

Welcome

And thank you for choosing Kastner Family Chiropractic

Patient Information

Today's Date: _____
Name: _____
Prefer to be called: _____ Male Female
Address: _____
City _____ State _____ Zip _____
SS#: _____ DL#: _____
Birthdate: _____ Age: _____ # Children: _____
 Single Married Divorced Separated Widow
Employer: _____
Employer Address: _____
Spouse's/Partner's Name: _____
Birthdate: _____ SS#: _____
Spouse's Employer: _____
How did you hear about us?: _____

Insurance Information

Insurance Co.: _____
Policy/Group #: _____
ID/Claim #: _____
Name on Insurance Policy: _____
Relationship to Patient: _____
Is patient covered by additional insurance? Yes No

Assignment and Release

I certify that I (or my dependent) have insurance coverage with _____ and assign all insurance benefits directly to Kastner Family Chiropractic. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand that my insurance policy is an arrangement between the insurance carrier and myself, and I am financially responsible for all charges whether paid by the insurance company or not. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

Contact Information

Home Phone: _____ Cell: _____ Work Phone: _____ Extension: _____
Email Address: _____ May we confirm appointments by email? Yes No

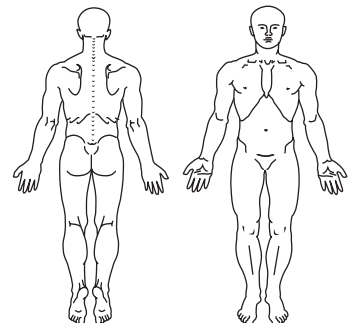
In case of emergency contact:

Name: _____ Relationship: _____ Home Phone: _____ Work: _____

Patient Condition

Mark X where you feel pain/problem

Your Present Complaint: _____
When did your condition begin? _____
Is condition due to an accident? No Yes, Auto Yes, Work Yes, Other
If so, what was the date of the accident? _____
When is your pain at its worst? _____
How often do you have this pain? _____ % of the time.
Does your pain interfere with your Work Sleep Daily Routine Recreation
Activities that are painful to perform: Sitting Standing Walking Bending Lying Down
Describe your pain (mark all that apply) Sharp Dull Throb Numb Ache Burn Tingle Stiff



Health History

Why this Form is Important

A thorough and accurate health history is essential for the best treatment for your condition. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most time the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Other health professional seen for your condition (please list):

Chiropractor _____ Results: _____
Medical Doctor _____ Results: _____
Other _____ Results: _____

Date of Last: Physical Exam _____ Spinal Exam _____ Spinal X-Ray _____
 Blood Test _____ Urine Test _____ MRI/CT Scan _____

Place an X to indicate if you have had any of the following:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headache | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Numbness | <input type="checkbox"/> Substance Abuse |
| Women <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pins and Needles | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaccine Reaction |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | | <input type="checkbox"/> Vaginal Infections |

Activities

Exercise

- Daily
 Frequently
 Periodically
 None

Work

- Sitting
 Standing
 Light Labor
 Heavy Labor

Habits

- Smoke _____/day
 Alcohol _____/week
 Caffeine _____/day
 High Stress Level

Injuries/Surgeries

Falls: _____
Head Injuries: _____
Dislocations: _____
Surgeries: _____
Broken Bones: _____
Serious Illness/Injury: _____

Medications

Please list any medications you take: _____

Please list any supplements/herbs you take: _____

This office requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If my account is not paid within 90 days from date of service and no other arrangements have been made, I understand I will be responsible for any expenses incurred in collecting my account.

I understand the information in this form and guarantee it was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my address, insurance, or medical status.

Patient Signature _____ **Date** _____

Kastner Family Chiropractic

Dr. Brenda Kastner

Financial Policy

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality chiropractic care in a relaxed and informative environment. It is our policy to make definite financial arrangements with you before any treatment begins. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, Master Card and Visa.
2. If requested, we will provide you with a copy of the charges to submit to your insurance carrier or cafeteria plan for reimbursement.
3. If your insurance benefits are assigned to the doctor, we will file your insurance for you, and you will be responsible for paying your deductible and co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company.
4. Your insurance benefits are a contract between you and your insurance company. It is your responsibility to see that they pay on time. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.
5. The office can not carry balances for longer than 90 days. Should this office be required to employ an attorney or collection service to collect delinquent payments, the responsible party agrees to pay the office cost of \$50.00 plus all reasonable attorneys' fees.
6. A \$5.00 monthly Rebilling charge will be added to your account if it is not paid within 60 days, even if your insurance has not paid.
7. Missed appointments or appointments cancelled without 24-hour notice will be subject to a \$50.00 charge for chiropractic appointments a \$40.00 charge for ½ hour massage and a \$70.00 charge for hour massages.
8. There will be a \$25.00 service charge for all returned checks.

I have read and accept the above Financial Policy, and I agree to the terms set forth regarding payment.

Patient Signature or Responsible Party if Minor

Date

7400 E. Arapahoe Rd., Suite 150 • Englewood, CO 80112

Phone: 303-224-9920 • Fax: 720-493-9566
