LAKECREST CHIROPRACTIC & WELLNESS
chiropractic • nutrition • massage

application for care

about you

Name: _____ Birth Date: _____ ○ Male ○ Female

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____ Primary E-mail: _____

SSN: ___-___-____ Name & Number of Emergency Contact: _____

Ethnicity: ○ Hispanic/Latino ○ African American ○ White ○ American Indian ○ _____

Employer: _____ Occupation: _____ Student? ○ Yes ○ No

Will you be using insurance? ○ Yes ○ No Insurance Company: _____

Policy Holder (if different): _____ Policy Holder DOB: _____

Policy Holder Address: _____

Records Varification Question: *(choose only one question by checking the box, then give the answer to that question)*

○ What is the name of your favorite pet? ○ In what city were you born? ○ What is your mother's maiden name?

Answer: _____

How did you hear about our office? _____

healthcare

Please list the names of your current healthcare professionals:

Primary Care MD: _____ Pediatrician: _____

OBGYN: _____ Massage Therapist: _____

Other: _____ May we update them on your condition? ○ Yes ○ No

Have you been adjusted by a chiropractor before? ○ Yes ○ No Was it satisfactory? ○ Yes ○ No

Current Medications or Supplements: _____

_____

_____

Surgeries or Hospitalizations (complete with month & year for each): _____

_____

Have you had an x-ray or MRI within the last 6 months? ○ Yes ○ No If so, where? _____

please identify the condition(s) that brought you into this office:

1 **Complaint:**_____

_____

How did it happen?_____

When did your symptoms begin? _____

How often do you experience these symptoms? _____

How long do these symptoms last? _____

Have you experienced these symptoms in the past? ○ Yes ○ No

Have you been treated for this condition in the past? ○ Yes ○ No

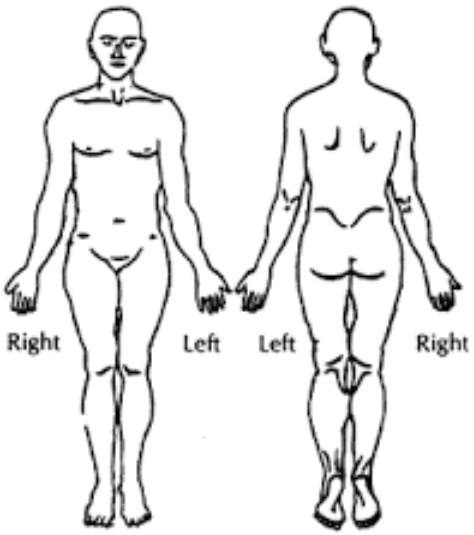
If yes, how & what were the results? _____

How does this condition affect your activity level?_____

_____

On a scale of zero to ten, how intense are your symptoms? *Zero being no pain.*

0 1 2 3 4 5 6 7 8 9 10



2 **Complaint:**_____

_____

How did it happen?_____

When did your symptoms begin? _____

How often do you experience these symptoms? _____

How long do these symptoms last? _____

Have you experienced these symptoms in the past? ○ Yes ○ No

Have you been treated for this condition in the past? ○ Yes ○ No

If yes, how & what were the results? _____

How does this condition affect your activity level?_____

_____

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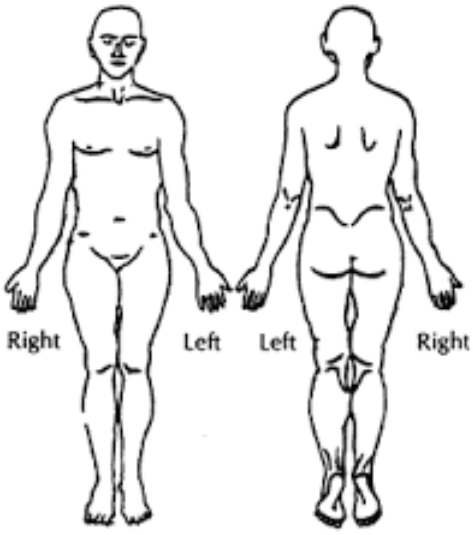

Is there any additional information you would like the doctor to know? _____

_____

_____

_____

_____

family history + lifestyle

Family History: List all major diseases & the relation to you of the individual _____

_____

Is there anything you are allergic to? _____ Are you dieting? ○ Yes ○ No

Do you exercise? ○ Yes ○ No If so, what activity? _____

Have you been diagnosed with Hypertension or Diabetes? ○ Yes ○ No If diabetes, what type? _____

1. **Smoking:** ○ Yes ○ Former Smoker ○ Never been a smoker

2. **Alcohol Frequency**: ○ Never ○ Past ○ Daily ○ Weekends ○ Occasionally

For women: Are you pregnant? ○ Yes ○ No Nursing? ○ Yes ○ No Last menstrual period_____

If appropriate, initial the following with: "**P**" for **Past** or "**C**" for **Currently Have**

