



Kylene Volz, DC

Office: (517) 699-3000
Fax: (517) 699-3610

1995 N. Cedar St.
Suite #3
Holt, MI 48842

CASE # _____

DATE _____

1ST APPT. _____

2ND APPT. _____

NEW PATIENT LOG

NAME _____ "NICKNAME" _____

ADDRESS _____ APT. / LOT NO. _____

CITY _____ STATE _____ ZIP _____

BIRTH DATE _____ AGE _____ GENDER _____

SOCIAL SECURITY # _____ HOME PHONE _(_____)_____

E-MAIL _____ CELL PHONE _(_____)_____

MARITAL STATUS: S M D W WORK PHONE _(_____)_____

NUMBER OF CHILDREN _____ OCCUPATION _____

PLACE OF EMPLOYMENT _____

COLLEGE STUDENT: Full Time Part Time Name of School _____

HOW DID YOU HEAR ABOUT US? TV Phonebook Newspaper Website Ins. Co. Drive By
 Friend or Family Member Other _____

INSURANCE: Medicare Medicaid Blue Cross PHP None Other _____

Insured Name _____ D.O.B. _____ Relationship _____

Insured ID # _____ Group # _____

Coverage: Deductible _____ Met? Yes / No Co pay _____

X-Rays _____ # of visits _____ Calendar / Fiscal Year

I UNDERSTAND AND AGREE ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME, AND ANY HEALTH OR ACCIDENT INSURANCE POLICIES ARE BETWEEN THE INSURANCE CARRIER AND MYSELF. DR. VOLZ'S OFFICE WILL ASSIST IN PREPARING ANY NECESSARY FORMS OR REPORTS IN MAKING COLLECTION OF MY ACCOUNT. ALL X-RAYS ARE A PART OF YOUR PATIENT FILE IN THIS OFFICE. ALL INFORMATION THAT I HAVE GIVEN TO YOU IS BELIEVED TO BE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE _____ DATE _____

PRESENT PROBLEM _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____ HAVE YOU HAD IT BEFORE? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

THE PAIN IS SHARP DULL ACHY BURNING SHOOTING NUMBNESS TINGLING

IS CONDITION GETTING WORSE? YES NO CONSTANT COMES & GOES

IS CONDITION INTERFERING WITH YOUR WORK SLEEP DAILY ROUTINE OTHER

RATE THE SEVERITY OF YOUR PAIN (1-mild, 10-unbearable) 1 2 3 4 5 6 7 8 9 10

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? YES / NO NAME _____ WHEN _____

HAVE YOU BEEN TREATED FOR THIS BY AN M.D.? YES / NO NAME _____ WHEN _____

DIAGNOSIS _____ RESULTS _____

ARE YOU TAKING ANY MEDICATION? IF SO WHAT KIND? _____

OPERATIONS? / EXPLAIN _____

HOSPITALIZED? _____

EVER HAD ANY BAD FALLS? / EXPLAIN _____

BROKEN BONES? _____

AUTO ACCIDENTS? / EXPLAIN _____

ARE YOU PREGNANT? / IF SO, DUE DATE? _____

PLEASE CHECK (✓) THE FOLLOWING CONDITIONS THAT YOU HAVE NOW. PUT A 'P' FOR CONDITIONS YOU HAVE HAD IN THE PAST.

- | | | |
|--|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gas / Gas Pains | <input type="checkbox"/> Pain Between Shoulders |
| <input type="checkbox"/> Angina / Heart Attack | <input type="checkbox"/> Gout | <input type="checkbox"/> Pain in Forearm, Elbow |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Pain in Hand, Wrist |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Trouble | <input type="checkbox"/> Pain in Head, Face |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pain in Lower Leg, Foot |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pain in Pelvic Region |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Pain in Thigh, Knee |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hip Pain (Sacroiliac Joint) | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Common Cold | <input type="checkbox"/> Hyper / Hypothyroidism | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Injury to Back | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malaise / Run Down Feeling | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Menstrual Pain (PMS) | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Disc Injuries | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Spasm | <input type="checkbox"/> Unable to Sleep |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Nausea | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Vertigo (Poor Balance) |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Night Sweats | |

Family History

Heart Disease Arthritis Cancer Diabetes Other _____

Daily Habits

Exercise None Light Moderate Heavy Daily

Work Habits Sitting Standing Repetitive Motions Light Labor Heavy Labor

Sleep Positions Side Stomach Back

Do You Smoke? Yes No Packs / Day _____

Do You Drink Alcohol? Yes No Drinks / Week _____

Coffee / Caffeine Drinks? Yes No Cups / Day _____

Do You Have High Stress? Yes No Reason _____

What Vitamins / Nutritional Supplements do you take? _____

My Health Attitude – Please mark which one applies to you.

