Dr. Brittany Warren D.C
Dr. Robyn Kuhn D.C.
Dr. Nathan Free. D.C.

## Patient Information

Patient Name ______________________________________________ Today's Date:___/___/___

Social Security Number: _______________________ Birth Date: ___/___/___ Age:____ Gender: F M

Street: ________________________________________________________________________________

City:_______________________________________ State: _____ Zip Code: ______________________

Phone: (_____) ___________________ Cell: (_____) _________________

*Would you like to receive Text Message Reminders for future appointments?* ☐ Yes ☐ No

Complete Billing Address: _______________________________________________________________________

**Marital Status**: ☐ Married ☐ Separated ☐ Widowed ☐ Single ☐ Divorced

Occupation/Student:___________________ Employer: ___________________________Full Time / Part Time

**Race**: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian

☐ Hawaiian/ Other Pacific Islander ☐ Other ☐ Prefer Not to Say

**Hispanic or Latino Background**: ☐Yes ☐ No ☐Prefer Not to say

Emergency Contact:__________________________________ Phone: (____)______________________

| For Office Use Only | **Height:** _____________________________ |
|---|---|
| | **Weight:**_____________________________ |
| | **Blood Pressure:**________________________ |

# Insurance Information

*If Policy Holder of Insurance is not Patient Above*

**Primary** Health Insurance Carrier: _________________________________________________________________

Full Name of Policy Holder: ___________________________ Policy Holder's Date of Birth: ___/___/___

Policy Holder's SSN: __________________________ Relation to Policy Holder: ____________________________

Policy Holder's Address: ___________________________________________________________________________

**Secondary** Health Insurance Carrier: ______________________________________________________________

Full Name of Policy Holder: ___________________________ Policy Holder's Date of Birth: __/___/___

Policy Holder's SSN: __________________________ Relation to Policy Holder: ____________________________

# Medical History

Primary Care Physician: ______________________________________ Phone: (____)_______________

Date of last physical examination: ______________________________

Do you have now or have you ever had:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Thyroid Problems

☐ Tuberculosis ☐ Prostate Disorder ☐ Ulcer ☐Asthma ☐ Kidney Problems ☐ Seizure Disorder

Other: _____________________________________________________

Surgeries/Hospitalizations and Dates: ________________________________________________________________

________________________________________________________________________________________________

Allergies (Please List All): ________________________________________________________________

List any previous accidents (automobile, work-related, slips, falls, sports, etc.) and provide accident date:

1)_____________________________________________________ ___/___/___

2)_____________________________________________________ ___/___/___

3)_____________________________________________________ ___/___/___

Smoker? ☐ Former ☐ Never ☐ Current Number of Packs per Day: ______________ Years Smoked: _________

Do you Drink Alcohol? ☐ Yes ☐ No Quantity/Frequency: __________________________________________

Caffeine Intake (Quantity/Frequency): _______________________________________________________

Water Consumption:_____________________________________________________________________

Medication List (Name of Medication, Dosage, Frequency):

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

WOMEN ONLY:

Are you pregnant or is there any possibility you may be pregnant? ☐ Yes ☐ No ☐ Uncertain

If checked YES, what is the estimated due date? ___/___/___

Are there any known pregnancy complications? ________________________________________

## General Information Related to the Condition

Approximately when did the conditions or symptoms begin to occur? ___/___/___

□ No Particular Condition or Symptoms – Just Seeking General Good Health

Please Describe the Conditions, Symptoms, or Purpose of the Appointment: ________________________________

______________________________________________________________________________

______________________________________________________________________________

Are there other Healthcare Professionals you have seen for this condition? (Physical Therapists, Injections, etc.)

| Name | Licensure | Date |
|---|---|---|
| ______________________ | ____________________ | ___/___/___ |
| ______________________ | ____________________ | ___/___/___ |

