ALL STAR HEALTH
SPINE & JOINT CARE

About You

First Name:_____ MI: _____ Last name: _____
[ ] Male [ ] Female SS#:_____ Birthday: _____/_____/_____ Age: _____
Ethnic Origin/Race: _____ Preferred Language:_____ Email: _____
Address:_____ Apt:_____
City:_____ State: _____ Zip: _____
Home #: _____ Cell: _____ Wk #: _____ Ext: _____
Occupation: _____ Employer: _____
Marital Status S M D W # of children: _____ Spouses Name: _____
(if Minor) Parent or Guardian: _____
In case of emergency, whom should we contact? Name: _____ Phone #: _____
Name of your family doctor: _____ Phone #: _____
Next appointment with your doctor: _____/_____/_____ (if applicable)
May we contact your family doctor if needed [ ] Yes [ ] No
Who may we thank for referring you to our office: _____

Insurance information

We will make a copy of your insurance card(s) However, please complete the following information.
Are you the policyholder? **[ ] Yes [ ] No** If **YES** skip this section If **NO** please complete this section.
Insurance name: _____ Insurance Phone #: _____
Policy Holder's Name: _____Policy ID# :_____
Birthday: _____/_____/_____ [ ] Male [ ] Female Policyholder's SS #: _____
Address:_____
Employer:_____
Do you have a secondary insurance coverage [ ] Yes [ ] No If **YES** please complete this section.
Insurance name: _____ Insurance Phone #: _____
Policy Holder's Name: _____Policy ID# :_____
Birthday: _____/_____/_____ [ ] Male [ ] Female Policyholder's SS #: _____
Address:_____
Employer:_____
We reserve the right to collect a $50 fee for cancellations with less than 24 hour notice.
Initial:____

Assignment & Release

* I understand & agree that health & accident insurance policies are an agreement between an insurance carrier & myself. Furthermore, I understand that this office will prepare any necessary reports & forms to assist me in making collection from the carrier & that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt.
* As a courtesy to you, we will verify your health care benefits for this office. You will then be responsible for any co-pays and deductibles.
* Your health insurance is a contract between you & the insurance carrier. In the "rare" event that your insurance company is in "bad faith" & after our office has made every attempt to have all claims paid, we will have you, the patient, be responsible for contacting your insurance carrier to have the claims paid.
* If your insurance company has not paid within 120 days of billing, you will be responsible to pay the balance due.
* If Collection efforts become necessary to enforce payment terms, the patient agrees to pay all collection costs, attorney's fees, & other costs associated with collecting this balance.
* I hereby authorize & release the doctor & his /her assistants, to administer treatment, physical examination, x-rays studies, chiropractic care, physical therapy, or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including & not limited to hospital or medical services companies, worker's compensation carriers, welfare funds, or the patient's employer.

Signature: _____ **Date:** _____/_____/_____

6625 5. Rural Rd, Ste. 104 • Tempe, Arizona 85283 • Phone: 480-833-4515 • Fax: 480-833-5078
2730 5. Val Vista Dr, Ste. 188 • Gilbert, Arizona 85295 • Phone: 480-324-0244 • Fax: 480-324-0589

