KINDLE CHIROPRACTIC CARE

101NE THIRD AVENUE, SUITE 1500, FT. LAUDERDALE, FL 33301

Phone Number: 954-495-4449

Patient Information

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: ◯ M ◯ F Height: _____ Weight: _____

Marital Status: ◯ Yes ◯ No Spouse Name: _____ # of Children: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

Email: _____

Referral Information

Referring Physician: _____ Referred Patient: _____ Referred by: _____

Advertisement: ◯ Yes ◯ No Advertisement: _____

Referred Directory: ◯ Yes ◯ No Referred Directory: _____

Employer Information

Employed: ◯ Full Time ◯ Part Time ◯ Homemaker ◯ Unemployed Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Insurance Information

Payment: ◯ Personal ◯ 3rd Party ◯ Self Resp. for Payment: _____ Responsible Phone : _____

Payment Name: _____ Primary Phone #: _____ Primary ID/Policy: _____

Payment Address: _____

Payment City: _____ Payment State: _____ Payment Zip: _____

Primary Group #: _____ Primary Name: _____ Primary DOB: _____

Secondary Name: _____ Secondary Phone #: _____ Secondary ID/Policy: _____

Secondary Address: _____

Secondary City: _____ Secondary State: _____ Secondary Zip: _____

Secondary Group #: _____ Secondary Name: _____ Secondary DOB: _____

Claim #: _____ Claim Contact: _____ Claim Phone #: _____

Attorney Name: _____ Attorney Phone #: _____

Complaint Information

Injury Occurred: ◯ Automobile ◯ Work ◯ Third-Party ◯ Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Frequency: ◯ Always ◯ Hourly ◯ Daily ◯ Occasionally

Interfere w/ Activities: ◯ Yes ◯ No Affected Sleep: ◯ Yes ◯ No

Missed Work: ◯ Yes ◯ No Unable to Work from: _____ Unable to Work til: _____

Affected Appetite: ◯ Yes ◯ No Explain: _____

Reduced Work: ◯ Yes ◯ No Explain: _____

Does it Worsen: ◯ Yes ◯ No Explain: _____

Weather Affects it: ◯ Yes ◯ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯ Yes ◯ No Explain: _____

X-rays Taken: ◯ Yes ◯ No Explain: _____

Same Condition Before: ◯ Yes ◯ No Date: _____ Practitioner: _____

History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ◯ Yes ◯ No Date: _____ Explain: _____

Chance Pregnant: ◯ Yes ◯ No Planning: ◯ Yes ◯ No

Medications: _____

Supplements: _____

Broken Bones: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain: _____

Sprains/Strains: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain: _____

Hospitalized: ◯ Yes ◯ No Explain: _____

Surgery: ◯ Yes ◯ No Explain: _____

Auto Accident: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain: _____

Struck Unconscious: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain: _____

Eating Disorder: ◯ Yes ◯ No Explain: _____

Stroke: ◯ Yes ◯ No Explain: _____

Family Health Hist: _____

Patient Social

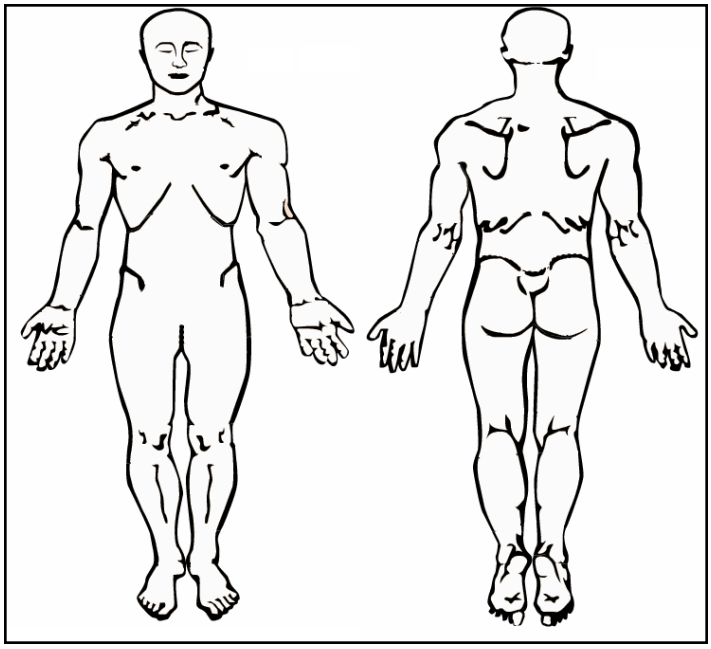
Alcohol:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Caffeine:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Drugs:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Exercise:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Homemade Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Processed Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Tobacco:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never					

Health Checklist

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ High Blood Pressure	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Nosebleeds
☐ Pacemaker	☐ Polio	☐ Poor Posture
☐ Prostate Trouble	☐ Sciatica	☐ Shortness of Breath
☐ High Blood Pressure	☐ Sinus Infection	☐ Insomnia
☐ Spinal Curvatures	☐ Stroke	☐ Swelling of Ankles
☐ Swollen Joints	☐ Thyroid Condition	☐ Tuberculosis
☐ Ulcers	☐ Varicose Veins	☐ Venereal Disease

☐ Other: _____

Patient Symptoms:



Patient Signature: _____ Date: _____

Consent

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 physician.

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

_____

Other than patient, print name and relationship

_____

Witness

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 AND ADMINISTRATIVE POLICIES AGREEMENT and RELEASE FORM

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 cards/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 (other health insurance that may be primary) denials, payment offset due to retroactive termination, failure to respond to your insurance plans 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 received in our office. All these circumstances are beyond our control. 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 including, but not limited to, those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment of the charges in full and agree to issue the payment to us immediately. We highly recommend you also contact your insurance carrier and check your available benefits before care is received.

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 with us. It is always the patient's responsibility to know if our office is participating with their plan. If you have health insurance and there is a discrepancy regarding your coverage or eligibility, the patient will be considered self-pay unless otherwise proven.

Missed Appointments

Kindle Chiropractic Care or Dr. Lori Kindle P.A. requires 24-hour notice of appointment cancellation. Appointments missed and not previously canceled may be charged a fee of $70.00 for office visits and $80 for massages.

Returned Checks/Credit Card Disputes

The charge for a returned check is $35 payable by cash or money order. This will be applied to your account 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 administrative fee.

Definitions

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

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 member’s name _____

Responsible party member’s signature _____

Date _____

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: _____

Parent/Guardian Signature (if under 18):_____ Date: _____

You do not have to print the next pages for the Notice of Privacy. This is only if you would like to keep a copy.