Describe your pain: □ Burning □ Sharp □ Dull □Ache

What Caused The Pain to Occur? ____________________________________________

______________________________________

What Aggravates It? ______________________________

______________________________________

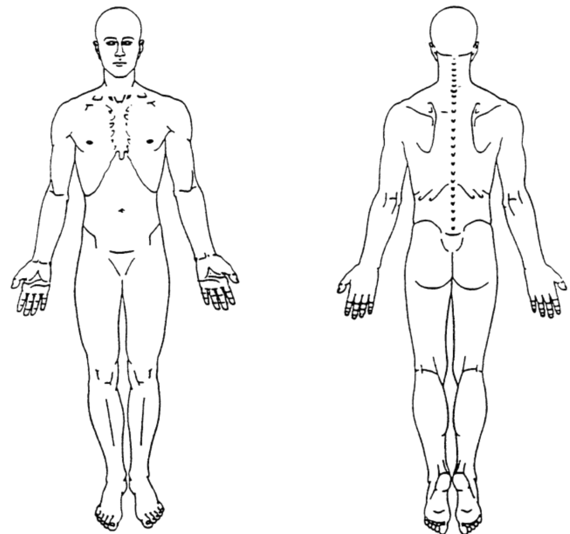
What Relieves It? ______________________________

______________________________________

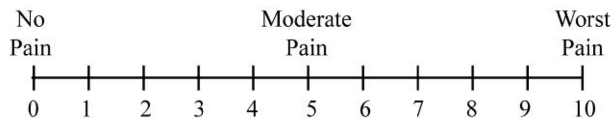
Have you ever had the same or similar conditions or symptoms previous to this most recent occurrence? □ Yes □No

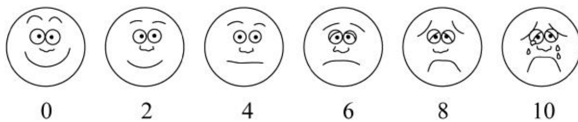
If checked YES, when? ___/___/___

Describe: ______________________________________



**Please circle on the Body Chart where there is the worst pain**



0 2 4 6 8 10

**Please identify your Pain Level on the Pain Scale**

## Please Check any of the Following Symptoms you are now Experiencing

| | | | | |
|---|---|---|---|---|
| □ Headache | □ Dizziness | □ Light Sensitivity | □ Diarrhea | □ Head Feels Heavy |
| □ Loss of Memory | □ Clumsiness | □ Feet Cold | □ Stiff Neck | □ Tingling Arms/Hands |
| □ Sleeping Problems | □ Face Flushed | □ Hands Cold | □ Nausea | □ Back Pain |
| □ Buzzing Ears | □ Loss of Balance | □ Constipation | □ Nervousness | □ Ears Ring |
| □ Shortness of Breath | □ Fainting | □ Fever | □ Tension | □ Fatigue |
| □ Chest/Rib Pain | □ Arm/Hand Pain | □ Loss of Smell | □ Jaw Pain | □ Cold Sweats |
| □ Loss of Strength – Arms | □ Burning Muscle Pain | □ Loss of Strength - Legs | □ Difficulty Swallowing | □ Irritability |
| □ Sharp/Shooting Pain | □ Leg/Foot Pain | □ Numb Legs/Feet | □ Numb Arms/Hands | □ Tingling Legs/Feet |
| □ Neck Pain | Other: ______________________________ | | | |

Who can we thank for referring you to our office? ____________________________________________

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 agree to pay my estimated patient responsibility and further understand that my estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including but not limited to, all court costs and attorney fees. I understand I will be financially responsible for all charges if I fail to provide complete and accurate information with the reference to my insurance company or companies.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: ____________________________________________ Date: ___/___/___

# Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Patient Name: ________________________________________ Date : _____/_____/_____

The Undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

In Order for our office to provide ANY information to your Spouse, parent, relative or other designates, we must have your permission. (This would include appointment schedules, X-Rays, receipts, Insurance Information, health records and any other information that pertains to your treatment.) You may indicate your permission by listing names here:

*My information may be shared with: (List Names and relationship to patient)*

Please indicate the name and contact information of your primary care physician for the purpose of care coordination with the chiropractic physician.

Primary Care Doctor Name: ____________________________________________________________

Address/Phone: ______________________________________________________________________

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA Compliance Manual, State Law and Federal Law.

