Lake Michigan
Chiropractic, LLC
Kraig Kirkdorfer, DC

Patient Information

First Name	Middle
Last Name	Nick Name
Address, City, State, Zip Code	
Home Phone	Home Email
Cell Phone	Work Email
Best Way To Reach You? (please circle) Home Cell Work Email	
Date of Birth	SS#
Gender	Marital Status
Employer	Work Phone
Employer Address-City, State, Zip Code	
Job Title and Job Duties-What you do for work may affect your body. Do you sit, stand, lift, etc?	
How did you hear about us? Who may we thank for referring you to us?	
Emergency Contact Name and Relationship	
Contact's Phone #1	***Contact's Phone #2***

Spouse/Partner Information

First, Middle, Last Name		
Address if different than above		
City, State, Zip Code		
Date of Birth	SS#	
Home Phone	Cell Phone	Work Phone
Employer		
Employer Address, City, State, Zip Code		

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Health History

Primary Physician	
Address	

Do you have **NOW** or have you had in the **PAST** any of the following? Please circle.

Arthritis	Now	Past	Headaches	Now	Past
Asthma	Now	Past	Heart Problems	Now	Past
Balance problems	Now	Past	HIV	Now	Past
Cancer	Now	Past	Osteoporosis	Now	Past
Depression	Now	Past	Pinched Nerve	Now	Past
Diabetes	Now	Past	Sleeping Problems	Now	Past
Disk Injuries	Now	Past	Stroke	Now	Past
Fractures	Now	Past	Thyroid Problems	Now	Past
Gout	Now	Past	Ulcers	Now	Past

Major Injuries/Illness:	
Broken Bones:	Dislocations:
Surgeries:	
Allergies:	Supplements:
Medications:	
Are you pregnant? No Yes	Due Date:

Exercise:	None	Light	Moderate	Heavy
Work:	Sitting	Standing	Light Labor	Heavy Labor

Smoke? Packs per day-	Alcohol? Drinks per week-	Caffeine? Cups per day-
Water? Ounces per day-	Are you under High Stress? Yes No Reason:	

Anything else you would like Dr. Kraig to be aware of?

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Problem Information

Please <u>fill out one Problem Information sheet for each problem area</u>.

Please ask for more sheets if needed.

Chief Complaint					
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)					
How did your pain begin?					
Date of onset?		**Is it constant, or does it come and go?**		**% of the day you have pain?**	
Is the pain radiating?					
If so, please describe					
Please circle the appropriate types of pain:					
dull	sharp	throbbing	burning	deep	aching
tingling	stabbing	cramping	numbness	radiating	
What makes the pain worse?					
sitting	standing	walking	bending	stooping	lifting
sleeping	sneezing	coughing	straining	reaching	twisting
looking up	looking down	movement	rest	lying supine	driving
typing	scooping	house chores	exercise	lying prone	stairs
What relieves the pain?					
sitting	standing	lying	knees bent up	support	
no movement	movement	heat	ice	analgesic	
ibuprofen	medication	rest	stretching/exercise	adjustments	

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Financial Agreement

In order to control your outstanding balance, it is our policy to collect co-pays, co-insurance, deductible, and the patient's portion of our fee at the time of service. Our office gladly accepts cash, personal checks, MasterCard, Visa and Discover. We may require a debit or credit card on file, which will be charged in the event of an unpaid balance. You will be notified by phone before any charges are made. If you are financially unable to make full payment at the time of service, we can set up a payment plan. You should request this option as early as possible, preferably on the first visit.

If you have health or accident insurance, our office will file your insurance claims for you to help you receive your chiropractic benefits. Assignment of benefits will be made to the clinic. Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. We ask you to be fully responsible for knowing the specifics of your particular insurance contract, and to understand that insurance coverage does not guarantee payment. The clinic cannot accept responsibility for collecting your insurance reimbursement or negotiating a settlement on a disputed claim. We can provide you with the necessary medical information to assist you. All unpaid charges will be your responsibility. If your insurance has not made payment within 30 days of the date your claim was filed, the balance will be transferred to your account.

If this account is assigned to an attorney/outside agency for collection and/or suit, Lake Michigan Chiropractic shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I have read the clinic's fee schedule and I understand and agree to the provisions of the Financial Agreement.

Patient or Responsible Party's Signature_____

Relationship_____

Date_____

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Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, certify that I (or my dependent) have insurance coverage and hereby assign and convey directly to Lake Michigan Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic**. I understand that I am financially responsible for all charges regardless of any applicable insurance of benefit payments.** I hereby authorize the doctor to release all medical information necessary to process this claim. I Hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses uncured as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring such suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient or Responsible Party's Signature_____

Relationship_____

Date_____

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Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by Kraig Kirkdorfer, D.C. and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for Kraig Kirkdorfer, D.C.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

Signature of Patient: _____ Date: _____

Signature of Patient's Representative: _____ Date: _____

To be completed by the patient's representative if patient is a minor or physically or otherwise legally incapacitated.

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Acknowledgement of Receipt of Privacy Policy

I acknowledge that Lake Michigan Chiropractic's Privacy Policy has been provided to me. I understand that I have a right to review Lake Michigan Chiropractic's Privacy Policy prior to signing this document. The Privacy Policy describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Lake Michigan Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information collected from me, and created or received by my physician. The Privacy Policy for Lake Michigan Chiropractic is also provided on request at the front desk of the clinic.

Lake Michigan Chiropractic reserves the right to change the privacy practices that are described in the Privacy Policy. I may obtain a revised Privacy Policy by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_____

Printed Name of the Patient or Representative

_____

Signature of the Patient or Personal Representative Date