Lake Michigan Chiropractic, LLC
Kraig Kirkdorfer, DC

Patient Information

First Name	Last Name
Address	
City, State, Zip Code	
Home Phone	Cell Phone
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**	
***Emergency Contact's Phone**	

Spouse/Partner Information

First, 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 fill out <u>one sheet for each problem area</u>, please ask for additional 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? Approximately what date did this problem begin?					
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	Aching	Stiffness
Tingling	Stabbing	Numbness	Other:		
What makes the pain worse?					
Activity	Bending	Lifting	Standing	Sitting	Temp. Changes
Any/All Movement	Twisting	Stairs	Coughing	Driving	House Work
Looking Up	Looking Down	Lying Down	Sleeping	Reaching	Stress
Computer/Desk Work	Straining	Walking	Yard Work	Other:	
What relieves the pain?					
Cold/Ice	Heat	Increased Activity	Lying Down	OTC Medication	Massage Therapy
Postural Changes	Rest	Stretching	Support Brace	Movement	No Movement
Chiropractic Adjustments	Sitting	Standing	Other:		

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Financial Agreement, Legal Assignment of Benefits and Release of Medical and Plan Documents

It is our policy to collect co-pays, co-insurance or deductible at the time of service. Our office gladly accepts cash, personal checks, MasterCard, Visa and Discover. 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. You will be billed for all unpaid charges. If you do not understand your statement balance, please call the office for an explanation of charges on the statement.

Please note that **your primary health insurance, and/or no-fault personal injury protection benefits (when applicable) are not a guarantee of payment** for treatment rendered, **and you, the patient, are responsible to verify your own benefits** as well. Your exact benefit amount is determined after we bill your insurance carrier and actually receive an explanation of benefits from them. *You will receive the same explanation from your insurance company describing your exact dollar amount owed.*

There are several parts to your Health Insurance Policy:

- "**Deductible**" refers to the first portion of care costs incurred during the year. For example, if you have a $200 deductible, that means that your Insurance Company expects you to pay for the first $200 of the care you receive in the given contract year. After that, they will pay their portion for whatever care you receive during that year, or until you have received all the benefits your policy provides.
- "**Co-insurance**" refers to that percentage of cost, which the Insurance Company expects you to pay. If your "co-insurance" is 80% / 20%, this means that the Insurance Company will pay 80% of what they consider "**usual and customary**" (or **U&C**), and that they expect you to pay all the rest of the costs (20%) for any and all services provided.
- "**Co-pay**" refers to a specific charge you may have to pay for a particular service. The most common co-pay is a flat fee for exams and re-exams. This is much less commonly encountered than standard co-insurance charges.

All reputable Insurance Companies utilize something called "**Relative Value Units**" (or **RVU**) to determine the usual and customary charge (**U&C**) that they will pay. The RV unit was designed to evaluate the time, complexity, and overhead costs associated with every service provided by your doctor. The RV unit is a **nationally accepted unit of value**, which may be modified by a "locality percentage". This explains why care in the Chicago region would cost more than in a smaller town that has lower overhead costs.

If you have health insurance, our office will file your insurance claims for you. Assignment of benefits will be made to the clinic. "**Assignment of Benefits**" is a legally binding agreement between you and your Insurance Company, asking them to send your reimbursement checks directly to your doctor. When our office accepts an assignment of benefits, this means that we have to wait for your insurance reimbursement to arrive. **We extend assignment to our clients as a courtesy**.

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, PLLC shall be entitled to reasonable attorney's fees and for cost of collection.

In considering the amount of medical expenses to be incurred, I certify that if I (or my dependent) have insurance coverage, I hereby assign and convey directly to Lake Michigan Chiropractic, PLLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I fully read and understand that I am personally and fully financially responsible to Lake Michigan Chiropractic, PLLC for all chiropractic/medical bills submitted Lake Michigan Chiropractic, PLLC for services rendered to me and this agreement is made solely for Lake Michigan Chiropractic's additional protection and in consideration awaiting payment. I understand that I am financially responsible for all charges regardless of any applicable insurance of benefit payments. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said charges for treatment. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

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 Kraig Kirkdorfer, DC and Lake Michigan Chiropractic, PLLC 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 incurred as a result of the medical services I received from the above named 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. I assign the rights and benefits, including the right to bring suit, to Lake Michigan Chiropractic, PLLC.

Patient Name: _____ Date: _____

Patient Signature: _____

Lake Michigan Chiropractic, 4082 Red Arrow Hwy, St. Joseph, MI 49085 ~ 269-408-8729

Lake Michigan Chiropractic, LLC

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Acknowledgement of Receipt of Privacy Policy (HIPAA)

Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral.

I acknowledge that Lake Michigan Chiropractic's Privacy Policy has been provided to me should I choose to read it. 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 any time 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 by asking for one at the time of my next appointment.

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic manipulation or adjustments, examination procedures, diagnostic x-rays, and other chiropractic procedures, including various modes of physical therapy or massage therapy, 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 or Certified Massage Therapists 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 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.