___ Abdominal Pain
___ Abnormal Weight Gain/Loss
___ Allergies
___ Arthritis
___ Anxiety/Stress
___ Frequent Bladder Infections
___Eczema
___ Indigestion/Heart Burn
___ Gas/Bloating
___ Diarrhea
___ Constipation
___ IBS/Celliac
___ Tumor
___ Cancer
___ Dizziness
___ Forgetfulness
___ Frequent Headaches
___ Fatigue
___ Depression
___ Joint Swelling/Stiffness
___ Heart Attack
___ Excessive Thirst
___ Frequent Urination
___ Loss of Bladder Control
___ Liver/Gall Bladder Disorder
___ Prostate Problems
___ Stroke
Other:_____
_____
_____

Patient's Signature:_____ Today's Date:_____ Doctor's Initials:_____

To be completed by clinic staff: Height:_____ Weight: _____ Blood Pressure: _____/_____

concent to treat + financial policies

Informed Consent to Treatment: I authorize Dr. Andrew J Klein and whomever he may designate as his assistant(s) to perform diagnostic tests, including radiographs, and to administer treatment, including joint manipulation and physiotherapy, on me (or on the minor patient for whom I am legally responsible) as deemed necessary.
I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment.
I have also been advised that although the incidence of complications associated with chiropractic services is extremely low, anyone undergoing manipulative procedures, physiotherapy or rehabilitation should know the possible hazards and complications which may be encountered or result. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetected by the doctor. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Authorization to Release Medical Information & Request for Payment to Provider of Care I authorize the release of any medical information necessary to process my insurance claim and certify that all insurance information given is correct and full.
I authorize/request my insurance company or attorney to pay directly to Klein Wellness Holdings the expense benefits allowable and payable to me under my current policy or settlement, as payment toward the total charges for services rendered. I agree that this office be given limited power of attorney to sign my name on any drafts for payment of my bill.
Financial Policies I understand and agree that insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt.
In some cases payment may be expected at the time of service including co-payments, deductibles and fees for non-covered services. We have never denied anyone the benefits of care in our office because of an inability to pay our published fees. Special arrangements must be worked out prior to initiating care. Outstanding balances are billed monthly and as closely as possible reflect “remainder balances” following a response from the insurance carrier. We accept cash, check, credit card, and bank cards.

- I understand and agree that I am ultimately personally responsible for payment of all services rendered to me and I am responsible for any costs, consisting of court, collection and attorney fees if a collection procedure is necessary to satisfy my bill.
- I understand returned checks are subject to a fee of what the bank charges this office plus $20.00.
- **I UNDERSTAND THAT I MAY BE CHARGED $35 FOR A MISSED SCHEDULED APPOINTMENT WITHOUT A 24 HOUR NOTICE.**

Acceptance Signature: I have read, clearly understand and agree to these policies.

Patient/Responsible Party Signature: _____ Date:_____

privacy policies

I, hereby state that by signing this Consent, I acknowledge and agree as follows: I have been informed about and given the chance to read the Notice of Privacy Practices. The notice includes a complete description of the uses and/or disclosures of my Private Healthcare Information (PHI) necessary for Klein Wellness Holdings, P.C. (LakeCrest Chiropractic) to provide treatment to me, obtain payment for that treatment and to carry out healthcare operations. LakeCrest Chiropractic reserves the right to change its privacy practices in accordance with applicable law.

I understand that, and consent to, the following appointment reminders and/or communications that will be used by LakeCrest Chiropractic:
1. Postcards or letters mailed to me at the address provided by me; and
2. Telephoning my home, office or cellular phone and leaving a message on a voice answering machine or with the individual answering the phone; and
3. E-mailing me at the address provided by me; and
4. Recognizing special events, referrals given, and similar information in LakeCrest Chiropractic publications including the LakeCrest Chiropractic Website, newsletters, and in-office postings

I understand that this Consent is valid for (7) years. I further understand that I reserve the right to revoke this Consent, in writing, at any time for all future transactions , with the understanding that any such revocation shall not apply to the extent that LakeCrest Chiropractic has already taken action in reliance on this consent.

I understand that if I refuse to sign or revoke this consent at any time, LakeCrest Chiropractic has the right to refuse to treat me.

Patient/Responsible Party Signature: _____ Date:_____

Office Representative/Witness: _____ Date:_____

x-ray concent

○ I am male. *(If so, read the statement at the bottom of the page and sign.)*

○ I am female and have had a total hysterectomy. *(If so, read the bottom of the page and sign.)*

○ I understand that if I am pregnant and have X-rays taken that expose my lower torso to radiation, it is possible to injure the fetus.

○ I have been advised that the 10 days following onset of a menstrual period are generally considered safe for X-ray exams *(low risk of pregnancy during that time).*

With those factors in mind, I am advising my doctor:

I am pregnant	○ Yes	○ No	○ Don't know
I could be pregnant	○ Yes	○ No	○ Don't know
My menstrual period is late	○ Yes	○ No	○ Don't know
I am taking oral contraceptives	○ Yes	○ No	
I have an IUD	○ Yes	○ No	
I have a tubal ligation	○ Yes	○ No	
I have had a partial hysterectomy	○ Yes	○ No	
I have irregular menstrual periods	○ Yes	○ No	
My last menstrual period began on: _____			
I have begun menopause	○ Yes	○ No	

An X-Ray may be performed on me or my ward with my consent.

Patient/Responsible Party Signature: _____ Date:_____