAWING



DRAW:	XXXX	=PAIN
	00000	=NUMBNESS
	.....	=TINGLING
	/////////	=TIGHTNESS

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INSURANCE INFORMATION

Do you have medical insurance coverage? _____ Yes _____ No (if no, skip to the next page)

Does the plan include chiropractic benefits? _____ Yes _____ No _____ Not sure

Is the insurance plan:

Through an employer _____

Your own individual private policy _____

If through an employer, whose policy is it?

My own _____

My spouse's, significant others, or parent's _____

The following information pertains to the **policyholder's** (if not patient) employer:

Employer : _____

Address: _____

Contact (Supervisor/HR): _____

Phone: _____ Ext: _____

The following information pertains to your insurance coverage:

Insurance company: _____

Effective date: _____

Member ID: _____

VERY IMPORTANT

NO-SHOW/LATE CANCELLATION POLICY AGREEMENT

Dr. Berkoff maintains a small, high-quality private practice in this facility. Office visits are scheduled in time blocks of 20 minutes. The amount of time blocked-off for each of your office visits will depend upon your needs as determined by the doctor. Most commonly, you may expect to be here for 20-30 minutes for each treatment. Because Dr. Berkoff spends so much time with his patients, your scheduled appointments require our staff to block-off or "reserve" this time for you. For this reason, you are expected to be on time or a few minutes early for each appointment. If you are late, a portion of your valuable time with the doctor is forfeited. Since Dr. Berkoff runs on time, it is unfair for him to run overtime with you if you are late, as this inconveniences every patient after you for the rest of the day. Similarly, if you fail to make an appointment or cancel an appointment without 24 hours notice (to include Friday evening cancellations for Monday morning appointments), you are expected to be financially responsible for the time that was reserved for you. Please realize that an appointment represents time that the doctor has prepared exclusively for you, during that time, no other patients can be seen. Therefore, a no-show or a late cancellation not only interferes with your treatment plan, but it causes the doctor to lose valuable time and prevents other needy patients from being able to access treatment. For this reason, a missed appointment or a late cancellation will result in a charge of $45 for each 20-minute block of time reserved for you. The purpose of this policy is not to penalize you, but to encourage responsibility and to compensate the doctor for the valuable time he has set aside for you. The no-show/late cancellation fee must be paid by you personally and may not be submitted to your insurance company for reimbursement.

EXCEPTIONS: If you miss an appointment as a result of an unavoidable emergency, Dr. Berkoff has instructed the staff to waive the no-show fee. However, it is up to the doctor to determine whether a missed appointment is the result of an emergency. Generally speaking, family and personal medical emergencies are excused, while work schedule changes are not. For instance, if your child or spouse is injured and must be rushed to the hospital, this would be considered an emergency, on the other hand, if you have an "important meeting" you realize you "have to" attend, this is not a valid emergency. Similarly, if you are incapacitated due to illness (such as the flu), you will be excused for a late cancellation (do try to call as soon as you start feeling sick), on the other hand, if you are feeling tired, have a headache, or simply forget your appointment, these excuses will not be considered as "emergencies".

I _____ understand the above no-show/late
(Please Print Your Name)
Cancellation policy and agree that it is fair. I understand that the purpose of the agreement is to compensate Dr. Berkoff for the valuable time he sets aside specifically to meet my medical needs. Therefore, I promise to be conscientious about making all my appointments on-time, and if I fail to make an appointment or fail to give 24 hours notice prior to cancellation of an appointment, I agree to pay $45 for each 20 minute block of time reserved for me.

_____
(Patient Signature)

_____
(Date)

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Dear Patient,

We are living at a time in which medical insurance can be very complicated and difficult to understand. There are hundreds of companies providing medical coverage in the United States, and many companies offer dozens of different coverage options.

Dr. Berkoff is a contracted provider with many insurance companies and as such, you may be entitled to coverage under your particular plan. We will do all we can to help you sort out just what you are and are not covered for. However, your insurance coverage is ultimately your own responsibility and if your insurance company denies coverage or reimbursement for products and services provided at this office, payment for such products and services shall be your responsibility.

It is important that you understand that, in most cases, Dr. Berkoff has already agreed to accept a reduced fee in order to be accepted as a contracted provider and we cannot afford, nor should we be expected to provide supports, appliances, or services free of charge. While we promise to work hard to help you through the insurance maze, you are ultimately financially responsible for your care here and will be billed for any products or services you receive for which you are not covered by insurance.

I, _____, understand that I am personally responsible for payment of non-covered services and products provided by Dr. Berkoff during the course of my care.

Patient Signature _____

Date_____

Please note: Dr. Berkoff's office does not accept cash. For payment we accept all major credit cards, debit cards and checks (w/gov't issued photo ID). There are no exceptions. Thank you in advance for your cooperation.

HIPAA Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, 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 physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management or your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we

may disclose your protected health information to medical school students that see patients in our office. 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 when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations 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 Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

NOTICE OF PRIVACY PRACTICES

PROOF OF SERVICE

We are required by law to maintain the privacy, 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 HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____