KIRSCHNER
Chiropractic & Wellness Centre

Arcadia Chiropractic Clinic
www.KirschnerWellness.com
12687 Southwest County Rd 769 * Suite 3A * Lake Suzy, Florida 34269 * 941-766-7110 *Fax 941-889-7683

Date___/___/_____ Patient Title ___Mr. ___Mrs. ___Ms. ___Dr.

First Name____________________________Middle________________Last_______________________________

Birth Date ___/___/_____ Social Security #__________________Preferred Name________________

Mailing Address____

City____________________________State______________Zip Code________________________________

Primary Phone__________________________ Alternate Phone_____________________________________

Is your primary phone your mobile phone?____If yes, please provide your carrier_________________

Primary Email ____Other Email________________________

How do you prefer us to contact you for appointment reminders? __Mobile # ___Alternate # ___Email

Preferred Language ___English ___Spanish ___Choose Not to Answer

Gender ___Male ___Female Marital Status ___Single ___Married ___Other

Race ___White ___Black/African American ___Hispanic ___Multi Racial ___Choose Not to Answer

Do you currently smoke or chew tobacco ___Yes ___No ___Former ___E Cigarette ___Other

Employment Status ___Employed ___FT Student ___PT Student ___Retired ___Self Employed

Business Name____Occupation_________________________

To whom can we thank for referring you to our office:____

You are here for:

_____Massage _____Chiropractic _____Nutritional/DETOX Program _____Laser Therapy

___Physical (If yes, please indicate) ___Sports ___School ___DOT ___Non-DOT

___Drug Screen ___Breath Alcohol ___Other _______________

Please tell us if you have had any major condition in the last 24 months___________________________

Are you still under a Doctor's care for this condition?________If yes, who__________________________

Please tell us who is responsible for payment of your visit today

___Self Pay ___General Insurance ___Work Comp ___Auto Liability ___Medicare ____Other

Name of Insurance Carrier______________________________________Please provide office with card.

_____________________________________ _________________ _________________

Patient Signature Date Staff

Please tell us why you are here today?____

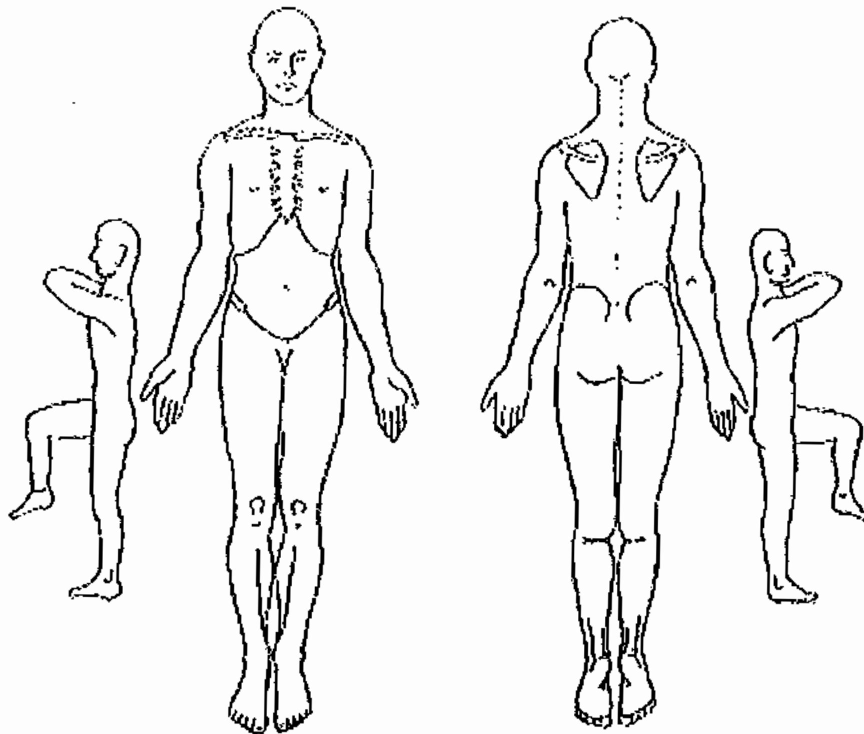
If you are experiencing pain today please describe it for us____________________________

What is the nature of your injury ___Auto Accident ___Work Injury ___Other____________________

When did your symptoms appear?____________________Any prior similar symptoms?________________

On a scale of 0 – 10 with 10 being severe pain, what level of pain are you at today?________________

