Dr. John Kim
Axiom Wellness Center
7633 John F. Kennedy Blvd.
North Bergen, NJ 07047
(201) 944-4552

Date:___/___/___
Diagnosis:_____
_____

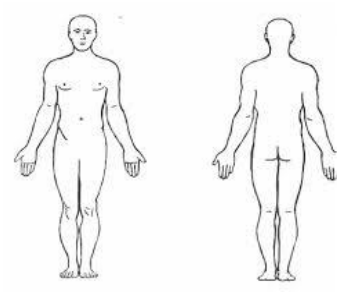
Patient's Name:_____
Date of Birth:___/___/___ ( ) Male ( ) Female
Street Address:_____
City:_____ State:___ Zip:____
Home Phone:_____
Work Phone_____
Cell: _____ Email:
_____
Occupation:_____
Employer or School Name:_____
Insurance Company:_____
Cash Patient ( ) Cash Patient ( ) Staff N/C ( )
Other:_____

Current Health Condition

Primary Complaint:
_____
_____
_____
_____

How did this condition develop (what caused it?)
_____
_____
_____
_____
_____

( ) Overexertion ( )Strenuous position ( )Auto Accident
( )Work Accident ( ) Fall ( )Trip
When was the first time (date) you were aware of it?_____
How would you describe the symptoms/pain?
( )Dull ache ( )Sharp ( )Stabbing ( )Throbbing
( )Other:_____
How long do the symptoms/pain last? ( )Intermittent
( )Occasional ( )Frequent ( )Constant
What aggravates the problem? ( )Coughing ( )Sneezing
( )Lifting ( )Bending ( )Driving
( )Riding ( )Prolonged Sitting ( )Walking ( )Standing
( )Sleeping ( )Other:_____
What relieves the problem: ( )Rest ( )Exercise ( )Sitting
( )Standing ( )Lying ( )Other:____
Have you ever had the same or a similar problem before?
( )Yes ( )No
( )Explain:_____
Have you ever had medical treatment for this condition before? ( )Yes ( )No
By whom/when?:
_____



X-Dull Pain A-Stabbing Pain O- Burning pain
Pain Scale: 0-Normal ,1-3 Normal, 4-6 Medium, 7-9 Intense

Past Health History

General Health L ( ) Excellent ( )Good ( )Fair ( )Poor (explain):_____
Surgery:_____
Major accidents or falls:_____
Broken Bones:_____
Alcohol:_____ Tobacco:_____ Allergies:_____
Drugs/medications (current):
_____
Hospitalization
Date(s):_____
_____

Reason:_____
_____

Exercise: Amount:_____ Type:_____
Difficulties:_____
Diet: ( )Excellent ( )Good ( )Fair ( )Poor(explain)_____

Family History:
_____
_____
_____
_____

Females: Pregnant? ( )Yes ( )No If Yes, how long?_____ Nursing child? ( )Yes ( )No
Additional History and Doctor's notes:
_____
_____
_____

Patient's Signature:_____Date:_____ ( )Adult ( )Parent/Guardian

Notice to all of our Patients

Outstanding Balance Policy

All outstanding balances must be paid in full before another appointment is made unless prior arrangements have been made with our office.

Cancellation Policy

There will be a $25.00 no show fee for any cancellations of appointments without a 24 hour noticeThis will be due at the next appointment.

Upon signing, you agree that you have read and understand our cancellation policy.

_____
Signature

_____
Date

Assignment of Benefits/ERISA Authorization Form
Axiom Wellness Center

Financial Responsibility

I have requested professional services from John Kim, D.C. on behalf of myself and/or my dependents and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

If any controversy or claim arising out of this agreement to pay for services and supplies rendered, the patient agrees that should a suit be instituted in the Superior Court of New Jersey to recover past due fees for services rendered that the patient shall compensate Axiom Wellness Center for any and all costs associated with such litigation, including but not limited to reasonable attorney's fees.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided is accurate as of the dates set forth below and that I am responsible for keeping it updated.

I hereby authorize the Provider , Axiom Wellness Center, to submit claims, on my and/or dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Axiom Wellness Center, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to the provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments,co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to : (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim,right, or cause of action in connection with said insurance policy and/or benefit plan,including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.503.1 (b) (4) with respect to any healthcare expense incurred as a result of the services I received from Provider Axiom Wellness Centerand to the extent permissible under the law, to claim on my behalf, such benefits,claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

Liability Disclaimer for Wellness Program

Axiom Wellness Center does not provide liability insurance for the protection of individuals, groups, organizations, businesses,spectators, or others who may participate in the Wellness Program.

In Consideration for your participation in said Wellness Program, the individual, group, organization,business,spectator,or other, does hereby release and forever discharge Axiom Wellness Center, and its officers, board, and employees, jointly and severally from any and all actions, causes of actions, claims, and demands for, upon or by reason of any damages, loss,or injury , which hereafter may be sustained by participating in the Wellness Program.

This release extends and applies to, and also covers and includes, all unknown, unforeseen, unanticipated, and unsuspected injuries,damages,loss, and liability and the consequences thereof, as well as those now disclosed and known to exist. The provisions of any state, federal, local, or territorial law or state providing substance that releases shall not extend to claims,demands,injuries,or damages , which are known or unsuspected to exist at this time, to the person executing such release, are hereby expressly waived.

I hereby agree on behalf of my heirs,executors,administrators,and assigns, to indemnify Axiom Wellness Center and its officers, board, and employees, joint and severally from any and all actions,causes of actions,claims, and demands for, upon or by reason of any damage,loss or injury , which hereafter may be sustained by participating in the Wellness Program.

It is further understood and agreed that said participation in the Wellness Program is not to be construed as an admission of any liability and acceptance of assumption of responsibility by Axiom Wellness Center, its officers,board, and employees , jointly and severally , for all damages and expenses for which Axiom Wellness Center, its officers,board, and employees, become liable as a result of any alleged act of the participant.

Name of Individual Participant (PRINT) :_____
Participant's Address:_____
Participant's Phone Number:_____
Participant's Signature_____
Date Signed:_____

All Participants must complete this Liability Disclaimer prior to starting Wellness Program.

Notice to Our Blue Cross and Blue Shield Patients

Blue Cross and Blue Shield do not make direct payments to out of network providers. Payments are sent to the patient to pay for their medical bills.

Axiom Wellness Center is an out of network provider. Therefore insurance payments for services rendered by Axiom Wellness Center and submitted to Blue Cross/Blue Shield will be sent to you. You are responsible to make timely payments to Axiom Wellness Center for rendered services.

Blue Cross / Blue Shield will notify us when they send you payment for services . When you receive your check, please endorse the check and send it to Axiom Wellness Center as soon as possible. All checks endorsed by you can be sent to Axiom Wellness Center in person at our clinic or by mail.

All outstanding balances must be made before another appointment is made.

In the event that there are any unpaid dates of services(s) and the debt goes to collection, you will incur collection and legal fees in addition to the unpaid balance due.

Patient Name (PRINTED)

_____

Patient Signature

_____ Dated _____/_____/20____