www.allstarspinecenter.com

PATIENT HEALTH QUESTIONNAIRE

ALL STAR HEALTH
SPINE & JOINT CARE

NAME _____ DATE _____/_____/_____

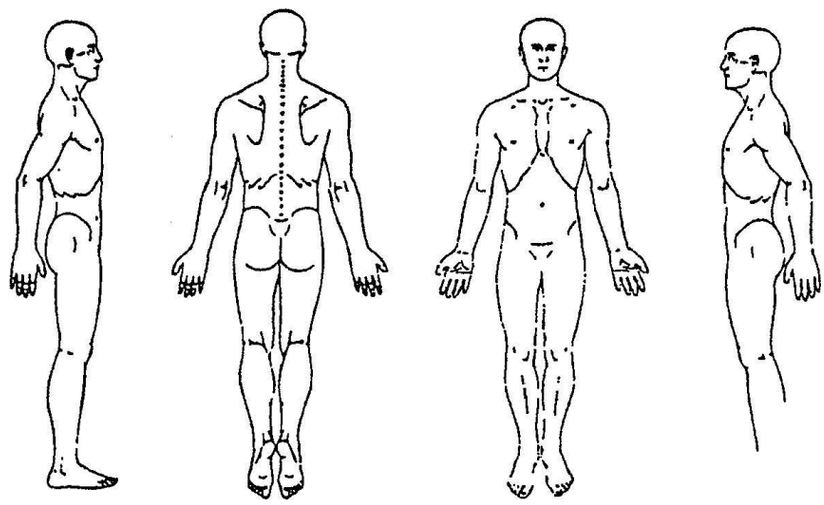
In the space below, please describe your major complaint.
If you have an additional complaint, please describe it on page 2

1. Please Describe your Complaint:_____

_____

_____

Description	**Frequency**
☐ Sharp Pain	☐ Constant (76-100%)
☐ Dull Pain	☐ Frequent (51-75%)
☐ Ache	☐ Occasional (26-50%)
☐ Weak	☐ Intermittent (1-25%)
☐ Throbbing	
☐ Numb	
☐ Shooting	
☐ Gripping	
☐ Burning	
☐ Tingling	



MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

a. **Indicate the intensity of your pain at its lowest and highest level** **No Pain** [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] **Unbearable Pain**
b. **Your symptoms are** ☐ decreasing ☐ not changing ☐ increasing
c. **Symptoms are worse in the** ☐ Morning ☐ Afternoon ☐ Night ☐ Increase during the day ☐ Same all day

2. Date Problem Began: _____ Describe how your problem began:_____

_____

_____

3. Have you ever been treated for this episode? ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other
Are you currently being seen? ☐ Yes ☐ No
When and what treatment? ____/____/____

_____

_____

4. **In the past** have you ever been treated for the same or a similar problem? ☐ Yes ☐ No
If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical Therapist ☐ Occupational Therapist ☐ Other_____
When and what treatment did you receive?

_____

_____

5. What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity
6. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity
7. How would you rate your general stress level? ☐ Little or No Stress ☐ Minimal Stress ☐ Moderate Stress ☐ Greatly Stressed
8. General Physical Activity: ☐ No regular Exercise program ☐ Light Exercise program ☐ Moderate Exercise program ☐ Strenuous Exercise program
9. Are your complaints affecting your ability to be active?
☐ No effect
☐ Some physical restrictions
☐ Need limited assistance with common everyday tasks.
☐ Need assistance often.
☐ Have a significant inability to function without assistance.
☐ Am totally disabled (impaired). Cannot care for self
10. Physical activity at work:
☐ Sitting more than 50% of the workday ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repeated motion
11. Occupation: _____ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ Yes ☐ No
12. What is your current work status?
[1] Full time, no restrictions.
[2] Full time, with restrictions.
[3] Part time, with no restrictions.
[4] Part time, with restrictions.
[5] Off work due to restrictions.
[6] Full time homemaker.
[7] Unemployed.
[8] Retired.
[9] Full time student.
[10] Other_____

Please Continue

Patient signature: _____ Date: ____/____/____

ALL STAR HEALTH
SPINE & JOINT CARE

on Page 2

MEDICAL HISTORY - REVIEW OF SYMPTOMS
CHECK SYMPTOMS/CONDITIONS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST

CONSTITUTIONAL
◯ LOSS OF APPETITE ◯ NIGHT SWEATS ◯ FEVER ◯ NAUSEA
◯ FATIGUE ◯ VOMITING ◯ WEIGHT ◯ CHILLS

CARDIOVASCULAR
◯ HYPERTENSION ◯ HEART ATTACK ◯ HIGH CHOLESTEROL
◯ REPID HEART BEAT ◯ CHEST PAIN ◯ PACEMAKER
◯ CLAUDICATION ◯ MURMUR ◯ STROKE

