KOSTERMAN
CHIROPRACTIC

Patient Intake Information

First Name: _____

Last Name: _____

Preferred Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

Date of Birth: ____-____-_____

Gender: ☐ Female ☐ Male ☐ Other

Occupation: _____ Location: _____

Name of Spouse: _____

Name of Children: _____

Emergency Contact Name: _____

Phone Number: _____

Are you working with an Attorney? Yes or No, If yes who:_____

What date did the accident occur: _____ - _____ - _____

How did you hear about Kosterman Chiropractic?

Internet **Physician** **Word of Mouth** (Who_____)

Other_____

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Patient Primary Complaint Form

Name: _____ Date: _____

What is the number one thing that is bothering you the most today?

_____

_____

_____

How did your symptoms begin? _____

_____

Pain level: 0 1 2 3 4 5 6 7 8 9 10

Is your condition: Getting Better or Getting Worse

Is your condition: On & Off or Constant

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore

Pain Radiating: Left/Right Base of skull Shoulder Arm Hand

Hip Leg Knee Foot Ribs Other: _____

What makes it better? Ice Heat Rest Movement Stretching

What makes it worse? Sitting Standing Walking Lying down Sleep

Overuse Other: _____

Have you seen anyone else for this condition? _____

Were you involved in an accident? Auto Fall Work

List of Medications you are taking:

_____

_____

List of past surgeries: _____

Do you have any other complaints? _____

_____

Patient Signature: _____

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Functional Rating Index

We must understand how much your symptoms have affected your ability to manage everyday activities. For each item please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain: 25% of the day	Intermittent pain: 50% of the day	Frequent pain: 75% of the day	Constant pain: 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain: any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Internal Use Only 1. Initial [___ / 40 = _____] 2. Follow up [_____ / 40 = _____] Clinical improvement [Total initial - Total follow-up / Total initial = _____

Primary Care Facility: _____

Contact Number: _____

Physician: _____

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Informed Consent

We encourage and support a shared decision-making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science, which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment.

In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life. In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence do not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

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I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective.

Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE:

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TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Patient Name: _____ Patient Signature: _____

Date: _____

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

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Office Policies for Personal Injury Patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctors recommendations and to provide the appropriate financial information so that payment for services can be received. *We will not release any information, such as bills or notes, until the patient has completed and been released from care.*

Patients need to bring the following:

1. Copy of police report and/or a copy of the exchange slip.
2. Name of individual and insurance company of party that is liable. Please include policy number and/or claim number.
3. Copy of personal automobile policy.
   This is to verify medical payments covered by your automobile insurance.
4. Name and telephone number of attorney if one has been retained.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party.

Signature: _____

Date: _____

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Election Not to File Health Insurance Claims
(Personal Injury/Accident)

The chiropractor(s) at this clinic are participating ("in-network") providers for your health benefit plan. As participating providers, we are obligated to file claims for reimbursement with your plan for all covered services provided to you UNLESS you instruct us in writing not to file.

You have indicated that rather than using your own health insurance, you wish to consider seeking payment from other third-party payors such as the at-fault driver's liability insurance. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1. The clinic will rely on your decision and extend credit to you for the cost of care based on the assumption that your bill will be paid by sources other than your health insurance. You will be required to assign to the clinic the right to receive monies paid by liability insurers, medical payments insurers or other third-party payers to the extent necessary to satisfy your bill.

2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.

3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.

4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.

5. None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.

2. You will be responsible for paying to the clinic the cost of any *non-covered* services you elect to receive, and your payment will be due at the time services are rendered.

3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.

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4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance for services associated with this accident/injury, and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payers who are potential sources of payment.
3. I understand that the clinic is relying on my decision not to file health insurance claims, and that with regards to claims related to this accident/injury, this decision is irrevocable.
4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payers; subject only to any contractual obligation the clinic may have to my health benefit plan.

_____
Printed Name of Patient

_____
Signature of Patient
(or parent/legal guardian, as applicable)

_____
Date:

_____
Printed Clinic Representative

_____
Signature of Clinic Representative

_____
Date:

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MEDPAY INFORMATION

A lot of people have benefits included in their automobile policies and don't even realize it. Our office highly recommends that you use your Medpay coverage, if you have it, in the event that you've been injured in an automobile accident, regardless of who is at fault.

