



# 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 \_\_\_\_\_

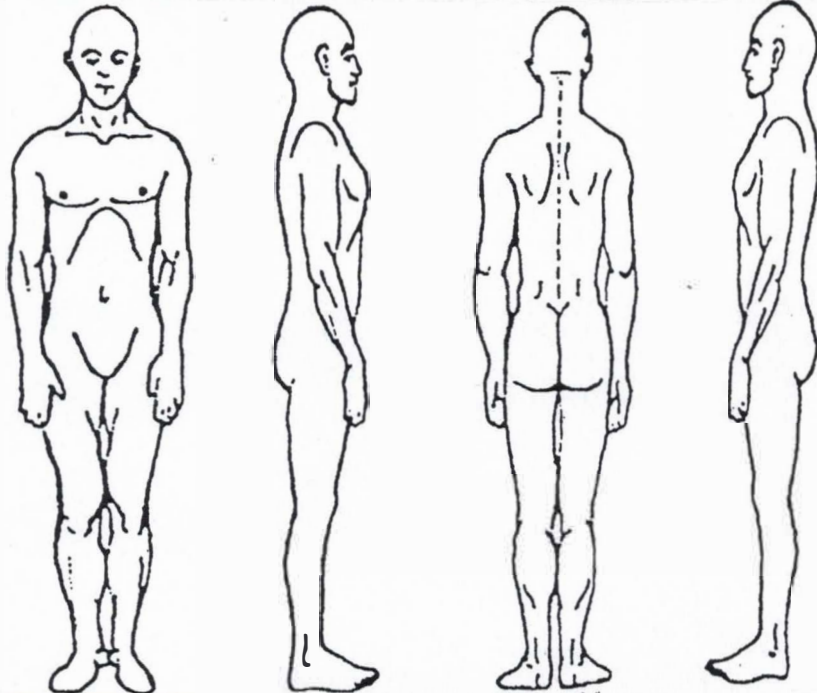


# F.I.R.S.T. HEALTH

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

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

<b>Aching</b> ~~~~~	<b>Numbness</b> +++++++	<b>Pins &amp; Needles</b> 000000000000	<b>Burning</b> XXXXX	<b>Stabbing &amp; Sharp</b> ////////////////////
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**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.

- |  |  |
|--|--|
| <input type="checkbox"/> Headaches/Migraines       | <input type="checkbox"/> Sinuses/Allergy       |
| <input type="checkbox"/> Neck pain                 | <input type="checkbox"/> Asthma/Allergy        |
| <input type="checkbox"/> Pain between shoulders    | <input type="checkbox"/> Ankle/Foot pain       |
| <input type="checkbox"/> Low back pain/Sciatica    | <input type="checkbox"/> Wrist/Hand pain       |
| <input type="checkbox"/> Spinal check-up for child | <input type="checkbox"/> Nutritional imbalance |
| <input type="checkbox"/> Sports injury             | <input type="checkbox"/> Arthritis             |
| <input type="checkbox"/> Auto accident/Whiplash    | <input type="checkbox"/> Numbness              |
| <input type="checkbox"/> Wellness/Prevention care  | <input type="checkbox"/> Rheumatic fever       |
| <input type="checkbox"/> Digestive disorder        | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Heart trouble         |
| <input type="checkbox"/> Other _____               |  |

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:

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

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

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

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____  |
| <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> _____               | <input type="checkbox"/> 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 an 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: \_\_\_\_\_



# F.I.R.S.T. HEALTH

19000 Hawthorne Blvd. Suite 302  
Torrance, CA 90503

## FINANCIAL POLICY

- \_\_\_\_ 1. I understand that I am required to pay for all charges on the date services are rendered. Unless, I am  
*initial* covered by a PPO or HMO-HPO health plan in which the physician is a participating provider and I am being seen for a service I know to be covered by my policy.
- \_\_\_\_ 2. I understand the F.I.R.S.T. HEALTH accepts MasterCard/Visa/American Express/Discover and Diners, my  
*initial* personal check, money orders or cash. If the bank returns a check payable, I will be charged a \$25.00 service fee, which is due and payable along with the amount of the original check.
- \_\_\_\_ 3. I understand and agree that if I receive a statement in the mail, the amount stating my responsibility is  
*initial* due in 10 days.
- \_\_\_\_ 4. If my account exceeds 90 days, I understand I am in a collection status, and a \$10.00 collection fee plus a  
*initial* finance charge equal to 1 ½% per month may be added to my account.

