Kent Station Chiropractic & Massage

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific chiropractic care.

Please note that all information is strictly confidential.
To help us provide you with a complete evaluation take the time to fill out this questionnaire carefully. If we believe that we cannot assist you with your health care needs, we will be more than happy to refer you to the appropriate health care professional. Thank you.

ABOUT THE PATIENT

Name ______________________________ Date: ___/___/_____

Address ______________________________ City ___________ State ________ Zip ________

Home Phone ______________________________ Cell Phone ______________________

Birth date ___________ Age __________ Gender ☐ M ☐ F ☐ Other Number of Children __________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer ______________________________ Type of Work ______________________________

Social security # ______________________________ E-Mail Address ______________________________

ABOUT THE SPOUSE/ PARENT OR EMERGENCY CONTACT

Name ______________________________ Employer ______________________________

Work/Cell Phone ______________________________ Type of Work ______________________________

ABOUT MY INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Insurance Company Name ______________________________

ID Number (Plan, Local, Policy #) ______________________________

Address ______________________________

Phone ______________________________

About the Insured Person

Name ______________________________

Insured Social Security # ______________________________

Relation ____________________ Date of Birth ___/___/___

You Do Not Need To Fill This Section Out, If You Have Given Our Office Staff Your Health Insurance Card And Identification.

EXPERIENCE & EXPECTATIONS WITH CHIROPRACTIC

What patient referred you to OR how did you hear about our office? ______________________

Have you ever been adjusted by a **Chiropractor** before? ☐ YES ☐ NO

Doctor's Name_ ____________________ Approx. date of your last visit ________________

Patients seek care in our wellness center for a variety of reasons. Some are looking for overall health and wellness, some are looking for correction of a condition and a few are looking for relief care. The doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired at this time.

☐ **RELIEF CARE** — **GET ME OUT OF PAIN**- Symptomatic relief of pain and discomfort only. May be anywhere from **5-10 Visits over 2-6 weeks**

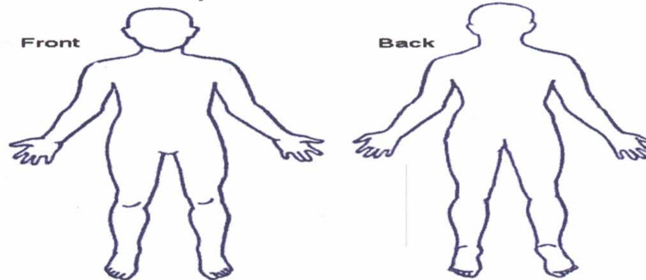
☐ **CORRECTIVE CARE** — **HELP ME STAY OUT OF PAIN**- Correcting and relieving the cause of the problem as well as the symptoms. Bring whatever is malfunctioning in my body to the highest state of health possible with chiropractic care. May be anywhere from **10-60 Visits over 20-50 weeks**

☐ **WELLNESS CARE** — Frequency is anywhere from **1-2x/month** to maintain a healthy spine and nervous system

☐ **I Want The Doctor To Select The Type Of Care That Is Appropriate For Me.**

HEALTH COMPLAINTS

Please Circle Or Label Any Other Areas Of Discomfort Or Concern



Main reason for contacting our office: ______________________________

Please rate your complaint on a scale 0-10 _____/10 (0 being no symptoms)

Is this complaint: mild moderate severe **Is this complaint:** constant intermittent

Do your symptoms: ↑ with activity OR ↓ with activity

Date of Injury: ________ **If no injury, when did this problem begin?** ____________________

To what extent does the condition(s) interfere with your daily activity (work, exercise, sleep, intimacy, etc)?

____

What kind of treatments have you tried for your problems? ______________________________

2nd reason for contacting our office: ______________________________

Please rate your complaint on a scale 0-10 _____/10 (0 being no symptoms)

Is this complaint: mild moderate severe **Is this complaint:** constant intermittent

Do your symptoms: ↑ with activity OR ↓ with activity

PLEASE RATE YOUR :	LOW/POOR				(PLEASE CIRCLE A NUMBER)					HIGH/GREAT
Exercise Level	1	2	3	4	5	6	7	8	9	10
Nutrition	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10
Stress Level	1	2	3	4	5	6	7	8	9	10
Overall Health	1	2	3	4	5	6	7	8	9	10

(Please Circle One Below)

I Feel **Older** than my actual age | **I Feel my age** | I feel **Younger** than my actual age

HEALTH GOALS

If you *did not* have any of the previously listed health conditions, how would your life be better?

