PATIENT INTAKE FORM

Dr. Corinne A Kennedy of Kennedy Chiropractic Center

11515 W. North Avenue -Ste. A- Wauwatosa WI 53226

414-443-1515

Office Use Only

Patient #:_____

Patient Name:_____Date:_____/_____/_____
First Middle Last

Sex: Male ☐ Female ☐ Birthday:_____/_____/_____ Age:_____ Social Security Number:_____

Address:_____

City:_____State:_____Zip:_____

Cell Number: (_____) _____ Land Line: (_____) _____

E-Mail:_____ May we contact you?_____Yes _____No

Emergency Contact:_____Phone #: (_____)_____Relation:_____

Married Single Widow Minor Separated Divorced Partnered_____Years_____

Employed Full-Time Student Part-Time Student Retired Other_____

Whom Can We Thank For Your Referral?_____

EMPLOYMENT/SCHOOL INFORMATION

Patient Employer/School:_____Occupation:_____

Employer/School Address:_____Phone: (_____)_____

INSURANCE INFORMATION

Primary Insurance Company:_____

ID #:_____Group #:_____

Secondary Insurance Company:_____

ID #:_____Group #:_____

<u>If your insurance is provided through your spouse, parent, guardian, etc., please complete below:</u>

Insurance:_____ Primary _____ Secondary

Responsible Party's Name:_____

Responsible Party's Date of Birth:_____/_____/_____

Relationship to Responsible Party:_____

Responsible Party's Employer_____

Kennedy Chiropractic Center Will Provide A Complimentary Insurance Check At Your Request

Informed Consent for Examination/Treatment

The purpose of Chiropractic services is to promote health naturally, through the reduction of the VSS (Vertebra Subluxation Syndrome) or VSC (Vertebra Subluxation Complex). Since there are so many variables, it is difficult to predict a time schedule or effectiveness of Chiropractic procedures. Sometimes the response is immediate, but in most cases, gradual. Occasionally, the results are longer than expected. There may be more than one condition to work on, therefore, care may vary in length of time.

As a patient of Kennedy Chiropractic Center, you are giving the doctor permission and authority to care for yourself or a minor in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course will not give a Chiropractic adjustment, or health care, if she feels the treatment may be contraindicated. It is the responsibility of the patient to make sure it is known or to learn through health care procedures whatever he/she is suffering from, be it latent pathological defects, illness, or deformities which would otherwise not come to the attention of Dr. Kennedy. Patient must inform the doctor of any possibility of pregnancy during or at any point in the treatment process.

_____ _____

Signature of Patient or Representative **Date**

_____ _____

Patients Name (Printed) **Relationship of Authorized Representative**

If patient is a minor: As of this date, I have the legal right to select and authorize health care services for the minor child named above. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify Kennedy Chiropractic Center.

_____ _____

Signature of Patient or Representative **Date**

_____ _____

Patients Name (Printed) **Relationship of Authorized Representative**

Patient Responsibilities

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Please let us know which category you fit into:

_____HEALTH INSURANCE:

If you would like us to file your claims for you, you must provide a current copy of your insurance card. As a courtesy we will file your claim(s) and when requested by your insurance company, we will supply them additional information, which may include medical records, to support a claim. We will verify your insurance, but also recommend that you contact your insurance for information on your network chiropractic coverage. If you have not met your deductible, we ask that you pay at your appointments until your deductible has been met.

_____SELF PAY: No Chiropractic Coverage or High Deductibles

We offer a day of service price of $50 on our services when the balance is paid in full on the day of service.

_____MEDICARE:

Medicare will cover chiropractic spinal adjustments that are considered medically necessary. Medicare does not cover exams, extremity adjusting, or exercises. After Medicare sends us an explanation of benefits (EOB), they will forward the claim to your supplement insurance if applicable. After we receive your primary (and secondary) EOB you will receive a statement from us specifying the amount paid and any remainder that is your responsibility.
Prompt payment is expected upon receipt of this statement.

_____WORK COMPENSATION/PERSONAL INJURY INSURANCE/PERSONAL INJURY ATTORNEY:

In the case of work compensation OR personal injury being covered by insurance, we will need a claim number and a contact number for the claims adjuster of the insurance agency covering the case. In the case of a personal injury being represented by an attorney, **Please ask at the front desk for an additional form.**

CHECKS RETURNED FOR INSUFFICIENT FUNDS:

The processing charge for a returned check is $50, payable by cash or money order. If two occurrences of checks returned for non-sufficient funds are noted in your account, you will be placed on a cash only basis for future services.

PAYMENTS FOR DEPENDENTS:

The parent(s) or guardian(s) is responsible for full payment and will receive all billing statements. Signature of this document authorizes treatment and acceptance of this payment responsibility for dependents.

PATIENT BILLING STATEMENTS:

We will send monthly statements after receiving the explanation of benefits from your insurance company or as arranged ahead of time for patients on payment plans. If no payment has been made after two statements have been sent, payment in full must be made prior to future service. If no payment has been made after 3 statements have been sent your account will be sent to collections.

CANCELATION POLICY:

Please provide our office a 24 hour notice via voice message, text or email in the event you are unable to keep your appointment, this will allow us the opportunity to provide care to another patient. A “no show”/”no call” missed appointment may be assessed at a $25 fee. If you are 15 or more minutes late for your appointment, your appointment may need to be rescheduled based on our schedule. As a courtesy, we send a appointment reminder notice 24 hours in advance. Please note, if a reminder call or text is not received, the cancellation policy remains in effect.

Patient Responsibilities Continued

In some cases, KCC fees are not covered, in full, by your insurance company. We want our patients to be aware of the fact that under any circumstances, the patient is **personally responsible** for any balance due after insurance has paid. KCC expects full payment within 30 days upon receipt of your statement. Any unpaid balance after 30 days will be charged a 1.5% monthly interest fee until all unpaid balances are paid in full. This balance due including provisions set by your insurance company, such as co-payments, co-insurances, deductibles and "usual and customary" allowances. The policy held by you or your employer is a contract between the policy holder and the insurance company. KCC does not accept insurance companies as patients; you are the patient. As the patient, you understand that you are financially responsible for all charges, whether paid by the insurance company or not. If you are unfamiliar with your insurance coverage, we ask that you discuss this with your employer or your insurance company before any charges are incurred. If your insurance requires any specific forms please bring those to our attention so that we can submit them prior to your care. It is always best for you to understand your coverage before beginning treatment, so you know what you are responsible for. We will do a complimentary benefits check for you, however, this is only an estimate of coverage and not a guarantee of payment. Your policy always rules as it applies on the day of service.

I consent to allow Kennedy Chiropractic Center to use and or disclose my Protected Health Information in compliance with their policy as indicated in their Notice of Patient Privacy Practices. My signature allows KCC to use my personal information for insurance purposes, including an assignment of benefits.

_____ _____

Signature of Patient or Representative **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our **Notice of Privacy Practices**, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received and had the opportunity to review the **Notice of Privacy Practices** on the date below on behalf of Kennedy Chiropractic. I understand that the Notice describes the uses and disclosures of my protected health information by Kennedy Chiropractic and informs me of my rights with respect to my **protected health information**.

_____ _____

Signature of Patient or Representative **Date**

In case of an emergency, I give my permission for my **Personal Health Information** to be released to the following individuals: (**If not, leave blank**)

Name:_____Phone:_____Relation:_____

Name:_____Phone:_____Relation:_____

CONFIDENTIAL HEALTH QUESTIONNAIRE— PRESENT HISTORY

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1. **Reason For Visit:**_____
2. **Describe Current Symptoms:**_____
3. **Date Symptoms Began:**_____**Related To:** ☐ **Work Injury** ☐ **Auto Accident** ☐ **Other** _____
4. **Describe How Your Symptoms Began:**_____

_____

5. How Often Do You Experience Your Symptoms:

- ☐ **Constantly (76-100% of the day)**
- ☐ **Frequently (51-75% of the day)**
- ☐ **Intermittently (26-50% of the day)**
- ☐ **Occasionally (0-25% of the day)**

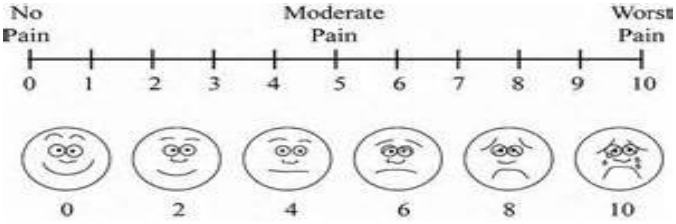
6. Type Of Pain Felt:

- ☐ **Sharp**
- ☐ **Dull Ache**
- ☐ **Numbness**
- ☐ **Throbbing**
- ☐ **Shooting**
- ☐ **Burning**
- ☐ **Tingling**
- ☐ **Stiffness**

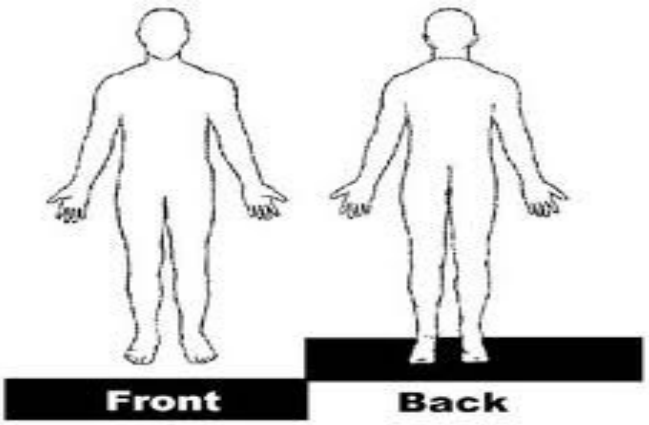
7. Does Your Pain Interfere With:

- ☐ **Work**
- ☐ **Daily Routine**
- ☐ **Driving**
- ☐ **Standing**
- ☐ **Bending**
- ☐ **Sleep**
- ☐ **Sitting**
- ☐ **Walking**

8. Please Rate Your Pain On A Scale From 1-10



Please Indicate Where You Have Pain Or Other Symptoms



9. How Are Your Symptoms Changing?

- ☐ **Getting Better**
- ☐ **Not Changing**
- ☐ **Getting Worse**

10. **Have You Had Similar Symptoms In The Past? (If Yes, Explain)**_____
11. **Have You Seen Any Health Care Professionals For Your Current Symptoms? (If Yes, What Was The Treatment Plan)**_____

_____

12. **Have You Had Any Tests Performed For Your Current Symptoms?**_____
13. **What Is Your Occupation?**_____**Stress Level (1-10)**_____
14. **Do You Smoke?**_____**Do You Drink Alcohol?**_____
15. **Are You Currently Taking Any Medication/Vitamins? (If Yes, Please List)**_____

_____

16. **Do You Have Any Allergies? (If Yes, Please List)**_____
17. **Are You Currently Pregnant?**_____**Date Due:**_____

CONFIDENTIAL HEALTH QUESTIONNAIRE—PAST HISTORY

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1. **Date Of Last Physical Exam?_____/_____/_____ Spinal X-ray?_____/_____/_____ Blood Test?_____/_____/_____**
2. **Have You Had Any Surgeries?_____When?_____/_____/_____**
3. **Have You Had Any Serious Illnesses Or Conditions ?_____When?_____/_____/_____**
4. **Have You Been Treated By A Physician For Any Health Condition In The Past Year?_____When?_____/_____/_____**
5. **Have You Had Any Serious Falls?_____ When?_____/_____/_____**
6. **Have You Had Any Head Injuries?_____ When?_____/_____/_____**
7. **Have You Had Any Broken Bones?_____When?_____/_____/_____**

Please Circle All Symptoms You Have Had In The Last 6 Months

Alcoholism	**Emphysema**	**Multiple Sclerosis**	**Thyroid Disease**
Allergy Shots	**Epilepsy**	**Nervousness/Anxiety**	**Tuberculosis**
Anemia	**Fractures**	**Numbness**	**Ulcers**
Anorexia	**Glaucoma**	**Osteoporosis**	
Appendicitis	**Gout**	**Pacemaker/Defibrillator**	
Arthritis	**Headaches**	**Parkinson's Disease**	
Asthma	**Heart Disease**	**Pinched Nerve**	
Backaches	**Hepatitis**	**Pneumonia**	
Bleeding Disorder	**Herniated Disc**	**Polio**	
Cancer	**High Cholesterol**	**Prostate Issue**	
Cataracts	**Kidney Disease**	**Prosthesis**	
Chemical Dependency	**Liver Disease**	**Psychiatric Care**	
Chicken Pox	**Measles**	**Rheumatoid Arthritis**	
Depression	**Migraine**	**Scarlet Fever**	
Diabetes	**Miscarriage**	**Sinus Issue**	
Dizziness	**Mononucleosis**	**Stroke**	