RESPIRATORY
◯ ASTHMA ◯ SLEEP APNEA ◯ COUGH ◯ DIFFICULT BREATHING
◯ EMPHYSEMA ◯ SHORTNESS OF BREATH ◯ WHEEZING

GENITOURINARY
◯ KIDNEY STONES ◯ PAINFUL URINATION
◯ FREQUENT URINATION ◯ UNINARY TRACT INFECTION
◯ BLADDER INFECTION ◯ LOSS OF BLADDER CONTROL
◯ KIDNEY DISORDERS

SKIN
◯ RASH ◯ BREAST PAIN ◯ ECZEMA ◯ ACNE ◯ PSORIASIS

PSYCHIATRIC
◯ ANXIETY ◯ PANIC ATTACK ◯ DEPRESSION ◯ ADDICTION

ALLERGIC IMMUNOLOGIC
◯ ALLERGIES ◯ RUNNY NOSE ◯ ITCHY EYES ◯ SNEEZING

EYES
◯ VISUAL DISTURBANCES ◯ BLURRED VISION ◯ CONTACTS
◯ CATARACTS ◯ GLASSES ◯ GLAUCOMA

EARS/NOSE/MOUTH/THROAT
◯ TINNITUS ◯ CHRONIC SINUSITIS ◯ RECURRING EAR INFECTIONS
◯ LOSS OF HEARING ◯ JAW PAIN

GASTRONINTESTINAL
◯ ULCER ◯ CONSTIPATION ◯ GALL BLADDER ◯ ACID REFLUX
◯ HEART BURN ◯ LIVER PROBLEMS ◯ DIFFICULTY SWALLOWING
◯ HIATAL HERNIA ◯ ABDOMINAL PAIN ◯ DIARRHEA

MUSCULOSKELETAL
◯ ARTHRITIS ◯ NECK PAIN ◯ JOINT PAIN ◯ WRIST PAIN ◯ GOUT
◯BURSITIS ◯ RHEUMATOID ARTHRITIS ◯ BACK PAIN
◯ FIBROMYALGIA ◯ FOOT PAIN ◯ STIFFNESS ◯ TENDONITIS
◯ MUSCLE PAIN ◯ SHOULDER PAIN ◯ KNEE PAIN ◯ ARM PAIN
◯ WEAKNESS ◯ CARPAL TUNNEL

NEUROLOGICAL
◯ EPILEPSY ◯ CONFUSION ◯ LOSS OF BALANCE
◯ DIFFICULTY/CHANGE IN HANDWRITING
◯ DIZZINESS ◯ VERTIGO ◯ NUMBNESS ◯ SEIZURES
◯ HEADCACHE ◯ SLURRED SPEECH ◯ SYNCOPE ◯ TREMOR

ENDOCRINE
◯ EXCESSIVE THIRST ◯ ABNORMAL WEIGHT GAIN
◯ THYROID PROBLEMS ◯ FREQUENT URINATION
◯ ABNORMAL WEIGHT LOSS ◯ DIABETES

HEMATOLOGICAL/LYMPHATIC
◯ BLOOD DISORDER ◯ CANCER ◯ HIV AIDS ◯ TUMOR

FEMALE ONLY
◯ CURRENTLY PREGNANT ◯ ENDOMETRIOSIS ◯ PMS
◯ INFERTILITY ◯ MISCARRIAGE ◯ HORMONE REPLACEMENT
◯ IRREGULAR MENSTRUAL FLOW ◯ PROFUSE MENSTRUAL FLOW
◯ TUBAL LIGATION ◯ MENOPAUSE

MALE ONLY
◯ ERECTILE DYSFUNCTION ◯ INFERTILITY ◯ PROSTATE PROBLEMS
◯ VASECTOMY

ALLERGIES
◯ NONE ◯ MEDICATION ◯ SEASONAL ◯ FOOD ◯ ANIMALS

FAMILY HISTORY
◯ CANCER ◯ RHEUMATOID ARTHRITIS ◯ DIABETES
◯ HEART PROBLEMS ◯ LUNG PROBLEMS ◯ STROKE ◯ UNKNOWN
◯ EPILEPSY ◯ CHRONIC BACK PROBLEMS ◯ CHRONIC HEADACHES
◯ LUPUS ◯ HIGH BLOOD PRESSURE ◯ _____

MEDICATIONS ◯ NONE
1.
2.
3.
4.
5.