Please circle the area(s) of pain:



Have you had previous Chiropractic care? ____If so, when and with whom?____________________

When was your last physical exam?___________With whom?______________________________

Are you pregnant?__________If so, when is your due date?____________OB/GYN________________

Do you have any difficulty lying on your front, back or side? If yes, please note________________

____ ____________________

Patient Signature Date

To Be Completed by Clinical Staff:

Height:________ Weight:________ BP:______/______ Eye Dominance Right/Left

Health Scan Results:____

____

____

Regarding your symptoms:	NO	YES	Details
Do you experience pain everyday?	____	____	______________________
Does your pain wake you up?	____	____	______________________
Does your pain affect your daily activity?	____	____	______________________
Does weather affect your symptoms?	____	____	______________________
Do you wear orthotics?	____	____	______________________

YOUR HEALTH HISTORY IS EXTREMELY IMPORTANT TO US! Please tell us if you have been treated for any condition in the last 2 years____

Who was the last Doctor you saw?______________________________When__________

Have you broken any bones?	YES/NO	When__________	Briefly Explain______________
Have you been hospitalized?	YES/NO	When__________	Briefly Explain______________
Have you had any surgeries?	YES/NO	When__________	Briefly Explain______________
Had a concussion?	YES/NO	When__________	Briefly Explain______________
Previous Auto Accidents?	YES/NO	When______________________________	

Please tell us if you currently take: ___Multi-Vitamins ___Fish Oils/Omegas ___Aspirin ___Calcium ___Weight Loss Products ___B Vitamins ___Vitamin D ___Greens or Protein Powders

Other(s)____

Our office regularly uses a variety of science based, high quality nutritional supplements. Do you have any concerns about ___Increasing Energy ___Joint Flexibility ___Allergies ___Digestion ___Stress ___Weight Control/Loss ___Cholesterol ___Pain Management or ___Genetic Predispositions to Disease

Please tell us if you currently take any medications________________________________

Who is the Doctor that manages these?______________________________________

Please circle if you have a family history of CANCER HEART DISEASE ARTHRITIS OTHER

____

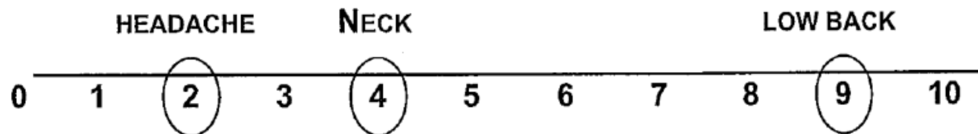
Of your habits:	NONE	LIGHT	HEAVY	FREQUENCY?
Alcohol				
Coffee/Tea				
Tobacco				
Drugs				
Sugar Foods				
Salty Foods				
Soft Drinks/Energy Drinks				

Name ______________________________ Number __________ Date ______________

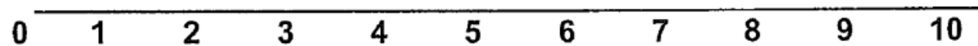
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

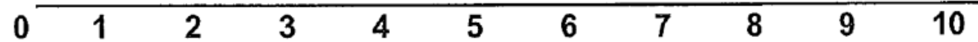
EXAMPLE:



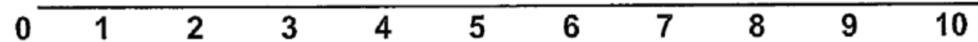
1. **What is your pain RIGHT NOW?**



2. **What is your TYPICAL or AVERAGE pain?**

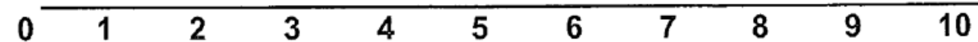


3. **What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?**



What percentage of your awake hours is your pain at its best? _______%

4. **What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?**



What percentage of your awake hours is your pain at its worst? _______%

Authorization to Release Health Information To Process Insurance Claims

Kirschner Chiropractic & Wellness Centre
Arcadia Chiropractic Clinic

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information.

I verify that I have no other insurance coverage than that listed above. I authorize the release of any medical or other information necessary to process any claims filed on my behalf. I also request payments of any insurance benefits including those from government programs to the party who accepts assignment on any claims filed. I authorize payment of medical benefits to the physician or supplier for services submitted on claims for services provided to me. Finally, I will notify the Practice promptly of any changes in my health insurance coverage.