- Treatment Only** - I only consult a doctor when I have an ache or a pain and discontinue as soon as it is cleared up.
- Prevention** - In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.
- Maintaining Health** - I am conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.
- Family Health** – I take an active part in assisting, informing, and maintaining health, with my family. I am concerned with the long-term affects of good health.

CONSULTATION (For Doctor’s Use Only)

Onset _____

Palliative _____

Provocative _____

Quality of Pain _____

Region/Radiating _____

Site/Severity _____

Time _____

OTHER NOTES AND DETAILS ON FALLS / ACCIDENTS / SURGERY / ETC.



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PATIENT CONSENT

CONSENT FOR CARE:

I voluntarily consent to the rendering of care, including care and performance of procedures. I understand that I am under the care and supervision of the attending Chiropractor and it is the responsibility of the staff to carry out the instructions of the Doctor of Chiropractic

RELEASE OF INFORMATION:

By signing this form, you are granting consent to **Volz Family Chiropractic** to use and disclose protected health information for the purposes of care, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (517) 699-3000. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of care, payment or health care operations. We are not required by laws to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF PREGNANCY / NON-PREGNANCY (Female Patients Only):

I do hereby state to the best of my knowledge, I am pregnant, or pregnancy is suspected. Due Date _____.
OR

I do hereby state to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

Print Patient Name

Patient Signature

If Patient is a MINOR, Signature of Parent or Legal Guardian

Witness



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HIPAA Privacy Papers

I received a summary of the Health Insurance Portability and Accountability Act (HIPAA) as it pertains to this office.

The full disclosure forms are available in the waiting room.

Print PATIENT Name

If patient is a MINOR, Signature of Parent or Legal Guardian

Date



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RECORD RELEASE AUTHORIZATION

DOCTOR / HOSPITAL _____

ADDRESS _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

Volz Family Chiropractic, PLLC
1995 N. Cedar Street, Suite #3
Holt, MI 48842

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

Patient's Signature

Date

Patient's Name (Please Print)

If Patient is a MINOR, Signature of Parent or Legal Guardian

Witness To The Above Signature



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OFFICE, FINANCIAL AND CANCELLATION POLICIES

Thank you for choosing our office to meet your Chiropractic healthcare needs. It is our optimal goal to provide you and your family with the highest quality of chiropractic care, while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your chiropractic needs, we ask you to please observe the following guidelines.

Office and Financial Policies

- We require you to pay any remaining deductible and the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. For your convenience, we accept cash, check, Visa, Mastercard, American Express and Discover.
- We cannot emphasize too strongly that the extent of your insurance benefits is a contract between you, your employer and your insurance company. We are not a party to that contract. We had no input into any of the decision-making. As your chiropractic health care provider, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claim form and sending it in promptly, however, we highly recommend that you know your specific chiropractic benefits before your care begins by calling your insurance company, as you are ultimately responsible for any of the monies not covered by your insurance.

Cancellation Policy

- The office requires a minimum of 24 hours notice if an appointment must be rescheduled. If less than 24 hours notice has been given a \$25 fee will be assessed. In the event that no notice is given and the patient does not show up for their appointment, then a \$45 fee will be assessed. Special circumstances will be taken under consideration. Please note that this fee is not covered by insurance and payment is the patient's responsibility.

I accept full financial responsibility for expenses incurred at Volz Family Chiropractic, Kylene Volz, DC.

I accept full financial responsibility for failures on my part to provide or know my insurance benefits information at the time services are rendered.

I have read and understand the above conditions.

Patient's Name (Please Print)

Signature of Responsible Party

Date