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:_____

Address: _____City:_____State:____ Zip:_____

Phone: (H)_____(M)_____(W)_____Ext._____

E-mail address:_____

Sex:_____ Age:____ Date of birth:_____ SSN_____-_____-_____

Referred by:_____

Name of Spouse/significant other:_____

Phone (in case of emergency): _____Relationship_____

Employer_____ Your job title: _____

Address:_____

City:_____ State: _____Zip:_____

Supervisor/HR_____Phone: _____Ext:_____

YOUR HEALTH INSURANCE

Do you have medical insurance coverage:☐Yes☐No.(if no, please skip to the next page)

Does the plan include chiropractic benefits? ☐Yes.☐No. ☐Not Sure.

Is the insurance plan: ☐through an employer? ☐Your own private policy?

If through an employer, whose policy is it? ☐My own. ☐My Spouse's, significant other's, parent's.

The following information pertains to the **policyholder's** employer: ☐Same as above

Employer: _____ Address: _____

Contact (Supervisor/HR): _____ Phone: _____Ext._____

The following information pertains to your insurance coverage:

Insurance company: _____Member number:_____

Effective Date_____ Group number: _____

Subscriber name: _____ Co-payment amount: _____

PERSONAL INJURY

If you have been in an accident for which you are seeking treatment other than through Worker's Compensation, please fill out the following form.

DATE OF INJURY: _____ TIME OF DAY: _____

1) Nature of Accident (Please Check) Auto v. Auto ☐ Auto v. Motorcycle ☐ Slip/Fall ☐

Other (Please Explain) _____

2) Were you the: Driver ____ Passenger ____ Pedestrian ____

3) Were you wearing a seat belt? Yes ____ No ____and shoulder harness? Yes ___ No ___

4) If you were a passenger, were you in the: Front Seat ____ Back Seat ____

5) What direction were you headed? North ____ South ____ East ____ West ____

on _____
(Name of Street)

6) If another vehicle was involved, what type of vehicle was it? (i.e. 2 door Toyota sedan, Chevy Blazer, Truck, etc.) _____

7) What type of vehicle were you in? _____

8) The other vehicle was headed: North ☐ South ☐ East ☐ West ☐

on _____
(Name of Street)

9) Were you knocked unconscious? Yes ☐ No ☐ If so, for how long?_____

10) Where did you go after the accident? _____

11) How did you get there? _____

12) Was your car driveable after the accident? Yes ☐ No ☐

13) Did any part of your body strike any part of the interior of the car? (i.e. knee against the underdash, forehead against the steering wheel, etc.): _____

14) Were the police notified of the accident? Yes ☐ No ☐

15) Was a police report made? Yes ☐ No ☐

16) Does your auto insurance have MEDICAL PAY? Yes ☐ No ☐

17) What is the medical pay limit? $_____ (if unknown, please call your auto insurance representative).

18) In your own words, please describe the accident (you may draw a diagram if helpful):

19) Did the amount of the accident come as a complete surprise to you, or did you see it coming?

_____

20) How was your head positioned at the moment of impact? Straight Ahead ☐

Looking Down ☐ Turned Left ☐ Turned Right ☐ Tilted Back ☐ Other _____

21) Where were your hands at the moment of impact? _____

22) Were you reclined or upright at the moment of impact? _____

23) Please describe how you felt:

A) Immediately after the accident: _____

_____

B) Later that day: _____

_____

C) The next day: _____

_____

24) How did you sleep that night? _____

25) Since the accident, have your symptoms: Improved ☐ Stayed Same ☐ Worsened ☐

26) List any and all activities you normally do but **cannot** do now as a result of the accident:

_____

_____

_____

_____

27) If you had any physical complaints before the accident, please describe each complaint in detail, including treatments received. Otherwise, write NONE: _____