HOSPITALIZATIONS/FRACTURES ◯ NONE
1.
2.
3.
4.
5.

SURGERIES ◯ NONE
◯ TONSILS ADENOIDS ◯ APPENDIX ◯ GALL BLADDER ◯ HEART
◯ C-SECTION ◯ HYSTERECTOMY ◯ NECK ◯ LOW BACK

SOCIAL HABITS
◯ SMOKE 0 1/2 1 2 >2 PACKS/DAY
◯ DRINK ALCOHOL 0 1-3 4-7 >7 DRINKS/DAY
◯ CAFFEINE 0 1-3 4-6 >6 CUPS/DAY
◯ CHILDREN 0 1 2 3 4 5 6 OTHER
◯ DRUG DEPENDENCE

EDUCATION (HIGHEST LEVEL COMPLETED)
◯ NONE ◯ ELEMENTARY ◯ JR. HIGH
◯ HIGH SCHOOL ◯ COLLEGE

DIET (MARK FREQUENTLY CONSUMED FOODS)
◯ BREAD ◯ PASTA ◯ CEREAL ◯ FRUITS
◯ POP ◯ COFFEE ◯ WATER ◯ VEGETABLES

VITAMINS/SUPPLEMENTS ◯ NONE
◯ MULTI-VITAMIN ◯ CALCIUM/MAGNESIUM
◯ ESSENTIAL FATTY ACIDS ◯ COO 10
◯ PROTEOLYTIC ENZYMES ◯ OTHER _____

SLEEP (AVERAGE HOURS PER DAY) 4 5 6 7 8 9 10 11 12 13
(POSITION) ◯ SIDE ◯ BACK ◯ STOMACH

DATE: _____
HEIGHT: _____
WEIGHT: _____
ADDITIONAL INFORMATION - PATIENT

PATIENT SIGNATURE _____

ADDITIONAL INFORMATION - PHYSICIAN

PHYSICIAN SIGNATURE _____

Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthday _____

Reviewed By _____ Date _____

Allergic reactions can cause inflammation, which can lead to joint and **muscle aches**. Chronic body **aches** may be a sign of an immune system reaction, such as arthritis, but also can be a sign of **allergies**. Repeated coughing or sneezing as a result of your allergies can also cause **soreness.**

1. Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring? **[ ] Yes [ ] No**
2. Have you ever been diagnosed with asthma or bronchitis? **[ ] Yes [ ] No**
3. Do you experience symptoms of allergies? **[ ] Yes [ ] No**
4. Regarding possible food allergies, do you experience any of the following: (check all that apply)

- ☐ Bloating after eating
- ☐ Constipation
- ☐ Stomach Pain
- ☐ Nausea
- ☐ Tingling of the mouth or any other unusual sensation
- ☐ Diarrhea
- ☐ Upset Stomach
- ☐ Indigestion
- ☐ Vomiting

ALL STAR HEALTH
SPINE & JOINT CARE

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures, physical examinations, tests, physiotherapy, physical medicine, physical therapy, medical treatment, injections, use of prescription medications, interpretation of labs, etc. on me by the doctor of chiropractic, doctor of medicine, physician's assistant, nurse practitioner, and/or other assistants and/or licensed practitioner employed by All Star Health LLC.

I am aware that in the performance of any procedure that there may be risks, including but not limited to infection, worsening of pain, the ineffectiveness of the procedure, bleeding into the joint, headache, nerve damage, increase in blood pressure or blood glucose, lung puncture, skin reaction or color changes, fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations, blood loss as well as reaction to medications. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I understand the above and have had the opportunity to ask questions. I may inquire of my provider for additional information, and I may require additional treatment for possible complications.

