

New Patient Intake Form

Kautz Chiropractic, LLC

First Name _____ Middle _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Email _____

Date of Birth ____/____/____ Sex: Male Female

Social Security Number: _____ - _____ - _____ Marital Status: Single Married Other

Employment Status: Employed Unemployed Student Other _____

Employer Data

Employer _____

Your Occupation _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

How did you hear about our office? _____

Medical Conditions: (Check all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries (w/ date): _____

Allergies: _____

Medications: _____

Social History: (Check all that apply to you)

Drink Alcohol:	occasional	often	never
Cigarettes:	<1 pack/day	>1 pack/day	never

Family History: (Check all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease:	Parent	Sibling
Hypertension:	Parent	Sibling
Stroke:	Parent	Sibling
Thyroid:	Parent	Sibling
Other _____		

Review of Systems:(Check all that apply)

General:	Weight Gain/Loss	Loss of Appetite	Fevers	Weakness
	Fatigue			
Respiratory:	Short of Breath	Cough	Asthma	Congestion
	Wheezing			
Cardiovascular:	Chest Pain	Palpitations	Varicose Veins	Swelling
	Sweating			
Gastroenterology:	Nausea	Heartburn	Diarrhea	Constipation
	Abdominal Pain	Indigestion		
Urology:	Frequency	Painful urination	Discolored urine	
	Erectile Dysfunction			
Ear, Nose & Throat:	Dizziness	Hearing loss	Nose bleeds	
	Sinus Infection	Difficulty Swallowing		
Eyes:	Blurred Vision	Double Vision	Vision Floaters	
Psychiatric:	Depression	Anxiety	High Stress	
Dermatology:	Rash	Flushing	Dry Skin	Wound
Musculoskeletal:	Joint Pain	Cramping	Muscle Pain	Neck Pain
	Back Pain	Leg Pain	Arm Pain	Osteoporosis

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

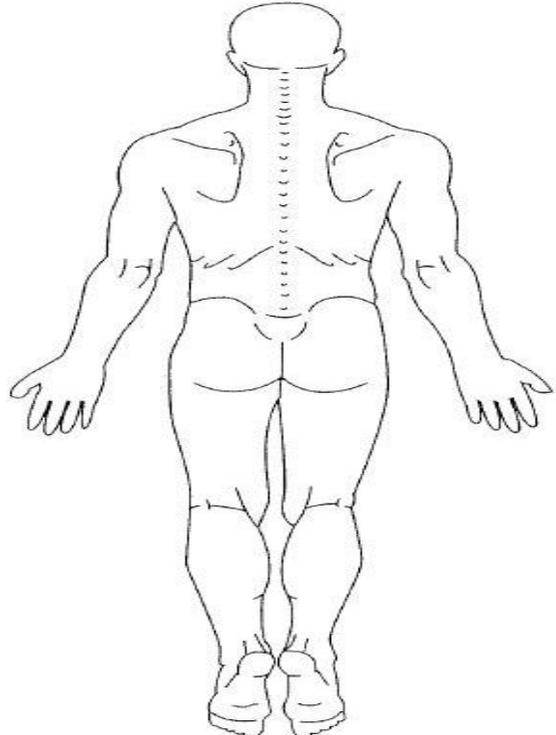
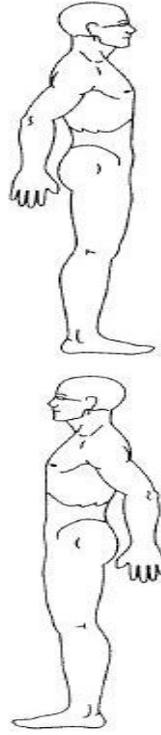
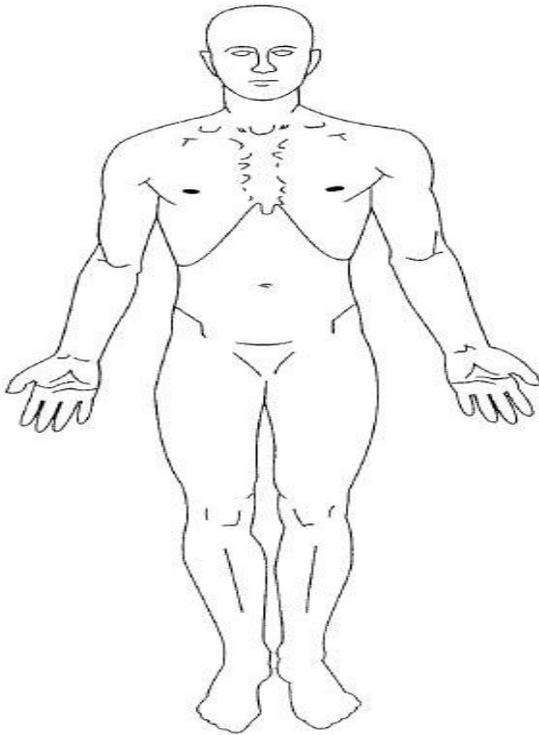
N=Numbness

B=Burning

S=Sharp

T=Tingling

A=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No If Yes, please list: _____

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other _____

How did your symptoms begin? _____

How often do you experience your symptoms?

Constantly
(76-100% of the day)

Frequently
(51-75% of the day)

Occasionally
(26-50% of the day)

Intermittently
(0-25% of the day)

What activities are affected by your symptoms?

Sleeping
Housework
Other _____

Working
Sitting
Driving

Walking
Standing
Hobbies/social activities

Exercising
Grooming

PAYMENT POLICY

Thank you for choosing Kautz Chiropractic, LLC as your chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **INSURANCE.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. **CO-PAYMENT AND DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. **PROOF OF INSURANCE.** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **CLAIM SUBMISSION.** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. **CONVERAGE CHANGES.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all 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 interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have read and understood the payment policy and informed consent and agree to abide by the guidelines.

Signature of patient or responsible party

Date

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