Here are 3 reasons why we recommend that we file your Medpay:

1. Medpay is similar to Health Insurance- Using it does not cause your rates to increase. If your rates increase, its not because you filed your Medpay, its most likely because: A) It was determined that you were at fault, B) You received the police citation or ticket, or C) You have been involved in numerous reported auto accidents within a brief period of time and there are not considered to be "high-risk".
2. Filing your Medpay doesn't relieve the other party from having to pay in full for your loss. On the contrary, by filing your Medpay, when you collect from the other driver's Liability Insurance, a greater amount of the settlement will go directly to you because your bill at our office may be paid in full. If the other driver's Liability Insurance refuses to make payment to your for whatever reason, filing your Medpay will help ensure that you are not stuck with all the medical bills.
3. If you have Medpay coverage and chose not to file it, then you are paying for an option but not receiving any benefit from it.

Patient Signature: _____ **Date:** _____

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Assignment of Benefits / Lien

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

IN CONSIDERATION of Kosterman Chiropractic's willingness to treat me on credit without demand of payment at the time services are rendered, I hereby agree and stipulate as follows:

I hereby authorize and direct any and all insurance companies, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, illnesses, past, present, future ("conditions") to pay directly and exclusively to Kosterman chiropractic, from any disability benefits, judgments, settlements, or other perceived of any kind that would otherwise be payable to me. Such sums are do or maybe come do to Kosterman Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check for draft in which I am named payee and to deposits said check or draft and apply the proceeds to any unpaid balance I may have with Kosterman Chiropractic.

I acknowledge that I remain personally liable for the total amount due to Kosterman Chiropractic for services rendered, including any balance remaining after the application of insurance payments and settlements or judgments proceeds. If Kosterman Chiropractic is required to take legal action to recover any unpaid balance on my account, I will reimburse Kosterman chiropractic for the cost of recovery, including reasonable attorney fees.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue an unrestricted letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of the office.

I authorize Kosterman Chiropractic to release to any issuer with applicable coverage or to my attorney any information regarding my injury, illness or treatment as may be necessary to facilitate collection under this assignment and waiver.

Print Name: _____ Signature: _____

Date: _____ Witness: _____

Notice of Lien

Pursuant to N.C.G.S. 44-49 and 44-50, Kosterman Chiropractic hereby assets and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein, "Assignment and Lien") "benefits" shall include, but not limited to, proceeds from any settlement, judgment or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payment benefits, personal injury protection, no fault coverage, insured and uninsured motorist coverage, third party liability distribution, workers compensation benefits, and any other benefits or proceeds payable to me for the purpose of stated hearin.

Kosterman Chiropractic hereby request that if its claims are not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds in continuity with N.C.G.S 44-50.1. Dr. Stephen F. Kosterman agrees to be bound by any confidentiality agreement regarding the contents of the accounting.

Dr. Stephen F. Kosterman _____

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AUTHORIZATION FOR RELEASE OF PATIENT HEALTH RECORDS

Patient Name (Print): _____ Date of Birth: _____
Previous/Maiden Name(if applicable): _____ Phone: _____

Facility/Provider Authorized to Disclose (Releasing Entity):
Name: _____
Address: _____
City/State/Zip: _____
Phone/Fax: _____

Facility/Provider Authorized to Receive of Use (Receiving Entity):
Name: _____
Address: _____
City/State/Zip: _____
Phone/Fax: _____

Information to be disclosed includes copies of:
__ Entire Record or **Partial Record, Including:**
__Daily Chart Notes
__X-ray Reports
__X-ray Films(copies)
__Discharge Summary
__Other, specify: _____
__ Intake Forms/History
__ Physical Examination Forms
__Plan of Treatment
__Consultations/Report of Findings

Purpose for Disclosure:
__ Treatment, Payment, or Operations or __ Other(specify): _____

Expiration: This authorization will expire(select one)
__ Transfer of records is for Treatment purposes, expiration not applicable.
__ On the occurrence of the following event/date: _____

Right to Revoke:
I understand that I have the right to revoke this authorization in writing by presenting the revocation to the clinic manager at Dr. Stephen F Kosterman Chiropractor, PA. I understand that revocation will not apply to information that has already been released prior to written revocation.

Signature:
I understand that the facility cannot condition treatment on whether I sign this authorization. I understand that authorizing the disclosure of this health information is voluntary and I may refuse to sign the authorization. A copy of this authorization is as valid as the original.

Patient Signature: _____ Date: _____
Legal Representative(if applicable): Name (print): _____
Relationship to Patient: _____
Legal Representative Signature: _____
If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.