Kindle Chiropractic Care

Patient Intake Form

1306 E. Broward Blvd. · Ft. Lauderdale, FL 33301 · (954) 495-4449

Date

Patient Information

First Name	Middle Name	Last Name

Sex	Birthday (MM/DD/YYYY)	Height	Weight
☐ Male ☐ Female			

Marital Status	Spouse Name	# of Children
☐ Married ☐ Single		

Home Phone	Cell Phone	Work Phone

Street Address

City	State	Zip Code

Emergency Contact	Relationship	Emergency Phone

Email Address

Referral Information

Referring Physician	Referred Patient	Referred By

Employer Information

Employment Status	Employer Name
☐ Full-Time ☐ Part-Time ☐ Homemaker ☐ Unemployed	

Occupation	Employer State

Insurance Information

Name of Insurance	Responsible for Payment

Patient Signature	Date (MM/DD/YYYY)

The information provided is confidential and protected under HIPAA regulations.

Kindle Chiropractic Care

Policies & Consent

1306 E. Broward Blvd. · Ft. Lauderdale, FL 33301 · (954) 495-4449

✍ Consent for Treatment

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician, and it is the responsibility of the staff to carry out the instructions of such physicians.

Release of Information: By signing this form, you are granting consent to Kindle Chiropractic Care to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our primary office at 954-495-4449. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Print Patient's Name

_____ _____

Patient's Signature Date (MM/DD/YYYY)

_____ _____

Other than patient — name & relationship

_____ _____

Witness Signature Date (MM/DD/YYYY)

_____ _____

Notice to Patients: Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons apart from any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary.

I declare that all information presented at date of service is complete and accurate. If insurance is inaccurate or incomplete, the patient will be responsible for all charges incurred.

Authorization & Assignment of Benefits

I authorize Kindle Chiropractic Care or Dr. Lori Kindle P.A. to release any information to my insurance company. I authorize direct payment of medical benefits to Kindle Chiropractic Care or Dr. Lori Kindle P.A. I understand that I am financially responsible to the Doctor for all charges, for any balance or fee not covered if I have no insurance, or my insurance is rejected. I further understand that I will be responsible for all costs incurred in the attempt to collect this debt.

Financial & Administrative Policies

Patient Financial Responsibility: If you have health insurance that we will be filing for payment, the patient is expected to present a current insurance card and valid picture ID at each visit. All co-payments and any previous outstanding balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. For your convenience, we accept cash, check, or credit/debit cards. No post-dated checks will be accepted.

Insurance Claims: You have a contract between you and your insurance company. It is your responsibility to understand your insurance plan benefits. We will bill your primary insurance company if we are contracted providers. To properly bill your insurance company, we require that you disclose ALL insurance information including primary and secondary insurance, as well as any change of insurance information prior to receiving services.

Failure to provide complete and accurate insurance information may result in the entire bill being your responsibility. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Once the claim is processed, if there is any additional liability you will be billed accordingly.

Services unexpectedly denied by your insurance plan due to retroactive terminations, Coordination of Benefits denials, payment offset, failure to respond to your insurance plan with requested information, or failure to provide our office with any new health insurance changes are all reasons patients may be responsible for payment of services. It is the patient's responsibility to resolve any issues that arise with their eligibility and benefits.

If we are not contracted with your insurance plan/network, and we are filing on your behalf, you agree to pay any portion of the charges not covered by insurance. If your insurance pays you directly, you are responsible for payment of charges in full and agree to issue payment to us immediately.

Self-Pay Accounts: Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file. If there is a discrepancy regarding your coverage or eligibility, the patient will be considered self-pay unless otherwise proven.

Missed Appointments: Kindle Chiropractic Care requires 24-hour notice of appointment cancellation. Appointments missed and not previously canceled may be charged a fee of $70.00 for office visits.

Credit Card Disputes: The charge for a returned check is $35.00, payable by cash or money order, applied in addition to the insufficient funds amount. You may be placed on a cash-only basis following any returned check. Unsubstantiated credit card disputes will incur a $35.00 administrative fee.

Definitions: For purposes of this Agreement, "we," "our," and "the practice" shall mean Kindle Chiropractic Care or Dr. Lori Kindle. The terms "I," "my," "you," and "your" refer to the patient or responsible party executing this Agreement.

I have read and understand Kindle Chiropractic Care's financial and administrative policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by Kindle Chiropractic Care from time to time.

Patient Name

Responsible Party Name

Responsible Party Signature

Date (MM/DD/YYYY)

By my signature below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices, that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my permanent file and maintained for five years.

Patient Signature

Date (MM/DD/YYYY)

Parent / Guardian Signature (if under 18)

Date (MM/DD/YYYY)

The information provided is confidential and protected under HIPAA regulations.