

Kapsner Chiropractic Centers

Michael A, Kapsner, D.C. • Michael J. Snow, D.C. • James R. Schiffer, D.C. • Thomas Neblett, D.C.

Current Health Conditions

Name: _____

Unwanted Health Condition: _____

Other Doctors Seen For This Condition? Yes No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____

Has This Condition Occurred Before? Yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other : _____

Date of Accident: _____ Time of Accident: _____

Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine
 Insulin Other: _____

Do You Wear A Shoe Lift? Yes No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Major Surgery/Operations: Appendectomy Tonsillectomy Gallbladder Hernia
 Back Surgery Broken Bones Other: _____
Major Accident or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: None Doctor's Name: _____

Approximate Date of Last Visit: _____

MEDICAL HISTORY

(If any of the following are relevant to your medical history, please check the accompanying box.)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Backaches |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Anemia |

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care Corrective Care Check here if you want the Doctor to select the type of care appropriate for your condition.

Patient's Signature

Date



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To Our Patients:

Your managed care policy may **NOT** cover certain services due to contract limitations of your plan. For those services that your company confirms that are **NOT** covered, you, as the member, are responsible for those services provided.

We know that your company/plan does **NOT** cover certain services and that you have been made aware of these non-covered service prior to those services being rendered and that you, as the plan member, have agreed to pay for those services.

Plan Member Signature

Date

Print Member Name

Witness



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Personal History

Name: _____ Birth Date: _____ Age: _____ Sex: F M

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Drivers License Number: _____ Social Security Number: _____

Business Employer: _____ Type of Work: _____

Circle One: Married Single Widowed Divorced Separated

Email Address: _____

I authorize this clinic to email me periodic clinic/health information Yes ___ No ___

Name and Ages of Children: _____

Name and Number of Emergency Contact: _____

Relationship: _____

Who is Responsible for Your Bill, You and, Spouse Worker's Comp. Auto Insurance

Medicare Medicaid Attorney

Personal Health Insurance (Type): _____

Policy #: _____ Group #: _____

Insured Person's Name: _____ Date of Birth: _____

Primary Care Physician/Clinic Name: _____

Is It Okay To Send Your Family Care Physician A Written Report: Yes ___ No ___

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's 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 the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The Patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Signature: _____

Date: _____

Consent to Treat a Minor: _____

Date: _____

Guardian or Spouse's

Signature of Authorizing Care: _____

Date: _____



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NAME: _____

PATIENT REFERRALS ARE A VERY IMPORTANT PART OF OUR PRACTICE. PLEASE
FILL IN THE FOLLOWING INFORMATION SO WE CAN ACKNOWLEDGE OUR
PATIENTS WHO REFER OTHERS.

HOW WERE YOU REFERRED TO OUR OFFICE?

___ Family or friends – *if so who?* _____

___ Sign _____

___ Yellow pages – *if so which book?* _____

___ Insurance book _____

___ Doctor – *if so who?* _____

___ Health Fair _____

___ Internet _____

___ Radio _____

___ Television _____

___ Other _____



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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR AND MEDICAL AUTHORIZATION

I hereby instruct and direct my insurance or the insurance of the party at fault to pay by check made out and mailed directly to:

Kapsner Chiropractic Centers
3005 S. Lamar, Ste D112
Austin, TX 78704

For the professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This payment will not exceed my total account balance to the above-mentioned assignee and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment according to the financial policy of the above assignee. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I agree that I am ultimately responsible for the cost of any and all services rendered to me. I permit this office to endorse co-issued remittances for the conveyance of credit to my or the at fault person's insurance company to pay Kapsner Chiropractic directly from any settlement payment.

I hereby authorize and permit any doctor or any other representative of Kapsner Chiropractic to contact any and all physicians, hospitals, clinics, pharmacies or other providers of medical services or products that have examined, treated or provided medical services or products to me at any time. I request said physicians, hospitals, clinics, pharmacies or other providers of medical services or products to furnish said person(s) full and complete reports covering the nature and extent of the treatment given or services and products provided and all information relative to my physical condition, past, present and future. This will also authorize said person(s) to obtain copies of all x-rays or x-ray reports, hospital records, narrative reports, lab tests, nurses notes and prescriptions.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case. **THIS AUTHORIZATION AND ASSIGNMENT OF BENEFITS TO THE PROVIDER LISTED ABOVE SHALL BE IRREVOCABLE FOR THE FULL EXTENT OF MY TREATMENT BY SAID DOCTOR AND UNTIL SUCH TIME THAT MY MEDICAL EXPENSES INCURRED HAVE BEEN PAID IN FULL.**

A PHOTOCOPY OF THIS ASSIGNMENT AND AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Signature of Policy Holder

Date

Signature of Claimant IF other than Policy Holder

Date

Witness

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic 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.