*The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.*

X____
Patient Name (PRINT)

X____ ____________________
Signature of Patient or Legal Representative **Date**

PATIENT NAME______________________________

FINANCIAL POLICY

My Account is:

___Self Pay ____General Insurance ___Medicare ____Auto PIP ____Work Comp

If your account is not self pay, please complete the following as well as provide our front desk with your insurance card so that we may keep it on file.

Primary Insurance Company_____________________________Phone #______________________
Member or Policy #____________________________________Group#_______________________
Are you the policy holder?_____If not, who is?__________________________DOB___________

Other Insurance Company_____________________________Phone #______________________
Member or Policy #____________________________________Group #_______________________
Are you the policy holder?____If not, who is?__________________________DOB___________

I,____________________________(Print Name) acknowledge, understand and agree that any health/accident/workmen's compensation insurance policies are an agreement between myself and the insurance company. I understand that all services rendered are ultimately MY responsibility and that if my insurance does not cover any services I choose to have that any unpaid fees are my responsibility. I understand that should my account ever be turned over to collections for non-payment, there will be fees associated with such transfer. Fees will be determined by each collection agency, separately from our office. I also understand the office hold the right to charge my account for any appointment I fail to keep without proper notification.______________(Initial)

As a courtesy to you we bill your insurance weekly. Our goal is to get accurate healthcare benefits from your insurance company immediately upon establishing yourself as a patient in our clinics. Often, however, these benefits may not always be accurate. You are responsible for your portion of the services at the time of visit. If you cannot make your scheduled appointment it is your responsibility to call our office with 24 hours notice. Any unpaid balances will be billed to you monthly and balances may not exceed $150.00 at any time. Refunds on services, programs of care or prepaid packages will not be given.

____ ____________________

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

I understand the Health Insurance Portability and Accountability Act (HIPPA). I have certain rights to privacy regarding my protected health information. I acknowledge that I have the opportunity to review the privacy practices of this practice and that I may contact the practice at any time to obtain a copy of the Notice of Privacy Practices. I understand this information can and will be used to 1) conduct, plan and direct my treatment and follow-up among multiple healthcare providers who are involved in my treatment either directly or indirectly and 2) obtain payment from third party payers and insurers and finally 3) conduct normal healthcare operations such as quality assessments and physician certifications.

______________________________ ______________

Patient Name Printed Date

____

Patient Name Signed

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO PROCESS INSURANCE CLAIMS

IF WE ARE FILING INSURANCE CLAIMS ON YOUR BEHALF, PLEASE COMPLETE THE AUTHORIZATION BELOW.

Patient Name______________________________ DOB______________

As a patient you understand and agree to allow this office to use your patient health information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. Be assured this office will limit the release of all PHI to the minimum needed for what insurance company may require for reimbursement of payment. As a patient you authorize payment of medical benefits to the physician or supplier of services submitted on claims for services provided to me. Finally, I agree to notify the office immediately of any changes to my health insurance coverage and I may revoke this authorization at any time.

______________________________ Date______________

Patient Signature

Welcome to our practice! The Doctors and staff here welcome you and intend to provide you with the best care possible. We will conduct a thorough examination and history to better determine if we can assist you. If we do not believe that your condition will respond to chiropractic care we will refer you to the appropriate provider. If you are a candidate, a treatment plan will be recommended to suite you.

______________________________ Date______________

Patient Signature

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

PLEASE FAX ALL RECORDS TO 941.889.7683

Occasionally, we will ask for your medical records, lab results or imaging reports from other locations. This form should be filled out and kept on file for this purpose.

Florida Law requires information contained in your medical records to be held in strict confidence and not released without your written authorization. The authorizations you, the patient, sign on this page will remain in effect until you request in writing that they be withdrawn. You have the right to have a copy of this authorization upon your request.

PRINT PLEASE

PATIENT NAME_______________________________ DOB_______________

OTHER NAMES USED___________________________ SS#_______________

To authorize release, please check any/all that apply. Please cross off any that do not apply.

_____1) General Medical Record on File with Facility _____2) Lab Reports

_____3) Radiology Reports (X-ray, CT Scans, MRI's) _____4) Other_______________

I understand that authorizing the use or disclosure of the information is voluntary and I need not sign this form to ensure my medical treatment.

X_______________________________ Date_______________

Signature of Patient or Legal Representative

X_______________________________

Witness Signature

Request faxed to___________________________ Fax #_______________

USE SPACE BELOW ONLY IF PATIENT REVOKES CONSENT

PATIENT SIGNATURE__________________________ DATE_______________