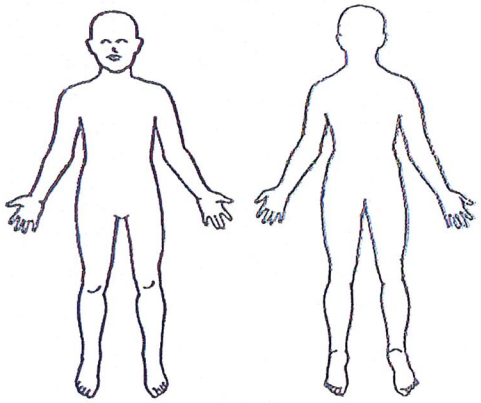
KIRSCHNER
Chiropractic & Wellness Centre

Kirschner Chiropractic & Wellness Centre / Arcadia Chiropractic Clinic **NEW PATIENT INTAKE**

Today's Date:____/____/____ Patient Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.
First Name_____ Nick Name_____
Last Name _____ Middle Name _____SSN_____
Address 1 _____
City_____ State_____ Zip Code _____
Primary Phone _____Secondary Phone _____Mobile Phone_____
Home email _____ Work Email _____
Contact Method: ❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth: ____/____/____Age:_____Gender: ❑ Male ❑ Female ❑ Unspecified **Marital Status:** ❑ Single ❑ Married ❑ Other
Do you have Children? ❑Yes ❑No **Employment Status** *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed **Business Name:**_____ **Title/ Occupation:**_____
Whom can we thank for referring you to our office?:_____

PLEASE CIRCLE YOUR AREAS OF PAIN



Nature of Your Injury:

❑Auto-Accident ❑Work Injury ❑Other
Date Symptoms Appeared:_____
Had Symptoms Prior? ❑Yes ❑NO **When:**_____
Previous Chiropractic Care? ❑Yes ❑No
With Whom:_____ **When:**_____
Are you Pregnant? ❑**Yes** ❑**No**
On A Scale of 1 (low) to 10 (Severe) please rate your PAIN LEVEL today:_____

Race: ❑ White ❑ Black/African American ❑ Hispanic ❑Other ❑ I choose not to specify
Multi-Racial: ❑Yes ❑No ❑ Unknown
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify
Preferred Language: ❑ English ❑ Spanish ❑ I choose not to specify
Do you currently smoke/ chew tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

Briefly list your main health problems: _____

Have you had an X-ray or CT scan or MRI in the past 28 days? ❑ Yes ❑ No **If YESWhere:**_____
Last Physical Examination:_____ **With Whom:**_____

Please tell us if you have been treated for any condition in the last two years:

_____
_____

Who was the last doctor you saw? _____ **when** _____

Patient Signature:_____ **Date:**_____

TO BE PERFORMED BY CLINICAL STAFF:

Height: _____inches **Weight:** _____ pounds **BP:** _____/_____ **Eye Dominance:** Right Left

Health Scan Results:

_____
_____

YOUR HEALTH HISTORY IS IMPORTANT TO US!

Patient Name:_____

Current medications, including frequency and dosage if known:

_____

_____

_____

If there are no current medications, check here: ❑

List any known allergies you have had to any medications:

_____

_____

If no allergies are known, check here: ❑

Do you currently take:

☐Multi-vitamins
☐Fish Oils/ Omegas
☐Aspirin
☐Calcium
☐Weight loss Products
☐B Vitamins
☐D Vitamins
☐Greens or Protein Powders
☐Other _____

Our office uses a variety of science based, high quality nutritional supplements. Do you have any concerns about:

☐Increasing Energy
☐Joint Flexibility
☐Allergies
☐Digestions
☐Stress
☐Weight loss/ Control
☐Cholesterol
☐Pain Management
☐Genetic Predispositions due to disease

Regarding your symptoms:

Symptoms	NO	YES	Details
Do you experience pain every day?			
Does your pain wake you up?			
Does your pain affect your daily activity?			

Condition	NO	YES	When	Details
Have you any broken bones?				
Have you been hospitalized?				
Have you had any surgeries?				
Have you had a concussion?				
Previous Auto Accidents?				