I affirm that the nature, purpose, risks, complications, and consequences of the above interventional procedure have been explained to me by the provider(s). I have been given the opportunity to ask all of my questions. They have been answered to my satisfaction. I hereby give my consent.
I affirm that I am aware that the practice of chiropractic and medicine is not an exact science and I acknowledge that I have not been given a guarantee or assurance as to any outcome/results that may be obtained.

I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for the foregoing procedure(s).

In the event I should require emergency/hospital intervention, 911 will be called and I will be transferred to the nearest receiving hospital.

If a staff person is exposed to my blood or bodily fluid, I consent to my blood being drawn and tested for HIV and Hepatitis. The results will go to me, my medical record, to the exposed worker, to the Employee Health Services Dept. and/or Infection Control here, and to the State Officials.

In consideration of our agreement and as part of entering into this contract, which we both agree is a valid and sufficient consideration for entering this Agreement, that claims controversies, disputes, or tort action arising out of or relating in any manner to the treatment or delivery of services by us to you, shall be submitted to binding arbitration, which shall be conducted according to the American Arbitration Association Guidelines. We both understand that by agreeing to arbitration we are both waiving our right to a jury trial. This Agreement also binds all parties whose claims may arise out of or relate to treatment or delivery of services by us to you, including claims by your spouse or heirs or children. The only time we can go to court and use the judicial process is for debt collection and such claims that are not subject to binding arbitration. Examples of these kinds of claims would be injunctive relief, guardianship proceedings, and declaratory relief. If there is a doubt, the arbitrator will decide whether or not it is not covered by this Agreement.

I certify that I have read and fully understand all paragraphs. All my questions have been answered.

X_____ X _____

Patient Printed Name | Patient Signature | Date

X_____ X _____

Physician Signature | Witness Signature

ALL STAR HEALTH
SPINE & JOINT CARE

INFORMED CONSENT FOR TRIGGER POINT/JOINT INJECTIONS

Name: _____ DOB: _____

Trigger Point Injections (TPI) are used to treat painful and tender areas of muscle. Normal muscle contracts and relaxes when it is active. A Trigger Point is a discrete knot or taught band of muscle that forms when muscles fail to relax. The knot often can be felt under the skin and may twitch involuntarily when touched (jump sign). A small needle is inserted into the trigger point and a local anesthetic (e.g. Lidocaine, Bupivacaine, Marcaine) and/or anti-inflammatory/steroid is injected. Insertion of the needle inactivates the Trigger point and thus alleviates pain. Joint Injections are given to treat inflammatory conditions, such as rheumatoid arthritis, gout, and occasionally osteoarthritis. Corticosteroids are frequently used for this procedure as they are anti-inflammatory agents that slow down the accumulation of cells responsible for producing inflammation within the joint space. Commonly injected joints include the hip, knee, ankle, shoulder, elbow, and small joints of the hand and feet. Additional treatment may be needed to achieve sustained relief. The details of the procedure have been explained to me in terms I understand.

Alternative methods and their benefits and disadvantages have been explained to me.

Before undergoing one of these procedures, understanding the associated risks is essential. No procedure is risk-free. Along with the needed effects of the procedure, I understand and accept that there are risks for possible adverse reactions or complications that can occur with any procedure. I understand and accept that there are complications, including the risk for death or serious disability that exist with any surgical procedure. The following risks and complications are well recognized, but there also may be risks not included in this list:

- Infection
- Trauma to nerves or vascular structures
- Allergic reactions to the medications
- Soft tissue swelling, bruising, or hematoma formation
- De-pigmentation (a whitening of the skin)
- Rupture of a tendon located in the path of injection
- Numbness
- Needle breakage
- Vasovagal reaction (fainting)
- Joint damage
- Local fat atrophy (thinning of the skin) at the injection site
- Pain may be associated with the procedure and healing process

I understand and accept the anticipated outcomes of the procedure to include but are not limited to:

- Increased circulation to the muscles
- Increased pain threshold at the trigger point
- Pain reduction
- Decrease in Inflammation

Increased exercise tolerance

- Increased range of passive and active motion
- Multiple sessions may be necessary
- Temporary injection and post-injection site tenderness and/or pain

I have informed the physician/nurse practitioner (provider) of all my known allergies. I have informed the provider of all medications I am currently taking, including prescription drugs, over-the-counter remedies, herbal therapies and supplements, aspirin, NSAIDs, and any other recreational drug or alcohol use. I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure. I have been informed of what to expect in the post-injection period, including but not limited to: estimated recovery time, anticipated activity levels, and the possibility of additional procedures. The provider has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all the blanks were completed prior to my signature.