_____________________________________________

Patient Signature

If patient is a minor or under a guardianship order as defined by State law:

_____________________________________________

Signature of Parent/Guardian (circle one)

## Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, electrical muscle stimulation, or spinal traction on me (or on the patient named below, for whom I am legally responsible:______________________________) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here: **Dr. Brittany Warren / Dr. Robyn Kuhn / Dr. Nathan Free**, and/or other Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the Doctors of Sunset Hills and Freedom Chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including but not limited to: fractures, disc injuries, dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in the best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

________________________________
Print Patient's Name

________________________________
Signature of Patient

To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated)

________________________________
Print Name of Patient

________________________________
Print Name of Representative

________________________________
Signature of Representative

# Financial Policy and Patient Rights

Thank you for choosing Sunset Hills Family Chiropractic • Freedom Chiropractic as your healthcare provider. We are committed to providing the best quality care for each of our patients. As a part of our professional relationship, it is important that you have an understanding of our financial policy and your rights as a patient. Each patient must read and sign this form before care is given.

**Regarding Insurance:** It is patient's responsibility to provide our office with the most current insurance information. If you fail to provide accurate insurance information in a timely manner, your insurance may deny your claim and the patient will be held responsible for all charges billed to the insurance.

If more than one insurance is offered for a patient, it is the patient's responsibility to ensure that the Coordination of Benefits has been properly established. If a claim denies for missing coordination of benefits, the balance will be passed to the patient's responsibility until the benefits are coordinated. A claim may be refiled to the insurance if the issue is resolved within a timely manner.

It is the patient's responsibility to verify his/her insurance benefits, including but not limited to: number of treatments his/her policy allows, if a referral is required and if the provider is an in-network provider.

If your insurance denies a claim as "medically necessary" the patient or responsible party will be responsible for all the charges billed to insurance. If your plan denies for "maxed benefits" we will continue to honor the allowable amount based on your current plan.

Copayments, coinsurance, and/or deductibles are due at time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim, regardless of estimation.

**Regarding Self Pay:** If a patient acknowledges him/herself as a self-pay, they state that they do not have any insurance or do not wish to file the claims through their insurance. In this case an initial self-pay visit will be $75 and collected at time of service. Starting January 1, 2016, follow-up visits will be $40. Our doctors hold the right to charge additional fees if additional therapies are introduced. If a new injury occurs and more time is needed, the doctors also hold the right to bill an office visit of $75. A $10 courtesy discount as long as the balance is paid in full and not carried over to any future appointments. If a balance is carried over, that $10 will be added back onto the account and will be due before the patient continues treatments.

If a Self-Pay patient wishes to add insurance to his/her account, Sunset Hills Chiropractic and Freedom Chiropractic will not be responsible for filing any past appointments to the insurance company. The insurance will also remain on file until another insurance card is presented or until the patient presents us with a letter of termination.

**Regarding Patient Balances and Payments:** Payment in full is due upon receipt of your statement. Please contact the billing department to set up payment arrangements if balance cannot be paid in full. If you fail to contact our office we hold the right to refer your account to a professional collection agency and/or attorney of law for further collections. You will be responsible to pay all collection costs incurred: including attorney's fees and court cost if applicable. If your account is assigned to a professional collection agency, you will be notified by certified mail and will no longer be able to receive services from any of the providers at Sunset Hills Chiropractic or Freedom Chiropractic.

In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $30 to your original balance and all treatments will be ceased until balance is paid.

**Minors and Separation and Divorce Policy:** Sunset Hills Chiropractic and Freedom Chiropractic is not a party to any separation or child support agreement or divorce decree. The adult accompanying a minor patient will be held responsible for paying any copays or charges predetermined by the insurance company and will be collected at the time of service.

I, ________________________________, am fully aware and understand all policies and rights of Sunset Hills and Freedom Chiropractic.

Print Patient Name: ________________________________________________________________________________

Patient or Responsible Party Signature: ________________________________________________________________________________

Sunset Hills Chiropractic • Freedom Chiropractic
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