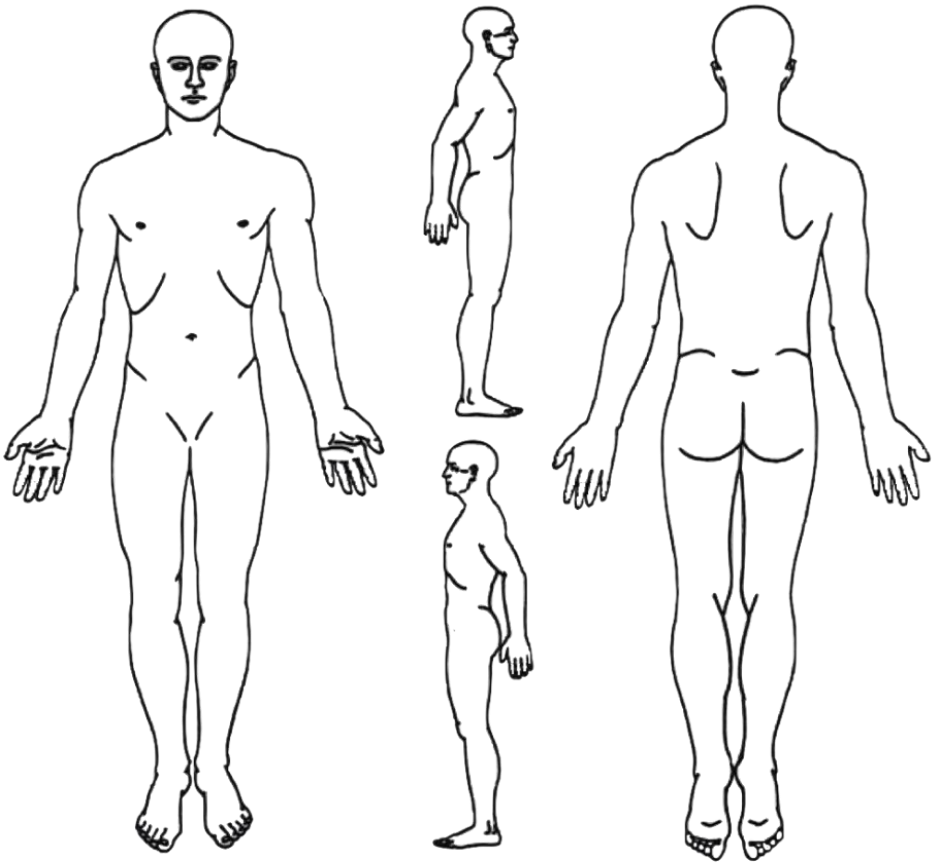
WEST L.A. MEDICAL
PAIN AND TRAUMA

Patient Name: _____ **DOB** _____/_____/_____

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - - - - - - - -	o o o o o o o o o o o o	^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^ ^	x x x x x x x x x x x x	● ● ● ● ● ● ● ● ● ●



Please circle your level of your pain:

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

FOR MEDICAL PROVIDER:

TX: _____ _____ _____

PRECAUTIONARY CORONAVIRUS LIABILITY RELEASE FORM

Due to the 2019 - 2020 outbreak of the novel Coronavirus, COVID-19, we are taking extra precautions with the intake of each client, health history review, as well as sanitation and disinfecting practices. Please complete the following and sign below.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry cough
- Difficulty breathing

I, _____ agree to the following:

1. I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.
2. I affirm that I, as well as all household members, have not been diagnosed with COVID-19 within the last 30 days.
3. I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.
4. I affirm that I, as well as all household members, have not traveled outside of the country, or to any city outside of our own that is or has been considered a “hot spot” for COVID-19 infections within the last 30 days.
5. I understand that this business and providers cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

By signing below, I agree to each above statement and release the massage therapist and business from any and all liability for the unintentional exposure or harm due to COVID-19. Your provider and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitation protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.

_____

Print Name

_____ _____

Signature Date

WEST L.A. MEDICAL
PAIN AND TRAUMA

Patient Intake Form

Patient Name: _____ Date: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Last 4 SSN: _____ DOB: _____ □ Male □ Female

Check appropriate box**:** □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Address: _____ City _____ State_____ Zip_____

Employer: _____

Emergency Contact: _____ Phone: _____

In case of a medical emergency, if the patient is a minor, they could be treated in my absence.

Parent or Guardian Signature: _____ Date: _____

Do you have any Medical insurance? □ Yes □ No **If yes, please select**: □ PPO □ Medi-Cal □ Medicare □ HMO

Past Medical History: List all medications (prescriptions), vitamins, and other supplements you are taking currently or have taken in the past year (attach additional sheet if needed)

Medication	**Dosage/Frequency**

Location of problem: _____
(Where is the pain/problem?)

Severity: _____
How severe is the pain/discomfort on a scale of 1-10 with 10 being the most severe? List your range of pain. When is it at its worst and best?

Timing: _____
(Does the pain/problem occur at a specific time?)

What other areas of your body are affected by this problem?

_____

_____
(Ex: ankle problems due to knee problems...)

What have you tried in the past to handle your problem?

_____
(Heat, ice, over the counter/prescription medications, rest, exercise, physical therapy, adjustments, massage, etc.)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

What activities have you given up or changed due to this problem?

_____

_____
(Example: stopped climbing steps as often)

What activities increase symptoms/makes problems worse? _____
(Ex: Going up and downstairs, brushing hair, etc.)

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PAIN AND TRAUMA

PATIENT CONSENT FOR COMMUNICATION:

We have the ability to call, text, and email you reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Patients in our practice may be contacted via phone/text messages to be reminded of an appointment, to obtain feedback on an experience within our office, and to provide general health reminders/information.

I consent to receiving appointment reminders and other healthcare communications via telephone, text messages and email messages from West LA Medical.

I understand that this request will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

INFORMED CONSENT TO CARE:

As with any healthcare procedure there are certain complications which may arise during therapy. Our doctors and nurse practitioners are required to advise patients that there are risks associated with such treatment. In particular, you should note:

1. Some patients may experience some stiffness or soreness following the first few days of treatment.
2. Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3. I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4. Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted). I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my medical provider.

I consent the Doctors and Nurse Practitioners of West LA Medical to treat my case as they deem appropriate through the use of diagnostic testing, trigger point injections, durable medical equipment, rehabilitation, manual therapy, chiropractic manipulation of the spine, and nutritional support. I realize the goal of holistic health care is to strengthen the patient's body in order to heal themselves. I intend this consent to apply to all my present and future care.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

Patient's or Patient Representative's Initials _____

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____	_____	By:_____	_____
Physician's or Authorized Representative's	(Date)	Patient's or Patient Representative's Signature	(Date)
_____		_____	
Print or Stamp Name of Physician, Medical Group or Association Name		Print Patient's Name (If Representative, Print Name and Relationship to Patient)	