BRUSVEEN Family CHIROPRACTIC

Thank you for choosing our office for your chiropractic care. Please complete this form **in ink.**

We are happy to help you—just ask! **Date:** _____

Last Name: _____ First Name: _____ M.I.:_____

Date of Birth (D.O.B.) _____/_____/_____ Age: _____ Gender: **M** **F**

Home Address: _____ Apt. #_____

City: _____ State: ____ Zip: _____ Height: ___ft. ___in. Weight: _____lbs.

Email: _____

*__Who may we thank for referring you__? _____

Home phone: _____ Cell phone: _____ Provider: _____

Work phone: _____

Preferred places for messages? **Home** **Cell** **Work** **Email** (Circle all that apply)

Marital Status: □ Married □ Single □ Divorced □ Widowed Spouse's name: _____

Women: Is there a chance you are pregnant? _____ Due date? _____

Children's names and ages: _____

_____

Your employer: _____ Job title: _____

Emergency contact: _____ Relationship to you: _____

Phone: _____ Address: _____

City:_____ State:_____ Zip:_____

Primary Doctor (PCP) Name:_____ Phone: _____

Have you had previous chiropractic care? Yes No Date of last care: _____

Is this an accident case? Yes No Date of accident: _____

Circumstances: Auto collision On the job Other_____

Details: _____

_____

Patient Name: _____

Insurance Company Name: _____ Contract #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's Employer: _____

Date of Birth: _____

Patient's Relationship to subscriber (Circle one): Self Spouse Child Dependent

_____I authorize KBC to copy my driver's license/personal I.D. --and insurance cards, if applicable--for my records.

Financial Responsibility With/Without Insurance: All services rendered to me are charged directly to me; I am personally and financially responsible for payment of all charges incurred at KB Chiropractic, PLLC ("KBC" or, "KBC, PLLC"), including insurance deductibles, copayments, and any & all services rejected/not covered by insurance. All charges are due at the time of service unless I have signed a payment plan agreement. I instruct and direct my insurance company to pay, by check made out to and mailed directly to KBC, PLLC, the professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward charges for professional services rendered by KBC, PLLC; a photocopy of this assignment shall be considered as valid as the original. I authorize KBC, PLLC to release any pertinent Protected Health Information (PHI) to any insurance company, adjustor, and/or attorney involved in my case, and I hereby release KBC, PLLC of any consequence thereof.
Health and accident insurance policies are an arrangement between the insurance carrier and me; I am responsible for knowing my carrier's rules, regulations, and payment policies. For specific questions regarding my insurance coverage, I must contact my carrier directly. **As a courtesy**, KBC will submit insurance bills within 4 weeks of date of service; KBC has no control over insurance carriers' response time(s). As KBC will collect approximated amounts from me, I may end up with a bill or credit on my account. For any automobile accident claim(s), I am responsible for any charges rejected, deemed unreasonable or unnecessary by my automobile insurance company and/or an independent medical examination, and KBC may require another form of payment guaranty. If workman's compensation is deemed unrelated to work, I will be responsible for all services.
Delinquent accounts (over 60 days of non-payment by patient and/or insurance) will be assessed a $25 billing charge. An additional $75.00 minimum amount will be charged if outside collection agency and/or small claims court are required to collect the balance on an account. I agree to resolve all financial matters with KBC on my own, without legal representation.
Chiropractic, like medicine, is an applied science as well as an art; absolute guarantees are not possible. I understand that regardless of individual results, I am responsible for payment for services received at KBC. If I suspend or terminate my recommended treatment of care, any fees for professional services will be immediately due and payable.

Health Insurance Portability and Accountability Act (HIPAA): KBC's current Notice of Privacy Practices (NOPP) has been made available to me. The NOPP explains my rights and KBC's duties regarding my PHI, including ways in which my PHI may be used or disclosed by KBC. KBC reserves the right to amend its NOPP. A printed copy of KBC's current NOPP is provided upon request at KBC's main administrative desk, or by calling KBC and asking that a copy be mailed to me.

These people are authorized to receive my health and financial information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand and agree to all the above financial responsibility/HIPAA terms and conditions:

Patient/Guardian Signature: _____ Date: _____

Medical History

Patient Name: _____ D.O.B.**:** _____

Major Complaint: _____

_____

Came on: □ Gradually □ Suddenly Date of onset: _____/_____/_____

Has this happened before? □ No □ Yes When? _____

What makes the condition worse? □ Cough □ Laugh □ Sneeze □ Bend/Lift □ Stand □ Sit □ Walk

What makes the pain better? □ Sit □ Stand □ Lie down □ Meds □ Heat □ Ice Other_____

When is the pain worse? □ Morning □ Afternoon □ Evening □ Night □ All the time □ Varies

When is the pain better? □ Morning □ Afternoon □ Evening □ Night □ All the time □ Varies

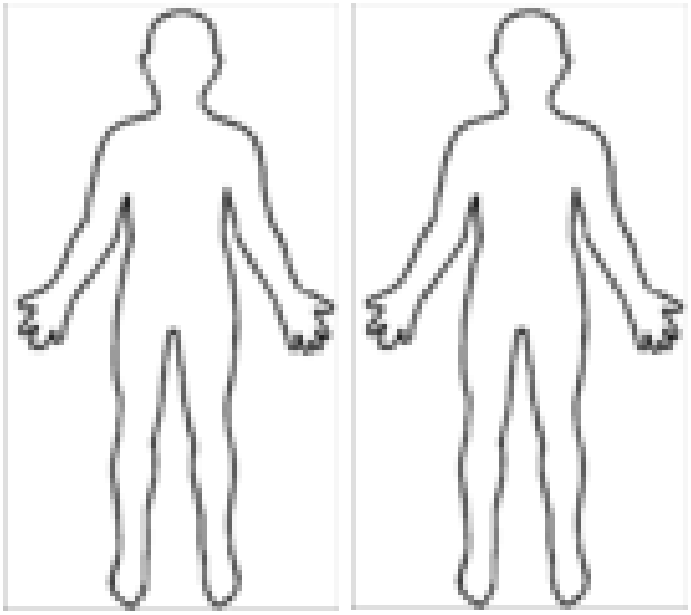
Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling Other_____

