WELCOME

1 one — REASON FOR VISIT

Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness

Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense

Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity

When did your condition/accident occur? ___/___/___ Where did your injury occur? ____________

Please explain what happened: ____________

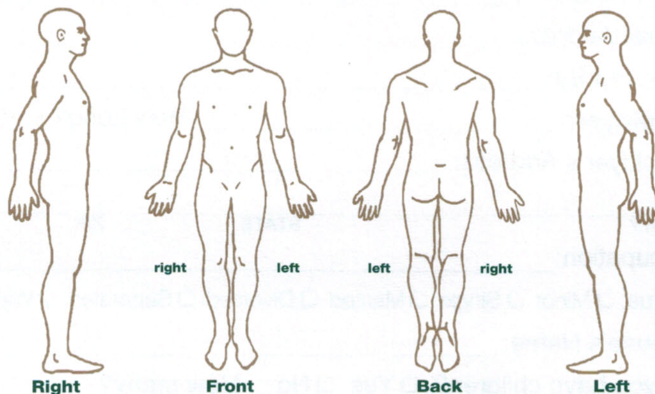
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.

Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: ____________

Has this or something similar happened in the past?

❑ Yes ❑ No Explain: ____________

Using the adjacent body charts, please circle all affected areas.



Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where? ____________

Have you ever been treated by a Chiropractor? ❑Yes ❑No

Clinic or Dr's name: ____________

Clinic phone#: ____________

2 two — HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ____________

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect	**Y N** Mitral Valve Prolapse
Y N Artificial Valves	**Y N** Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis	**Y N** HIV+ / AIDS / ARC
Y N Shingles	**Y N** Cancer	**Y N** Frequent Neck Pain	**Y N** Glaucoma	**Y N** Anemia / Diabetes
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe / Frequent Headaches	**Y N** Kidney Problems
Y N Ulcers / Colitis	**Y N** Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema / Asthma	**Y N** Tuberculosis
Y N Difficulty Breathing	**Y N** Chemotherapy	**Y N** Lower Back Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: ____________

List any past serious accidents with dates: ____________

Please list anything that you may be allergic to: ____________

Family Health History: ____________

Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes _____ hours per week

Do you smoke? ❑ No ❑ Yes How much? ________ How long? ________

Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___

For woman: Are you taking Birth Control? ❑ Yes ❑ No Are you taking Hormonal Replacement? ❑ Yes ❑ No

Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks? ________ ©

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

PLEASE CONTINUE ON BACK

three — ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____ (LAST / FIRST / MI)

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ____ SS#: ____

Mailing Address: ____

CITY ____ STATE ____ ZIP ____

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY ____ STATE ____ ZIP ____

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

four — IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

five — INSURANCE INFO

Primary Insurance

Co. Name: ____

Address: ____

CITY ____ STATE ____ ZIP ____

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ___/___/___

Insured's Employer: ____

Please provide any Primary/Secondary Insurance cards with this form.

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

six — ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY ____ STATE ____ ZIP ____

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ /

❑ Credit Card - Enter card # above (if accepted)

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

____ Initials **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Signature ____ Date ___/___/___

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials	Date	Comments
____	___/___/___	____
____	___/___/___	____
____	___/___/___	____

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Mackenzie Kolt , D.C.

12217 Santa Monica Blvd. # 208., Los Angeles, CA 90025

INFORMATION CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures, including examination, various modes of physiotherapy, and/or x-rays, on me (or on the patient named below, for whom I am legally responsible) by Mackenzie Kolt, D.C.

I understand that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocation, 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 interest.

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

____

Patient's Name (Please Print)

______________________________ _______________

Signature of Patient (or guardian if patient is a minor) Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

The effective date of this Notice of Privacy Practices is ________ (year)

I hereby acknowledge receipt from Mackenzie Kolt, D.C. of a copy of his Notice of Privacy Practices for Protected Health Information effective on the date set forth above.

PATIENT:

____

Patient's Name (Please Print)

______________________________ _______________

Signature of Patient (or guardian if patient is a minor) Date:

Kolt Chiropractic Wellness Center
12217 Santa Monica Blvd. #208
Los Angeles, CA

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Kolt Chiropractic is required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your case.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment. Or we may send a report of your progress to your insurance company.

Health Care Operations. We may use and disclose Health Information for our normal health care operations. For example, one of our staff will enter your information into our computer.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or another person who is responsible for your care. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services, 200 Independence Ave, SW, Room 509F, Washington, DC, 20201. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By signing my name below, I acknowledge receipt of a copy of this notice if I so wish, and my understanding and my agreement to its terms.

Patient Signature ______________________________ Date ______________

Print Name ______________________________

FINANCIAL AGREEMENT HEALTH INSURANCE

Kolt Chiropractic Wellness Center 12217 Santa Monica Blvd. Ste 208 Los Angeles, CA 90025

We would like to welcome you to Kolt Chiropractic wellness Center, and to assure you that you will be receiving the very best care available for your condition. To help you understand the financial policy of our office, we have provided you with the following information.

Explanation of Insurance Coverage

Although most insurance policies cover chiropractic care, they can differ greatly in terms of deductible and percentage of the fee covered. We must ask that you be personally responsible for the payment of your deductible and for unpaid services provided by this office. We will do our best to verify your insurance, inform you of your benefits and bill your insurance company in a timely manner.

Payment Arrangements

It is our policy to maintain your account on a current basis; therefore, we may ask you to make a payment in full, for your initial visit. For all follow up visits we require that you pay for all services until your deductible is met. Thereafter, we require that you pay your copayment portion for all covered services and 100% of the services not covered by your insurance company. We accept cash, personal checks, and all major credit cards to assist you in taking care of your charges.

Assignment of Benefits

Attached is an "Assignment of Benefits" form which we would like you to sign, This forms instructs your insurance company to send their payments directly to this office for all services cover (those services in which you only paid your co-payment portion) If the Insurance carrier, for any reason sends the Insurance payment to you, you are responsible to mail or bring the payment into our office within 2 days of receipt

Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due. All services rendered by this office are charged directly to you and you, ultimately, are responsible for payment regardless of your Insurance coverage.

We hope this answers any question you might have concerning the financial policies of this office.

Patient name ____

Patient Signature ______________________________ Date__________________

Assignment of Benefits

Kolt Chiropractic Wellness Center 12217 Santa Monica Blvd. Ste. 208 Los Angeles, CA 90025

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits which I'm entitled, I hereby authorized and direct my Insurance carrier(s) including private Insurance and any other health medical plan to issue payment check (s) directly to **Dr. Mackenzie Kolt, D.C.** for services rendered to me regardless of my Insurance benefits, if any. I understand that I'm responsible for any amount not covered by my Insurance.

Authorization to Release Information

I hereby authorize **Dr. Mackenzie Kolt, D.C.** to (1) Release any information necessary to Insurance carriers regarding my illness and treatment; (2) process Insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process Insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested Chiropractic services from Dr. Mackenzie Kolt, D.C. and understand by making this request; I become fully financially responsible for any and all charges incurred in the course of treatment.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred immediately upon receiving services. A photocopy of this assignment is to be considered as valid as the original.

Patient Name ____

Patient Signature ___________________________________ Date__________