I authorize and direct Michael T. Kelley, PA-C/Tim Lane, PA-C, with associates or assistants of his choice to perform the procedure of trigger point injections. I further authorize the physician/nurse practitioner and assistant(s) to do any other procedure that in their judgment may be necessary or advisable should any unforeseen circumstances arise during the procedure.

Patient signature: _____ Date: _____

As the provider, I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative fully understands what I have explained.

Provider Signature: _____ Date: _____

Michael T. Kelley, PA-C Tim Lane, PA-C

Date of Request: _____

To: ALL DOCTORS, HOSPITALS, HEALTH CARE PROVIDERS, and BILLING ENTITIES

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Name of Physician/Facility: _____
Address: _____
Phone Number: _____ Fax Number: _____
Patient Name: _____ Date of Birth: _____

I authorize the following information to be disclosed:

_____
_____
_____
_____
_____

I authorize disclosure of the above listed information to the following individual or organization:

ALL STAR HEALTH

◯ **6625 S. Rural Road Suite 104 Tempe, AZ 85283 Phone: 480-833-4515 Fax: 480-833-5078**

◯ **2730 S Val Vista Drive Suite 188 Gilbert, AZ 85295 Phone: 480-324-0244 Fax: 480-324-0589**

I understand that I have a right to revoke this authorization in writing at any time. I understand that cancellation will not apply to information that has already been released under this authorization. Unless I cancel it sooner, this authorization will expire on the following date, event, or condition: 180 days from the date of signature. If I fail to specify an expiration date, event, or condition, this authorization will expire in 180 days from the date appearing at the bottom.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules which are in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an authorized disclosure and the information may not be protected by federal confidentiality rules. I understand that healthcare cannot be conditioned on this authorization.

Patient Signature: _____ Date: _____

ALL STAR HEALTH
SPINE & JOINT CARE

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

INSURANCE: I request that payment of authorized insurance benefits be made on my behalf to All Star Health for services furnished to me by All Star Health. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. All Star Health accepts the charge determination of the insurance carrier as the full charge; I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the insurance carrier.

RELEASE OF INFORMATION: All Star Health may disclose all or any part of my medical record and/or financial ledger to any person or corporation which is or may be liable or under contract to All Star Health for reimbursement for services rendered, and any health care provider for continued patient care.

OTHER INSURANCE: I understand that All Star Health maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that All Star Health has no contract, express or implied, with any plan that does not appear on the light. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by All Star Health if I belong to a plan that does not appear on the above-mentioned list.

NON-COVERED SERVICES: I understand that All Star Health contracts with health care services plans, (i.e., HOM'S, PPO'S). Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care services plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patients' contract with a health care service plan or in the benefit summary the health care service plan furnished to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with All Star Health to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by All Star Health, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to All Star Health for payment. If an account is sent to an attorney for collections, I agree to pay collection expenses and reasonable attorney fees as established by the court. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient are hereby assigned to All Star Health. If my insurance company or health plan designs co-payments and/or deductibles, I agree to pay them to All Star Health. However, it is understood that the undersigned and/or the patient is primarily responsible for the payment of the bill. I also agree that if I have to miss a scheduled appointment without giving at least 24 hours' notice, I can be charged a $50.00 cancellation fee.

PRIVACY PLAN: I agree that I have been given the opportunity to read and receive a copy of the All Star Health agreement. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____

Patient Name of Guardian Name (Print) Date

_____

Patient or Guardian Signature**

***If an authorization is signed by an individual's personal representative, authority is based on:
_____ (e.g., state law, court order, etc.)