____

What are your health goals: (please circle)

Get fit | Eat better | Reduce stress | Stop smoking | Reduce pain

Increase my mobility | Improve my posture | Improve my sleep | Lose Weight

HEALTH HABITS

Do you smoke? ☐ Yes ☐ No | **Do you drink alcohol?** ☐ Yes ☐ No

Do you drink coffee? ☐ Yes ☐ No | **Do you exercise regularly?** ☐ Yes ☐ No

PRIOR HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Severe or Frequent Headaches ☐ Arthritis ☐ Tuberculosis ☐ Sinus Problems
☐ Diabetes ☐ Shingles ☐ Dizziness ☐ Cancer
☐ Hepatitis ☐ Frequent Neck Pain ☐ Chemotherapy ☐ HIV/AIDs
☐ Loss of Sleep ☐ Heart Murmur ☐ Anemia ☐ Rheumatic Fever
☐ Asthma ☐ STDs ☐ Lower Back Problems ☐ Thyroid Problems
☐ Digestive Problems ☐ Kidney Problems ☐ Alcohol/Drug Abuse
☐ Ulcers/Colitis ☐ Difficulty Breathing ☐ Congenital Heart Defect
☐ Heart Surgery/ Pacemaker ☐ Heart Attack/Stroke ☐ High/Low Blood Pressure

CURRENT MEDICATIONS

☐ Nerve Pills (Neurontin, Naproxen, etc...) ☐ Pain Killers (Vicodin, Oxycontin, etc...)
☐ OTC Meds (Ibuprofen, Aspirin, Tylenol, Advil) ☐ Muscle Relaxer ☐ Stimulants
☐ Blood Pressure Medicine ☐ Insulin ☐ ____________
☐ Blood Thinners ☐ Tranquilizers ☐ ____________

FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No | Are you nursing? ☐ Yes ☐ No
Are you taking birth control? ☐ Yes ☐ No | Do you experience painful periods? ☐ Yes ☐ No
Do you have irregular cycles? ☐ Yes ☐ No | Do you have breast implants? ☐ Yes ☐ No

AUTHORIZATION FOR CARE AND POLICIES

I hereby authorize the practitioners of Kent Station Chiropractic and Massage to work with my condition through the use of adjustments, massage, or other physical therapy modalities to my affected areas, as he or she deems appropriate. I intend this consent form to cover the entire course of treatment for my presenting condition and for any future conditions for which I seek treatment.

Chiropractic: including but not limited to, spinal and extremity adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function, nutritional advice, home and wellness care, muscle and myofascial release.

Massage: including but not limited to, manual therapy to assist with relaxation, stress reduction, pain management, body awareness and integration of mind, body and spirit.

~Please understand that massage is booked hourly and your massage will end five to ten minutes prior to the next scheduled appointment. (This means that a one-hour massage is approximately 55 minutes and a half hour massage is approximately 25 minutes.) If you are running late, kindly take a moment to call and we will do our best to accommodate you. If you are more than 15 minutes late, your session will either be shortened or rescheduled.

~Please be advised that when a chiropractor of Kent Station Chiropractic and Massage refers you for massage you have the freedom to choose any licensed massage therapist to perform your treatment. The purpose of our office to have massage therapy is to expand our patients' choice of quality Therapists, not to direct you to any particular therapist unless required by your insurance carrier.

Cancellation Policy: Please be on time for your appointment as our hours are limited and we are often booked in advance. There is no-show charge for cancellations and reschedules received less than **24 hours in advance**. If the appointment is for a Monday, we must be notified by 6:00pm on the Friday prior to your Monday appointment. If you must rebook or reschedule with less than 24 hours notice we reserve the right to charge **$35.00** for the scheduled appointment and the appointment must be rebooked.
If you call and cancel your appointment without 24 hours notice or do not show for your appointment or do not reschedule your appointment, there will be a **charge of $75** for the missed or cancelled appointment or a fee equivalent to the scheduled appointment. We will also be doing a courtesy reminder call prior to your massage appointment.

We reserve the right to refuse or discontinue service at any time, for any reason, in an effort to ensure the safety of our clients and ourselves. If possible we will provide a referral to another provider.

I hereby release Kent Station Chiropractic and Massage from any and all liability, which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation. I have reported to the best of my knowledge all health conditions that I am aware of and will inform my practitioner of any changes to my health. The practitioner will not be held responsible for any health conditions or diagnosis' which are pre-existing, given by another health care practitioner, or are not related to the conditions diagnosed and/or treated at this clinic.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider for services rendered. I hereby authorize my practitioner(s) of Kent Station Chiropractic and Massage permission to consult the patients' primary health care providers regarding my health and treatment.

Patient's Signature ____ Date ____/____/____

Guardian or Spouse's
Signature Authorizing Care ____ Date ____/____/____

The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet and in the cause and prevention of disease.

