

WELLNESS FIRST CHIROPRACTIC, PLLC
Robert S. Kimberlain, DC

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form.

Your Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Age: _____ Date of Birth: _____ SS#: _____ E-mail: _____

Marital Status: M S D W Drivers License # _____

Your Occupation: _____ Employed by: _____

Address: _____

Your Spouse's Name: _____

Spouse's Employer: _____ Spouse's work phone #: _____

Name of person to contact in case of emergency: _____

Their home and work phone number: _____

Name of nearest relative not living with you: _____

Their phone number: _____

Who referred you to this office so we may thank them? _____

Family Physician: _____

Is your visit due to an accident? Yes / No

I attest that the above information is true and correct to the best of my knowledge.

Patient's Signature: _____ Date _____

Parent or Guardian: _____

Signature: _____ Date _____

Insurance Coverage Information

Medical Insurance:

Insurance Carrier: _____ Phone: _____

Policy Holder name: _____ Policy Number: _____

Group Number: _____

Deductible/Co-pay amount: _____

Workers Compensation Injury:

Was injury/accident reported to supervisor? Yes/No

Name of Supervisor: _____

Date of injury: _____ Date reported: _____

Employer: _____ Work Number: _____

Address: _____

Workers Comp Carrier: _____ Policy #: _____

Carriers Phone: _____ Adjuster: _____

Claim Number: _____

Auto / Personal Injury:

Date of Accident: _____

Have you reported your claim to **your** insurance company? Yes/No

Did you receive and complete your application for benefits? Yes/No

Are you aware of any deductible on your policy for medical benefits? Yes/No

If yes, amount \$ _____.

Insurance Carrier Name: _____ Phone: _____

Adjuster: _____ Claim Number: _____

If you would like to see our payment packages, Please check box.

Patient Name: _____ **Date:** _____

Present Complaints (please circle the appropriate ones) Page 3

GENERAL SYMPTOMS:

NERVOUSNESS	JAW PAIN	CONSTIPATION	LOSS OF APPETITE
IRRITABILITY	DEPRESSION	FATIGUE	TENSION
NAUSEA	LOSS OF SLEEP	BLURRED VISION	DOUBLE VISION
EYE STRAIN/ PAIN	FEAR	MENTAL DULLNESS	LOSS OF MEMORY
ANXIETY	DIZZINESS	LOSS OF SMELL	EARS RINGING OR BUZZING

NECK: PAIN STIFFNESS RESTRICTED MOVEMENT

SHOULDERS: PAIN- RIGHT/ LEFT STIFFNESS PAIN UNDER SHOULDER BLADE

ARMS: UPPER ARM PAIN/NUMBNESS FORE ARM PAIN/NUMBNESS
PINS/NEEDLES- RIGHT/ LEFT/ BOTH

HANDS: PAIN IN HAND/ WRIST PINS/NEEDLES- RIGHT/ LEFT/ BOTH

UPPER BACK/ MID BACK: PAIN STIFFNESS CHEST PAIN SHORTNESS OF BREATH
RIB PAIN MUSCLE SPASMS

LOWER BACK: PAIN STIFFNESS HIP PAIN- RIGHT/ LEFT LEG PAIN-RIGHT/ LEFT
PINS/ NEEDLES IN LEGS- RIGHT/ LEFT

Difficulty in: Standing, Sitting, Bending, Walking

Pain radiation to the: Right arm, Left arm, Right leg, Left leg

Cannot lift: Light, Moderate, Heavy, Repetitive

Pain radiating to: Neck, Base of skull, Ribs, Shoulders, Arms

Pain in the: Foot, Ankle, Knee, Hip, Heel spurs

OTHER: _____

Since the time your complaint(s) began, what, if anything, have you tried that **did not** work? _____

