SOHMA INTEGRATIVE HEALTH CENTER

4195 N Viking Way Suite G, Long Beach CA, 90808

Patient Name: _____ Date: _____

ASSINGMENT OF HEALTH PLAN BENEFTIS AND RIGHTS

AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE

AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **SOHMA INTEGRATIVE MEDICINE** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/ insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/ our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

X_____
(Patient Name)

X_____
(Patient Signature)

X_____
(Signature of Guardian if applicable)

_____
Date

If Patient Is Under 18, please have Parent/Guardian complete:

Parent/or Guardian Name: _____

Relationship to Patient: _____ Cell Phone: _____

In case of a medical emergency, if the patient is of school age (14 years or older), is it okay to treat in my absence. □ Yes □ No

_____
Parent or Guardian Signature

_____
Date

Health History

Chief Complaint: _____

History of Present illness:

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

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

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Context: _____
(Where were you at the onset of this issue?)

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

Modifying Factors: _____
(What makes the pain/problem/discomfort worse?

Associated Signs/Symptoms _____

_____
(What other areas are affected by your chief complaint?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication:(include nonprescription)

_____
_____

Do you have any allergies to medications? NO YES
If yes what type:

_____

_____

Indicate which of the below you have experienced in the last 1-2 months: 1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Joint Pain	1 2 3 4 5	Fatigue	1 2 3 4 5
Low Back Pain	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Neck Pain	1 2 3 4 5	Arthritis	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5	Headaches	1 2 3 4 5
Elbow Pain	1 2 3 4 5	Migraines	1 2 3 4 5
Shoulder Pain	1 2 3 4 5	Dizziness	1 2 3 4 5
Hip Pain	1 2 3 4 5	Numbness	1 2 3 4 5
Knee Pain	1 2 3 4 5	Tingling	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5	Pins/needles in hands or feet	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____ _____
Signature of Doctor Date

Pain Assessment

On a scale of 0 -10, (0) being minimal pain and (10) maximum pain, please answer the following questions:

Rate the pain you have right now: 0 1 2 3 4 5 6 7 8 9 10

Rate your average pain in the past week: 0 1 2 3 4 5 6 7 8 9 10

Rate your pain at its best in the past week: 0 1 2 3 4 5 6 7 8 9 10

Rate your worst pain in the past week: 0 1 2 3 4 5 6 7 8 9 10

Please mark on the body diagrams all the areas of pain, discomfort, or altered sensation.