_____

_____

_____

28) What are your present complaints and symptoms? _____

_____

_____

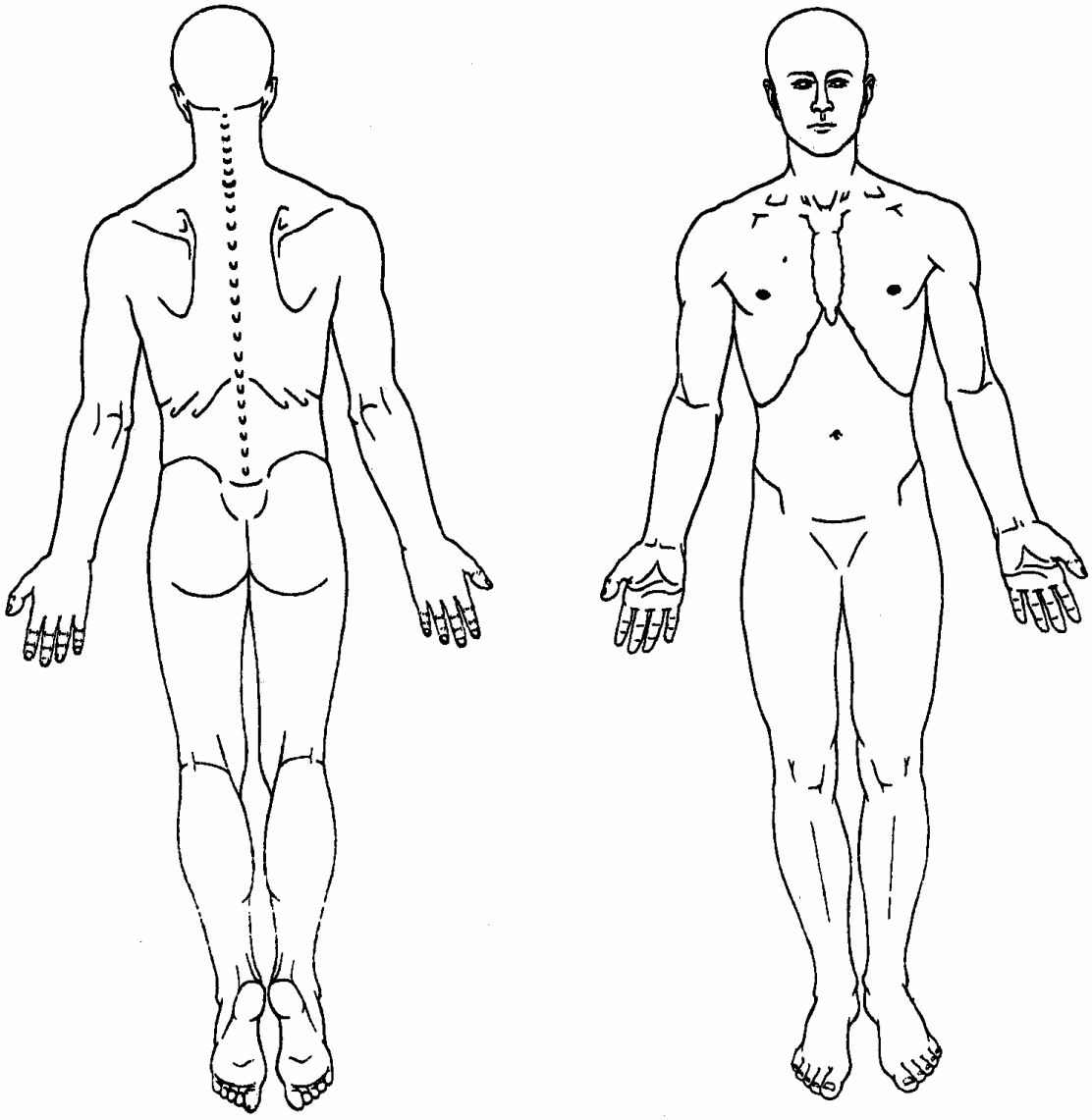
_____

29) Check symptoms you have experienced since the accident:

☐ Back Stiff	☐ Dizziness
☐ Neck Stiff	☐ Numbness in Hands
☐ Difficulty Sleeping	☐ Numbness in Feet
☐ Difficulty Concentrating	☐ Loss of Memory
☐ Nervousness	☐ Ringing/Buzzing in Ears
☐ Tension	☐ Headaches
☐ Frustration	☐ Fatigue
☐ Irritability	☐ Heads Seems too Heavy

Please use the PAIN DRAWING on the following page to illustrate how you feel. Use the legend at the bottom of the page to draw in pain, numbness, tingling, or stiffness/tightness. Please include all of your symptoms, even those you feel only slightly or occasionally.

