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: _____ 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: _____

_____

KB Chiropractic, PLLC

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

_____ **(initial)** 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 or Guardian Signature: _____ **Date:** _____

KB Chiropractic, PLLC

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

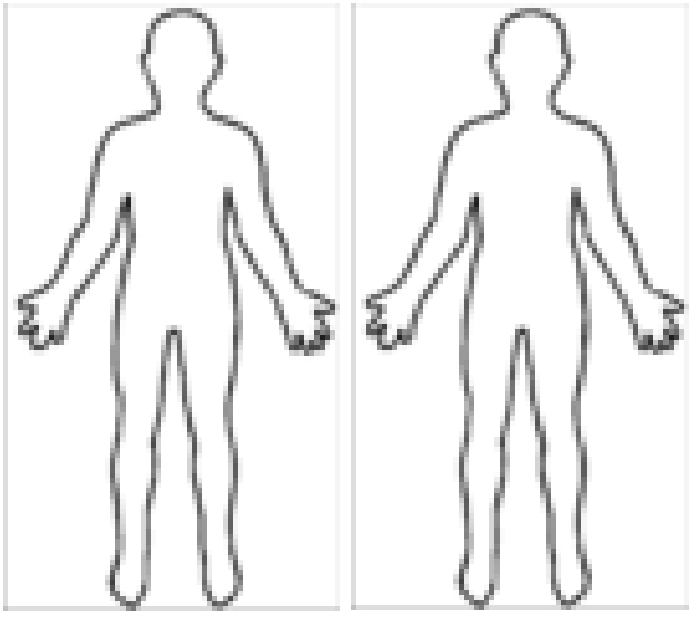
When is the pain better? □ Morning □ Afternoon □ Evening □ Night □ All the time □ Varies

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:

Front Back



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):

KB Chiropractic, PLLC

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 Heart disease
O Osteoporosis
O Shingles

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 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 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 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 does not 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 do not 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:**
_____	_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and sports.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case, and hereby release this clinic of any consequence thereof.

Missed Appointments

I understand that if I do not contact you the day before my chiropractic appointment, I will be charged a $10 fee ($40 for a New Patient, Report of Findings, or Re-exam appointment). If I do not contact you within 24 hours of a massage appointment, I will be charged a $40 missed massage appointment fee.

_____	_____	_____
Name (Printed)	Signature (Patient or Guardian)	Date