Pain is □ Constant □ Comes and goes

Rate severity of your pain:

(No symptoms) 0 1 2 3 4 5 6 7 8 9 10 (Extreme symptoms)

Please draw where you are experiencing symptoms:



Which activities are hard to perform?

□ Sitting □ Standing □ Walking

□ Bending □ Lying down

Is this condition interfering with your…?:

□ Work □ Sleep □ Daily routine Other_____

What diagnostic tests have you had for this?

What treatment have you received for this?

□ Medication □ Surgery □ Physical Therapy

Other_____

Name/address of other doctor(s) who have treated this condition(s):

Patient Name: _____

Exercise:	**Work activity:**	**Habits:**
□ None	□ Sitting	Chemical abuse:
□ Moderate	□ Standing	___ use per week □ None
□ Daily	□ Light labor	Alcohol:
□ Heavy	□ Heavy labor	___ drinks per week □ None
□ Weekend	□ Computer work	Coffee/caffeine:
		_____ per day □ None

EXAMS WITHIN THE LAST YEAR: Circle those that apply

Spinal exam Spinal x-ray Blood test Urine test Physical exam

MRI/CT Chest x-ray Other:_____

INJURIES OR SURGERIES DESCRIPTION DATE

Falls: _____

Head Injuries: _____

Broken Bones: _____

Dislocations: _____

Surgeries: _____

HEALTH HISTORY (Check only those conditions you have had at ANY TIME now or previously)

O Change in bowel/bladder habits
O Thickening or lump in breast or elsewhere
O Unusual bleeding/discharge
O Obvious change in wart or mole
O Unintended weight loss over 10 lbs.
O Indigestion or trouble swallowing
O A sore that does not heal
O Nagging cough or hoarseness
O AIDS/HIV

O Chemical Dependent
O Alcoholism
O Allergy shot
O Anemia
O Anorexia
O Appendicitis
O Arthritis-Osteo
O Asthma
O Bladder issues
O Bleeding disorder
O Breast lump
O Bronchitis
O Bulimia
O Cancer
O Carpal tunnel
O Cataracts
O Heart Disease
O Chicken pox
O Colon issues
O Depression
O Diabetes
O Ear infection
O Emphysema
O Epilepsy
O Fibromyalgia
O Fractures
O GERD
O Glaucoma
O Goiter
O Gonorrhea
O Gout
O Osteoporosis
O Hepatitis
O Hernia
O Herniated disc
O Herpes
O High cholesterol
O Hypertension
O Kidney disease
O Liver disease
O Lung issues
O Measles
O Migraines
O Miscarriage
O Mononucleosis
O Multiple Sclerosis
O Shingles
O Pacemaker
O Parkinson's
O Pinched nerve
O Pneumonia
O Polio
O Prostate issues
O Prosthesis
O Psychiatric care
O Rheumatoid arthritis
O Rheumatic fever
O Scarlet fever
O Sexually transmitted disease
O Sinusitis
O Stroke
O Scoliosis
O Suicide attempt
O Thyroid issues
O Tonsillitis
O Tuberculosis
O Tumors/growths
O Typhoid fever
O Ulcers
O Vaginal infection
O Whooping cough
Other_____
_____

KB Chiropractic, PLLC

Patient Name: _____

FAMILY HISTORY:

Please fill in spaces that apply. Since environment can be a factor, please circle if they live close to you.

CONDITION	FATHER age	MOTHER age	BROTHERS age(s)	SISTERS age(s)	SPOUSE	CHILDREN age(s)
Arthritis						
Asthma						
Back problems						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc problems						
Ear aches						
Emphysema						
Epilepsy						
Hay fever						
Headaches						
Heart trouble						
High blood pressure						
Insomnia						
Kidney problems						
Liver problems						
Nervousness						
Neuritis						
Pinched nerve						
Scoliosis						
Sinus problems						
Stomach problems						
Other						

BRUSVEEN FAMILY CHIROPRACTIC

5164 Lake Michigan Dr, Suite D, Allendale, MI 49401 (616) 777-0309

Patient Name: _____

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If your health insurance doesn't pay for the service listed below, you may have to pay.

Your insurance company does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance company may not pay for the following items below.

Non-covered Services	Reason Insurance Company May Not Pay	Estimated Cost
1. New or Established Patient Exam	1. Non-Covered Service General Insurance	1. $115 - $260
2. Intersegmental Traction (IST)	2. Non-Covered Service	2. $10 - $45
3. Rehab	3. Non-Covered Service	3. $10 - $45
4. Decompressive Therapy (DTS)	4. Cash Only Service	4. $20

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the non-covered services listed above.

Note: If you choose Option 1 or 2, we may help you with other financing options.

Options: Check only one box.

❑ OPTION 1. I want the non-covered services listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance company by following the directions on the MSN. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ OPTION 2. I want the non-covered services listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if my insurance is not billed.

❑ OPTION 3. I don't want the non-covered services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my insurance would pay.

Signing below means that you have received and understand this notice. You will also receive a copy.

Patient Signature:	Date: