# Kilkenny Chiropractic, LLC

## New Patient Intake

Name: _____ Today's date: _____

Date of birth: _____ Gender: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell phone: _____ Home phone: _____ Work phone: _____

**Please circle your preferred phone number for communications from our office.**

Single Married Divorced Widowed Spouse's name: _____ Children yes no Ages: _____

Occupation: _____ Full-time Part-time Retired Unemployed Disabled

Employer: _____

Student: Full-time Part-time School/Major: _____

Insurance: _____ Insured's Name: _____

Insured's date of birth: _____ Relationship to insured: _____

Insured's address (if different from the patient's): _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Last seen (month/year): _____

How did you hear about our office? _____

Have you seen a chiropractor before? yes no Comments: _____

_____

Do you have/want X-rays, MRI, CT imaging? Yes No _____

Patient Name: _____ Today's date: _____

Date your symptoms began: _____ Briefly describe your symptoms:_____

_____

How did your symptoms begin? _____

_____

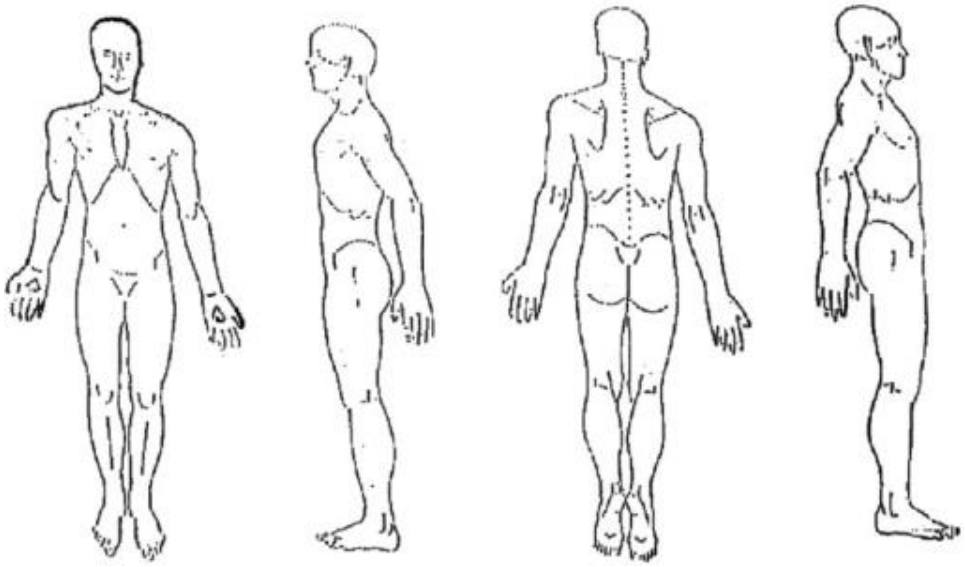
Sleep: Normal Trouble falling asleep Trouble staying asleep Comments: _____

Circle all that apply to your pain: Sharp Stabbing Shooting Dull Achy Numb Tingling Burning Stiff Tense

Rate your pain: None Mild Moderate Severe Worst possible

0 1 2 3 4 5 6 7 8 9 10

**Please mark *all* areas where you have pain.**



_____

_____

GOALS:_____

**Health History Information Sheet**

Patient Name: _____ Today's date: _____

Date of birth: _____ Age: _____ Height: _____ Weight: _____lbs. Right Left handed

Past Medical History: Please mark <u>all</u> that apply to ***you*** with a "C" (current) or "P" (past).

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | High Blood Pressure | | Stroke TIA | | Diabetes Type I or II | | Osteopenia / porosis |
| | Heart Condition | | DVT / blood clots | | Dizziness Vertigo | | Migraines headaches |
| | High Cholesterol | | Marfan's Syndrome | | Scoliosis | | Circulatory Condition |
| | Kidney Disease | | Ehlers-Danlos | | Thyroid Condition | | Arthritis |
| | Autoimmune Disease | | HIV or AIDS | | Reflux | | IBS / UC |
| | Hepatitis - Type ___ | | Anxiety PTSD | | Depression | | Epilepsy / Seizures |
| | Neurological Disease | | Fibromyalgia | | Tinnitus hearing issues | | Visual problems |
| | Respiratory Condition | | Nausea or vomiting | | Peripheral Neuropathy | | Skin Condition |
| | Unexplained weight loss | | Hair loss | | Loss of: smell taste | | Urinary Issues |
| | Reproductive Issues | | Concussions # ____ | | Physical/Emotional Abuse | | Cancer |

Other: _____

Please explain positive responses above: _____

_____

_____

**<u>Tobacco</u>** Use: Never / In the past / Presently How much: _____ How long: _____ Year quit: _____

Alcohol use: Daily / Weekly / Rarely / None Other substance use or abuse: yes no _____

Current medications/supplements: _____

ANY serious traumas/hospitalizations: _____

ANY surgeries/allergies: _____

Family Medical History: Please mark <u>all</u> that apply to your ***immediate family*** only (grand/parents/siblings).

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | High Blood Pressure | | Stroke TIA | | Diabetes Type I or II | | Osteopenia / porosis |
| | Heart Condition | | DVT / blood clots | | Dizziness Vertigo | | Migraines headaches |
| | High Cholesterol | | Marfan's Syndrome | | Scoliosis | | Circulatory Condition |
| | Kidney Disease | | Ehlers-Danlos | | Thyroid Condition | | Arthritis |
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| | Hepatitis - Type ___ | | Anxiety PTSD | | Depression | | Epilepsy / Seizures |
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| | Unexplained weight loss | | Hair loss | | Loss of: smell taste | | Urinary Issues |
| | Reproductive Issues | | Concussions # ____ | | Physical/Emotional Abuse | | Cancer |

Other: _____

Please explain positive responses above: _____

_____

## Notice to All Patients

Welcome to our practice! We strive to provide you with excellent chiropractic care. We ask for your help by reading and cooperating with our patient and financial policies as outlined below.

- Please sign in upon entering the facility for your scheduled appointment. Please let us know if your insurance, address, or any other personal information has changed.
- All payments are due at the time of service: Self-pay fees, Insurance co-payments, and deductibles.
- Any open balances such as co-insurances and deductibles will be collected on the day of service. Charges are payable by cash, check, Zelle, Visa, MasterCard, Discover, or American Express.
- A returned check will result in a $25.00 service charge and all future payments will be collected in the form of cash, Zelle, or credit card.
- Refund requests may take up to 4 (four) weeks from the date requested, if there are no pending claims.
- Any balance over 90 (ninety) days old will be processed and sent to a collection agency.
- Our practice participates with United Healthcare, Medicare, and VA CCN; it is your responsibility to understand the requirements and covered benefits of your plan. **We will bill your insurance company as a courtesy, but it is your responsibility to follow up on all insurance issues.** The billing department will do everything that can be done to resolve insurance issues, but it is your responsibility in the end as you are their subscriber.
- You are responsible for any non-covered and/or denied claim; you will receive a statement of denied charges and payment is due within 30 (thirty) days after the date on the statement.
- If your insurance policy requires a referral, it is your responsibility to contact your primary care physician and have a referral sent to our office prior to your appointment date.
- **Failure to notify the clinic of needing to cancel your scheduled appointment with at least 24 hours advanced notice will result in a $25.00 charge billed directly to you.** Your insurance company will **NOT** cover this fee.
- We value your time. If you have a limited amount of time for your scheduled appointment, please let us know in advance or upon arrival in our facility so that we are able to accommodate you the best that we can.
- In order to provide all of our patients with proper care, it is imperative that you arrive on time for your scheduled appointment. Please call or text the office as soon as you know that you will be arriving late for your appointment so that we can prepare for this change. You may have to wait to be seen depending on the other scheduled appointments for that day.

Thank you for your patience and cooperation. By signing below, you acknowledge and certify that you have read, understood, and agreed to the patient policies as listed above. We realize that temporary financial problems may affect timely payment of accounts. If such problems arise, we urge you to contact us promptly for assistance in the management of your account. Please call the office at (407)707-5234.

I have read and understood the above Patient and Financial Policies and agree to all listed obligations.

_____ _____

Patient Signature Date

RESPONSIBILITY STATEMENT (No expiration on authorization unless specified by patient)

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Kilkenny Chiropractic, LLC for any services provided to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ _____

Patient, Parent, or Guardian Signature (if child is under 18 years of age) Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to Kilkenny Chiropractic, LLC for any services provided to me by the physician. I understand that I am financially responsible for any amount not covered by my contract, such as any deductible, co-payment, co-insurance, non-covered services, or services rendered if my insurance is terminated. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent, or Guardian Signature (if child is under 18 years of age) Date

MEDICAL RECORDS RELEASE:

I hereby grant permission to Kilkenny Chiropractic, LLC to release medical information to my **insurance carrier(s)** in response to their request for information required to file a claim for reimbursement on MY or MY DEPENDENT'S behalf.

_____ _____

SIGNED: (PATIENT, PARENT, OR GUARDIAN) Date

List below the **names and relationships of people** to whom you authorize Kilkenny Chiropractic, LLC to release Protected Health Information (PHI). This allows us to acknowledge that you are being treated here, discussion of your condition, and/or allow them to pick up records on your behalf. I understand that there may be a fee for this service, not to exceed the usual and customary rates.

_____ _____

Full name Relationship

_____ _____

Full name Relationship

Kilkenny Chiropractic, LLC

1945 W County Road 419, Suite 1111

Oviedo, FL 32766

(407) 707-5234

## Informed Consent

Doctors of chiropractic, medical doctors, osteopathic physicians, and physical therapists using manual therapy treatments for patients with neck problems are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause strokes, sometimes with serious neurological injury. The chances of this happening are extremely remote. Appropriate tests will be performed to help identify if you may be susceptible to that kind of injury and an appropriate response will occur. Additionally, there is a risk of soreness following the examination and/or treatment. Certain health conditions, medications (ex. steroids, fluoroquinone), and smoking increase your risk of fracture and stroke so please be thorough and truthful with your health history. If you have any comments or questions about this, please speak with Dr. Whooley.

I have read and understood the above statement, accept the mentioned risk, and hereby consent to treatment.

Signature: _____ Date: _____

Witness: _____ Date: _____

### Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that a copy of the Notice of Privacy Practices was available and that I have read them or declined to read them. I understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for 6 (six) years.

By completing the lines below, I _____ authorize being contacted for practice reminders, information, and changes by:

Email at: _____ Phone call at: _____

Permission to leave a voice message? Yes No

Permission to send a text message? Yes No

_____ _____

Patient's printed name

Date

_____ _____

Patient's signature

Parent/guardian if for a minor