~Thomas Edison

KENT STATION CHIROPRACTIC & MASSAGE
PROFESSIONAL FEE SCHEDULE
(Effective January 1, 2020)

Chiropractic Consultation...complimentary
Chiropractic Examination...$60-$190
Chiropractic Office Visits (averages)...................................$60-$200
Chiropractic Radiographic Studies (averages)...........................$30-$240
Massage..$75-$152
(All fees are standard and based on our professional association's guidelines)

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your needs. Please read carefully and choose the plan which you prefer. This information will enable us to better serve you and avoid misunderstandings in the future. If special arrangements are necessary, please consult with the Doctor. Our main concern is your health and wellbeing, and we will do our best to help you.

(Check One)

____PLAN #1 Time of Service Agreement: Fees are discounted to $60 per visit after the initial visit and are due at the time of service. We can work with you visit by visit; however, it may be more economical to consider our Wellness Program. If you decide to participate in our Wellness Program, the doctor will design a personalized regimen for you, which consist of weekly visits (2-3 per week), metabolic nutritional recommendations, and re-evaluations.

____PLAN #2 Monthly Cash Agreement: For those wishing to participate in corrective care, we have several plans which cover a set amount of visits for a monthly fee. Payment for the month will be due on the 1st or 15th of each month. Details of each plan are disclosed on a separate sheet. We can determine together which plan is appropriate for your treatment recommendations after an exam has been performed.

____PLAN #3 Health Insurance: If you have health insurance that covers Chiropractic care, we will bill your insurance directly and expect to be reimbursed by your insurance company. Please be aware that payment from your insurance company cannot be guaranteed, and benefits are not determined until your claim is processed. Until we have the completed, necessary insurance information to verify chiropractic coverage, you will be required to pay for your care. Our staff will collect any applicable deductible, co-payments, and any charge for non-covered services from you at the time of service. In the event the check should come to you, you are expected to bring the check to us. Most ordinary "health" policies are designed and intended to only take care of acute problems. Extended care in our office is available at affordable rates despite whether your insurance covers it or not.

____PLAN #4 Industrial Injury: You need to report your accident to your employer, bring in the necessary insurance information (is your company self-insured?), and sign industrial accident forms for billing by your second visit. We will bill your insurance directly.

____PLAN #5 Automobile Injury: You need to supply us with the accident report, your car insurance, the liable party's automobile insurance, and the name of your attorney if applicable. Until necessary insurance information is gathered and verified for Chiropractic Care, you will be required to pay for your care. We will bill your insurance directly. In the event the final payment check should come to you, you are required to bring the check to us.

___PLAN #6 Medicare: Medicare requires that an examination be performed and x-rays be taken which demonstrate the need for chiropractic care, but they do not cover this expense. There is a $141 deductible to meet, required by Medicare. They do cover 80% of the charges for adjustments, after an annual deductible is met. If you have secondary insurance coverage, they usually cover 20% that Medicare does not. Some insurance companies cover your Medicare deductible, and some do not cover anything. We will need your Medicare and secondary identification cards to verify your exact coverage with both plans. We will bill both insurance companies for you.

I UNDERSTAND AND QUALIFY FOR PLAN #____________________________

I understand that regardless of Insurance plan, I am ultimately responsible for my account.

If we do not have the necessary information to bill your insurance for your first visit, $75.00 of the total charges will be due at the time of service.

____ ___________________

Signature Date

At this time, please provide the front desk with any insurance information (claim numbers, accident reports, identification cards, etc.) so we are able to verify your coverage and finalize financial agreements. Thank you!

Kent Station Chiropractic & Massage

HIPAA Privacy Authorization Form Acknowledgement of Receipt of Notice of Privacy Practices

Federal law requires that we seek your acknowledgement of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of

__ / __ / __ and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature: ______________________________________ Date: ____________

Printed Name: ____________________________________

Signature of Parent/ Guardian (Specify Which): ________________________ Date: _______

<u>For Office Use Only</u>

Signed Acknowledgement of Receipt Received on: ____________ Initials: _____

Patient Refused or Failed to Acknowledge Receipt on: __________ Initials: ______

Massage Appointment and Cancellation Policy

(Effective January 1st, 2021)

We value your business and ask that you respect our business scheduling policies as stated:

____I understand that if an appointment is missed, cancelled or rescheduled without 24 hour notice, **there will be a $35 rescheduling fee or a full charge fee of $85 if the appointment is cancelled and not rescheduled.**

____I understand that if I am unable to keep a scheduled appointment, I will give 24 hour advance notice to ensure that I will not be charged for the appointment.

____I understand that due to high volume, KSCM will do their best to schedule appointments as time slots are available and at K.S.C.M's discretion.

____I understand that children are not permitted in the massage room and childcare must be provided for them during the massage. *K.S.C.M. does not provide childcare services.

Signature ______________________

Printed name ___________________ Date_______________