Of Your Habits:	NONE	LIGHT	HEAVY	FREQUENCY
Alchol Consumption				
Coffee/ Tea				
Drugs				
Soft Drinks/ Energy Drinks				
Other				

Is there a family history of:

☐ CANCER ☐ HEART DISEASE ☐ Arthritis ☐ OTHER:_____

Is there anything else you would like to bring to the Doctor's attention that has not been previously discussed? If so, please note:

_____

_____

Patient Signature: _____ Date: _____

Financial Patient Name:_____

My account is a:

□CASH □INSURANCE □MEDICARE □WORKMEN'S COMP □AUTO INSURANCE

If there are any other parties responsible for your bills at our facilities please fill in the information below:

Primary Insurance Company: _____ Telephone Number: _____
Plan Name: _____ Policy Number: _____ Group Number: _____
Are you the policy holder? □YES □ NO If not, who is: _____
Policy Holder DOB: _____ SSN: _____ Relationship: _____

Secondary Insurance Company: _____ Telephone Number: _____
Plan Name: _____ Policy Number: _____ Group Number: _____
Are you the policy holder? □YES □ NO If not, who is: _____
Policy Holder DOB: _____ SSN: _____ Relationship: _____

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 MY responsibility and that if my insurance does not cover services, any unpaid fees are MY responsibility. I also understand that the office holds the right to charge my account for any appointment that I fail to show for (No Show Fee) or fail to cancel 24 hours in advance.

Patient Signature: _____ Date: _____

PLEASE MAKE SURE TO PROVIDE A CURRENT COPY OF YOUR INSURANCE CARD AND ID TO THE FRONT DESK

Welcome! The Doctors and Staff welcome you and intend to provide you with the best care possible. We will conduct a thorough examination and history to decide 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 for chiropractic care, a treatment plan will be recommended to fit your specific needs.

Patient Signature: _____ Date: _____

1. I _____ (patient name) give permission for **Kirschner Chiropractic & Wellness Centre/ Arcadia Chiropractic Clinic** to give me medical treatment.
2. I allow **Kirschner Chiropractic & Wellness Centre/ Arcadia Chiropractic Clinic** to file for insurance benefits to pay for the care I receive.
   I understand that:
   - **Kirschner Chiropractic & Wellness Centre/ Arcadia Chiropractic Clinic** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my provider.

Patient Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgment

Kirschner Wellness Chiropractic & Wellness Centre
Arcadia Chiropractic Clinic

I understand that the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly or indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been notified that a copy of *Notice of Privacy Practices* is located in the waiting room and that I may review it and have any/all questions that I may have answered. I understand that your Notice of Privacy Practices contains a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

X_____ _____

Patient Name or Legal Guardian (PRINT) **Date**

X_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____

Attempt:_____

Staff Name:_____

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**

Kirschner Wellness Centre & Arcadia Chiropractic Clinic
www.kirschnerwellness.com
What type of patient were you? _____
When were you a patient at our office? From_____ to _____
Phone Number:__(___)_____

Patient Name:_____
Other Names Used:_____
S.S.N.:_____
D.O.B.:_____
Current Address:_____

CONSENT FOR RELEASE OF INFORMATION

Florida law requires information contained in medical records be held in strict confidence and not released without you, the patient's, written authorization. The authorization(s) you, the patient, sign on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. However, revocation will not apply to the information which has already been released. You have the right to receive a copy of any part of this authorization upon your request. For you, the patient's, protection we will ask to see a form of identification.

The below initial records are to be released **FROM**:

_____
_____
_____

The below initial records are to be released **TO**:

_____
_____
_____

AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL INFORMATION

To release, initial by (a.,b.,c.,d.,e.) any or all that apply. There cannot be any blanks. Initial all and CROSS OUT any part(s) that do(es) not apply.

__**a.** The general medical record created by the facility.

__**b.** The following information from the medical record:_____

__**c.** Labs Reports

__**d.** Radioloy Reports

__**e.** Other:_____

For the purpose of:_____

I understand authorizing the use or disclosure of the information above in voluntary. I need not sign this form to ensure medical treatment.

X_____ _____ _____
Signature of Patient or Legal Representative **Relationship to Patient** **Date**

X_____ _____
Witness Signature **Date**

USE THIS SPACE ONLY IF PATIENT REVOKES CONSENT

_____ X_____ _____
Date Consent Revoked Patient or Legal Representative's Signature Relationship to Patient

X_____ _____
Witness Signature Date