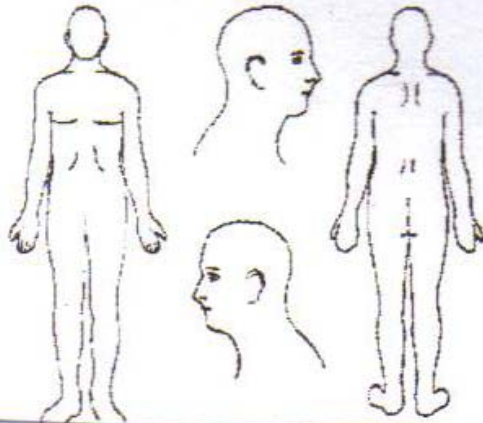
Has the problem interrupted your sleep? Yes / No How:

List any doctors or therapists that you have seen for this complaint:

1. _____ Specialty _____
2. _____ Specialty _____
3. _____ Specialty _____

Patient Name: _____ **Date:** _____

S:



Indicate any areas of pain/problems with the following symbols:
wwwwww – Aches
ooooo – Numbness
xxxxx – Burning
//////// - Stabbing
●●●●● - Pins/Needles

- 1. _____ Level of Pain: (low) 0 1 2 3 4 5 6 7 8 9 10 (worst)
- 2. _____ Level of Pain: (low) 0 1 2 3 4 5 6 7 8 9 10 (worst)
- 3. _____ Level of Pain: (low) 0 1 2 3 4 5 6 7 8 9 10 (worst)
- 4. _____ Level of Pain: (low) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Females Only:

Do you take birth control pills?

- Yes No

Are you taking hormonal replacement therapy?

- Yes No

Is there a chance that you are pregnant?

- Yes No

VERIFICATION OF NON-PREGNANCY By my signature on this form I do hereby state that 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 _____.

X _____

Patient Name: _____ **Date:** _____

WELLNESS FIRST CHIROPRACTIC, PLLC

ROBERT S. KIMBERLAIN, DC

2024 Brownsboro Road

Louisville, KY 40206

(502) 259-9670

THERAPY QUESTIONNAIRE

NAME: _____

DATE: _____

IN OUR OFFICE WE USE VARIOUS THERAPY MODALITIES INCLUDING INTERFERENTIAL STIMULATION, INTERSEGMENTAL TRACTION, MOIST HEAT PACKS AND COLD PACKS. IN ORDER TO PROVIDE YOU WITH PROPER THERAPY PLEASE COMPLETE AND SIGN BELOW.

CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

- METAL INPLANTS- LOCATION _____
- PACEMAKER
- CANCER
- PREGNANT
- HEART CONDITION- SPECIFY _____
- EPILEPSY
- SKIN ERUPTIONS
- RECENT SURGERY- SPECIFY _____
- NERVE DAMAGE PRESENT
- HISTORY OF STROKE
- RECENT SERIOUS INJURY- SPECIFY _____
- NONE OF THE ABOVE

SIGNED

WELLNESS FIRST CHIROPRACTIC, PLLC
Robert S. Kimberlain, DC

OFFICE FINANCIAL POLICY

1. **If You Do Not Have Insurance:** All payments are expected at the time of service. Your personal balance may not exceed \$100 at any time or care may be terminated.

2. **If You Have Insurance:** All deductibles and co-payments are expected ***at the time of service***. You are considered a cash patient until you bring in your insurance information, and we verify and accept your insurance coverage.

Be advised the information given to us by your insurance company is not a guarantee of payment only any estimation of benefits and any coverage is subject to deductibles, co-payments, policy provisions and eligibility at time of service. *If you have any question as to how your insurance company pays or processes your claim, please contact your insurance carrier.*

We ***do not accept assignment for secondary insurance carriers***, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for *payment in full* of any outstanding balance.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

WELLNESS FIRST CHIROPRACTIC, PLLC
Robert S. Kimberlain, DC

PATIENT CONSENT

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Wellness First Chiropractic, PLLC to use and disclose your protected health information for the purposes of treatment, 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, a copy is posted in our waiting room 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 telephoning our office at (502)259-9670. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law 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 on your consent.

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do hereby designate Dr. Robert S. Kimberlain, DC and Wellness First Chiropractic, PLLC to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or health care services benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

Print Patient's Name

X _____

Patient's Signature

X _____ Date _____

Other Than Patient, Print Name & Relationship

X _____