

Discover Chiropractic and Wellness, P.A.

PATIENT INFORMATION

Date: _____ Email: _____

Name: _____ SS#: _____

Address: _____
City State Zip

Home Phone: _____ Work: _____ Cell: _____

Sex: M F Age _____ Date of Birth: _____ Marital Status: S M W D # of Children: _____

Occupation: _____ Employer: _____

Student at: _____ Part Time: Y N Full Time: Y N

Spouse's Name: _____ Occupation: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Referred by: _____

HEALTH INFORMATION

Have you ever experienced significant problems past or present from the following?

1. Dizziness	Y N	7. Arthritis	Y N	13. Digestive	Y N	19. Cancer	Y N
2. Backaches	Y N	8. Headaches	Y N	14. Nervousness	Y N	20. Fractures	Y N
3. Heart Trouble	Y N	9. Numbness	Y N	15. Ear Nose Throat	Y N	21. Work Injuries	Y N
4. Diabetes	Y N	10. Respiratory	Y N	16. Anemia	Y N	22. Slip & Falls	Y N
5. Hernia	Y N	11. Neuritis	Y N	17. Skin Disorder	Y N	23. Other Accidents	Y N
6. Eyes	Y N	12. Allergies	Y N	18. Mental Disorder	Y N		

Purpose of this appointment: _____

Other Doctor seen for this condition: _____

Have you been treated for any health condition by a physician in the last year? Y N If yes, describe:

Date of last physical exam: _____ Name of physician: _____

What operations have you had? _____ When: _____

Any serious illness? _____ When: _____

What medications/ nutritional supplements are you taking: _____

CURRENT COMPLAINTS

1. What is your major symptom? _____
 2. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Y N Same Better Gradually Worse
If yes, when & how? _____
 3. How frequent is the condition? Constant Daily Intermittent Night Only
How long does it last? All Day Few Hours Minutes
 4. Are there any other conditions or symptoms you have that may be related to your major symptom? Y N
If yes, describe _____
Are there other unrelated health problems? Y N If yes, describe _____
 5. Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other _____
 6. Is there anything you can do to relieve the problem? Y N If yes, describe _____
If no, what have you tried to do that has not helped? _____
 7. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other _____
 8. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Y N
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ACCIDENT INFORMATION

- Is this condition due to injury or sickness arising out of employment? Y N _____
- Auto Accident? Y N Other? _____
- Days lost from Work? _____ Date symptoms appeared or accident happened? _____
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FINANCIAL INFORMATION

PAYMENT IS EXPECTED AT TIME OF SERVICE. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself- NOT between my insurance company and this office. I authorize **Discover Chiropractic and Wellness, P.A.** to release any medical information and to complete any usual and customary reports and forms to assist in collecting from my insurance company. I know that I am responsible for my annual deductible, any percentage that my insurance company **does not** pay for and/or my office visit co pays.

I, the undersigned, have read and agree to the guidelines of the above statement.

Patient's Signature

Date



Kristin B. Kulju, D.C.

1859 Lakewood Ranch Blvd., Bradenton, FL 34211

(941) 749-8552

FINANCIAL POLICY

INSURANCE CARRIERS

Financial responsibility for services rendered is the patients' responsibility regardless of any insurance coverage. As a courtesy we will call your insurance company ahead of time for benefit quotes and will do everything possible to facilitate re-imbursement from your insurance company, but a quote of insurance is NOT a guarantee of benefit payment or coverage. Claims will be filed to insurance companies that we have agreed to work with. You will be responsible at the time of service for all co-pays, co-insurance, deductibles and services not covered by your plan. Insurance follow-up is the responsibility of the patient. If the claim becomes the patient's responsibility, the claim must be paid within 30 days.

MEDICALLY NECESSARY SERVICES

The insurance company may deny some services as not medically necessary. The patient is responsible for all billable services. Please see your contract for benefit coverage.

CHANGE OF INSURANCE

IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH ANY INSURANCE CHANGES. Claims denied due to "untimely billing" will be the patient's responsibility, if we were not initially provided with the correct billing information, which resulted in late submission.

STATEMENTS

Regardless of any claim pending, if there is an open balance a statement may be sent to you once a month. Any patient balances remaining after insurance payment must be fully paid within 30 days.

COLLECTIONS AND NSF CHECKS

If financial arrangements have not been made in our office within 30 days after receiving your statement, accounts will be forwarded to our collection agency. A collection fee of \$25 will be added to the unpaid balance to recover our costs for collection. There will be a fee added to your account for NSF checks. The fee depends upon the bank fee charged to us.

By signing below, I acknowledge that I have read and understand the information presented above and wish to receive diagnostic and treatment services from Discover Chiropractic and Wellness. I agree to be fully responsible for any and all charges for services rendered and not covered by my insurance plan.

SIGNATURE _____ DATE _____



Kristin B. Kulju, D.C.

1859 Lakewood Ranch Blvd., Bradenton, FL 34211

(941) 749-8552

CANCELLATION POLICY

Dr. Kristin & staff have set aside time, sometimes up to an hour, to provide care to you as a patient. As a courtesy, we may call and remind you of your appointment for the next business day, but it is ultimately your responsibility to remember your appointment. Any appointment missed or cancelled without 24 hours notice of the scheduled appointment time will be subject to a \$30.00 cancellation fee. If you need to cancel an appointment, please make sure that you have given us at least 24-48 hours notice. You may leave a message on our answering machine if it is after hours.

By signing below, I acknowledge that I have read and understand the information presented above and wish to receive diagnostic and treatment services from Discover Chiropractic and Wellness. I agree to be fully responsible for any and all charges acquired for not providing timely cancellation.

PRINT NAME _____ **DATE** _____

SIGNATURE _____

NOTICE OF PRIVACY PRACTICES/ PROTECTED HEALTH INFORMATION

Discover Chiropractic & Wellness is committed to maintaining the privacy of your Protected Health Information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care.

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice:

1) Postcard mailed to you at the address *originally* provided by you **OR** to the following address:

2) Telephoning your home and leaving a message on your answering machine or with the individual answering the phone **OR** to the following phone number ONLY: _____

3) Permission to mail "Thank you for the Referral" card to person who referred you to our office:
____ Yes OR ____ NO

I acknowledge that I have read the above and understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Name of: Parent, Guardian or Patient's legal representative (please print)

Signature

Date

RELEASE OF PATIENT RECORDS AUTHORIZATION ~
to Discover Chiropractic & Wellness

(**leave top portion blank)

I hereby authorize:

Phone: _____ Fax: _____

to release a copy of my **Patient records, X-Rays and any other related health information** to **Discover Chiropractic & Wellness, P.A.**
1859 Lakewood Ranch Blvd. Bradenton, FL 34211
Phone: 941-749-8552 ~ Fax: 941-749-8553. *This*

authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

Patient's Name(PRINTED)

Patient's Date of Birth

Patient's or Patient's Legal Representative's Signature

Date Signed

Any other information to be disclosed: _____