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 other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks in treatment, including, but not limited to, 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 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(s) and for any future condition(s) for which I seek treatment.

To be completed by patient or patient's representative, if necessary (e.g., if patient is a minor or is physically or mentally incapacitated):

Print Patient's Name

Print Name of Patient's Representative

Signature of Patient

Signature of Patient's Representative

Date Signed

As: _____
Relationship or Authority of Patient's Rep.

KAPSNER CHIROPRACTIC CENTERS

To be completed by doctor or staff:

Name and address of clinic (Please check one):

3005 S. Lamar, Ste D-112

8440 Burnet Rd., Ste 118

2000 S. IH 35 Ste K5

Name of Doctor treating this patient

Michael Kapsner, D.C.

Thomas Neblett, D.C.

Michael Snow, D.C.

James Schiffer, D.C.

Witness to Patient Signature

Date

Translated By

Date



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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient ID#: _____

I hereby acknowledge that I have received a copy of Kapsner Chiropractic Centers Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Patient or Legal Representative

Date

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

- Parent or guardian of unemancipated minor
- Court appointed guardian
- Executor or administrator of descendant's estate
- Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ but acknowledgement could not be obtained because:

- Patient/representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- Communication barriers prohibited obtaining acknowledgement (Explain)

- Other (Specify)

PAIN DRAWING
DIBUJO DE DOLOR

MARK WHERE YOU HAVE PAIN OR ALTERED SENSATION
MARQUE DONDE SIENTA DOLOR O SENSACION ALTERADA

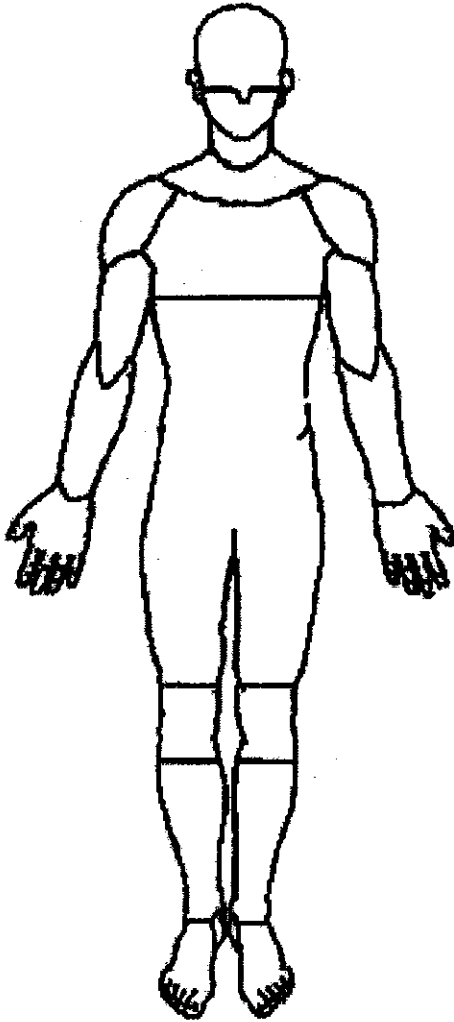
P= Pain
Dolor

T=Tingling
Hormigueo

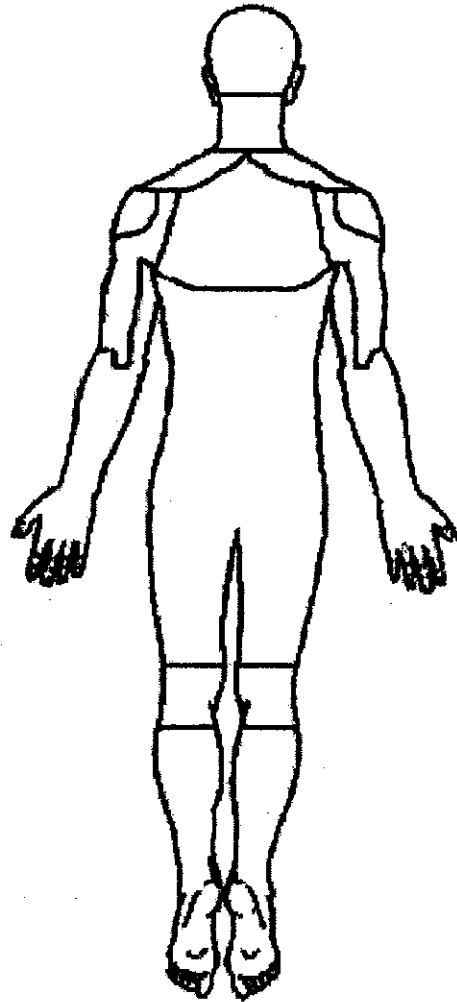
B=Burning
Quemadura

N= Numbness
Adormesido

S=Stiffness
Tieso



FRONT
enfrente



BACK
Espalda

Name: _____
Nombre

Date: _____
Fecha