PAIN DRAWING



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

If you have been seen by any other doctor(s) since the accident, please provide the name(s) and phone number(s) with dates of evaluation/treatment. Otherwise, write NONE.

_____	_____	_____
(Name)	(Phone)	(Date)
_____	_____	_____
(Name)	(Phone)	(Date)
_____	_____	_____
(Name)	(Phone)	(Date)

If you have retained an attorney since the accident, please provide your attorney's name, phone number and address. Otherwise, write NONE.

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Please list all current medications:

Please use the remaining space to add any additional information you think is relevant at this time:

Gregory M. Berkoff, D.C.

MOTOR VEHICLE ACCIDENT
INSURANCE SUPPLEMENT

Our contract with your health insurance plan requires us to "coordinate benefits" which means we must bill the primary responsible insurance carrier first. In the event of a motor vehicle accident this almost always means your auto insurance.

Please take a moment to fill out the following information:

Patient Name: _____ **Date of Accident:** _____

Were you the: Driver ☐ **Passenger** ☐ **Pedestrian** ☐

Vehicle you were traveling in:

Auto insurance name: _____

Address: _____

Phone: _____

Policy Holder: _____

Claim adjuster: _____

Claim Number: _____

Medical Pay? Yes ☐ **No** ☐ **If "Yes", what is the amount?** _____

Other vehicle involved in accident:

Auto insurance name: _____

Address: _____

Phone: _____

Policy Holder: _____

Claim adjuster: _____

Claim Number: _____

<u>If you do not have this information available to you at the time of service, please contact our office within 72 hours to avoid being held responsible for the bills.</u>

Thank you.

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 her 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)

Please read carefully before signing

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

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 my course of care.

Patient Signature _____ Date _____

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's Name: _____ Date of Accident: _____

I, _____, authorize Dr. Gregory Berkoff to evaluate and treat me for injuries, which I have sustained as a result of the above accident. I understand that the doctor will exercise his best efforts to effect recovery but that recovery cannot be guaranteed and that the doctor cannot be responsible for the normal risk of providing medical treatment. I authorize Dr. Berkoff to furnish my attorney with medical reports and chart notes concerning my injuries and with an itemized statement of charges. I hereby grant a lien to Dr. Berkoff against proceeds of any settlement paid to me or to my attorney as the result of the injuries for which I have received evaluation, treatment or attention by Dr. Berkoff, in the full amount of his total billings. I authorize and specifically instruct my attorney to pay Dr. Berkoff, in full, the amount of his bill for professional services rendered to me by reason of the above accident. In the event that another attorney is substituted in the matter, I hereby instruct that attorney and all subsequent attorneys retained to honor this lien.

I understand that I am directly responsible to Dr. Berkoff for payment in full of any and all professional services which he renders on my behalf. I understand that his fees are not amenable to negotiation and not in any way contingent upon any settlement I may or may not receive on a claim pursuant to the above mentioned accident. I understand that the purpose of this lien is to protect Dr. Berkoff's right to be paid in full for his professional services and in consideration of his willingness to await payment until the settlement of my claim. I agree that all sums owing under this lien become due and payable immediately upon the occurrence of any of the following: 1) my case settles or trial court renders judgment; 2) I drop my case; 3) more than one year passes following cessation of care with Dr. Berkoff for injuries related to this case. I hold Dr. Berkoff harmless with regard to the outcome of any claim I make and order my attorney to pay Dr. Berkoff directly and immediately upon the receipt of any settlement funds. I further understand that in the event my attorney refuses or fails for any reason to comply with this lien agreement by not paying Dr. Berkoff immediately and directly the full sum of his charges, I will be charged interest on the balance due at a rate of 10% APR.

_____	_____	_____
Date	Patient's Signature	Parent/Guardian

_____	_____	_____
Date	Dr. Berkoff's Office Manager	Dr. Berkoff

I, the under-signed being the attorney of record for the above patient, do hereby agree to observe and be bound by all terms of this agreement and further agree to withhold from the patient's settlement, judgment or verdict, sufficient sums to pay Dr. Berkoff's lien in full. I understand that Dr. Berkoff is not bound in any way by contingency pursuant to this claim and that he does not negotiate his fees.

_____	_____	_____
Date	Attorney's Signature	Attorney's Printed Name