## MEDICAL INSURANCE POLICY

- \_\_\_\_ 1. I understand and agree that I am ultimately responsible for my account in full, even though I have medical  
*Initial* insurance. Should there be a problem with my insurance company not paying in a timely manner or for the correct amount, I agree to pay the doctor and settle my difference with my insurance company.
- \_\_\_\_ 2. I will pay all co-pays, deductibles or percentages due on the date of service.  
*initial*
- \_\_\_\_ 3. I hereby authorize payment directly to Craig E. Morris, D.C. or F.I.R.S.T. HEALTH insurance benefits  
*initial* otherwise payable to me. I understand I am financially responsible for charges not covered by this authorization. I also authorize that a photographic copy of this authorization is as valid as the original.
- \_\_\_\_ 4. I hereby authorize the disclosure of medical information to my stated insurance company for the purpose  
*Initial* of obtaining payment for service rendered.
- \_\_\_\_ 5. I will pay for all nutritional supplements, orthopedic supplies, plus any other healthcare supplies in stock,  
*Initial* on the date they are dispensed.
- \_\_\_\_ 6. I will pay for all custom ordered supplies in advance. I agree to pay for custom- fitted foot orthotics on the  
*initial* day I am cast for them.
- \_\_\_\_ 7. I understand and agree that all orthotics, appliances, supplies and supplements are not refundable or  
*initial* exchangeable at all once they leave this office.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

Signature: \_\_\_\_\_ Staff Initials: \_\_\_\_\_



## **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

**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

19000 Hawthorne Blvd. Suite 302  
Torrance, California 90503

## **INFORMED CONSENT TO CHIROPRACTIC CLINICAL MANAGEMENT**

I hereby request and consent to the performance of chiropractic clinical management, including but not limited to, examination, diagnostic x-rays, adjustment and other manual therapeutic methods (treatment by hand or instrument), physiotherapy (modalities such as ultrasound therapy), rehabilitation (exercises and training) and counseling, on me (or on the patient named below, for whom I am legally responsible) by the clinicians, their associates and employees, of the clinic.

Our clinicians employ standard examination methods, which include the following:

- 1: Observation: general assessment/ appraisal in various positions.
- 2: Inspection: Viewing/ looking at your body (for bruising, atrophy, swelling, posture, abnormal motion, etc.)
- 3: Auscultation: Placing a stethoscope on your skin to listen for blood pressure and body sounds.
- 4: Palpation: The clinician will touch you, feeling for tenderness, heat, swelling, nodules, muscle spasm, misalignment, laxity of tissues, integrity and abnormality.
- 5: Percussion: Tapping on bones, tendons and other tissues with a rubber reflex hammer or hands/fingers.
- 6: Orthopedic/ Neurological testing: Standard test to assess your neuromusculoskeletal (i.e. nerves/ muscles/ bones/ joints) system. Some tests may be uncomfortable or painful, especially if you are already in pain.

I understand, and am informed that, as in the practice of medicine, there are some risks to chiropractic treatment including, but not limited to, fracture, disc injuries, strokes, dislocation and sprains. I do not expect the clinician(s) to be able to anticipate and explain all risks and complications, and I wish to reply on the clinician(s) to exercise judgment during the course of the procedure, which the clinician feels at the time, based upon the facts then known, is in my interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for the present, or any future condition(s) for which I (or my ward named below) seek treatment.

---

Print Patient's name

---

Print Guardian's name

---

Signature of Patient

---

Signature of Guardian

---

Witness to Signature

---

Translator

Date this \_\_\_\_\_ Day of \_\_\_\_\_ 20\_\_\_\_ Original/File/Patient



# F.I.R.S.T. HEALTH

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS 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 and/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 providing 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:

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Print Name

Signature

Date



# 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**