**Patient Contact Information** **Today's Date** ______________________
**Last Name** ____________________ **First Name** ____________ Preferred to be called ______________
**Date of Birth** __________________
**Gender** Male/Female
**Social Security Number**: _______________
**Height** ______"
**Circle**: Married/Single/Other
**Circle**: Employed/Full-time Student/Part-time Student/_____________
**Employer**____________________________________ **Occupation**______________________________
**Language** Circle: English/______________
**Smoking status** Current everyday smoker ☐ Current someday smoker ☐ Former smoker ☐ Never smoked

| **Frequency** | ☐ 1-5 cigarettes/day | ☐ 6-10 cigarettes/day | ☐ ½ pack/day | ☐ 1 pack/day |
|---|---|---|---|---|
| (if current) | ☐ 1 ½ pack/day | ☐ 2 pack/day | ☐ 2 ½ pack/day | ☐ 3+ pack/day |

**Are you interested in quitting?** Yes/No

| **Race** | ☐Decline to disclose | ☐ White | ☐ American Indian or Alaska Native | |
|---|---|---|---|---|
| (circle) | ☐Asian Indian | ☐ Black, African American | ☐ Chinese | ☐ Filipino |
| | ☐Guamanian | ☐ Japanese | ☐ Korean | ☐ Samoan |
| | ☐Vietnamese | ☐ Native Hawaiian, Other Pac. Islander | | |
| | ☐Other Asian | ☐Other Race | | |

| **Ethnicity** | Decline to disclose ☐ | Not of Hispanic, Latino, or Spanish Origin |
|---|---|---|
| (circle) | ☐ Puerto Rican | ☐ Another Hispanic, Latino, or Spanish |
| | ☐ Cuban | ☐ Mexican, Mexican American, or Chicano |

Address ______________________________________ City______________ State______ Zip__________
Home (______) ______-_________ Work (______)______-_________ Cell (______)______-_________
**Email** ____________________________________________________

---

**Insurance Information (if applicable)**
Insurance Company ______________________________________________________________
Relationship to patient: Self ____ Spouse ____ Parent ____ (please bring a copy of your insurance card)
Name of the Insured _______________________________________ Insured's Date of Birth______________
Insurance ID # ___________________________ Group # ________________________________________
Plan Name___________________________________________________________________________
Phone # ____________________________________________________________________________

---

Who may we thank for referring you? _____________________________________________________
Have you visited www.KutyChiropractic.com? Circle: Yes/No
Spouse's Name _____________________________________________________________________
Names and Ages of Children ________________________________________________________________
Parents/Guardians (if patient is a minor) ____________________________________________________
Primary Doctor (PCP)____________________Phone # _____________ May we contact your Doctor? Yes/No
Do you have any open liability or work compensation claims? Yes/No
Have you ever been to a Doctor of Chiropractic for treatment? Yes/No
When? ____________ What was the focus of your treatment? ________________________________________

---

**Name** ________________________________**Date of Birth** _____________**Date**________________________

**Your Health**

What health-related concerns prompted today's visit?

1.____________________________________________________________________________
2.____________________________________________________________________________
3.____________________________________________________________________________
4.____________________________________________________________________________

Have you had any imaging or lab work related to these symptoms? Yes/No
If yes, where and when? ________________________________________________________
________________________________________________________________________________

**Symptom 1** ____________________________________________________________________

- On a scale from 0-10, with 10 being the worst, please rate your symptom: 0 1 2 3 4 5 6 7 8 9 10
- When awake, what percentage do you experience the above symptom: 10 20 30 40 50 60 70 80 90 100
- When did the symptom begin? ___________________________________________________
- Did the symptom begin suddenly or gradually? (circle one)
- How did the symptom begin? ____________________________________________________
- What makes the symptom worse? (check all that apply)

| | | | | |
|---|---|---|---|---|
| __ Lying on back | __ Getting in/out of car | __ Housework | __ Walking | __ Standing |
| __ Lying on side | __ Gripping | __ Sleeping | __ Squatting | __ Sneezing |
| __ Turning in bed | __ Dressing self | __ Pulling | __ Bending forward | __ Coughing |
| __ Laying on stomach | __ Kneeling | __ Reaching | __ Bending backward | __ Reading |
| __ Exercise | __ Stretching | __ Computer use | __ Stress | __Sit to Stand |
| __ Moving Neck | __ Getting in/out of bed | __Moving Back | __ Sitting | __ __________ |

- What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, chiropractic, nothing, Other ______________________________________
- Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, annoying, numb, tingling, stiff, swollen, Other ______________________________________
- Does the symptom travel/radiate? (circle): yes no If yes, where? ____________________________
- Is it worse at certain times? (circle) Morning Afternoon Evening Night or Unaffected by time of day

What are your goals related to this symptom?______________________________________________

---

**Symptom 2** ____________________________________________________________________

- On a scale from 0-10, with 10 being the worst, please rate your symptom: 0 1 2 3 4 5 6 7 8 9 10
- When awake, what percentage do you experience the above symptom: 10 20 30 40 50 60 70 80 90 100
- When did the symptom begin? ___________________________________________________
- Did the symptom begin suddenly or gradually? (circle one)
- How did the symptom begin? ____________________________________________________
- What makes the symptom worse? (check all that apply)

| | | | | |
|---|---|---|---|---|
| __ Lying on back | __ Getting in/out of car | __ Housework | __ Walking | __ Standing |
| __ Lying on side | __ Gripping | __ Sleeping | __ Squatting | __ Sneezing |
| __ Turning in bed | __ Dressing self | __ Pulling | __ Bending forward | __ Coughing |
| __ Laying on stomach | __ Kneeling | __ Reaching | __ Bending backward | __ Reading |
| __ Exercise | __ Stretching | __ Computer use | __ Stress | __Sit to Stand |
| __ Moving Neck | __ Getting in/out of bed | __Moving Back | __ Sitting | __ __________ |

- What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, chiropractic, nothing, Other ______________________________________

**Name ________________________________Date of Birth _____________Date________________________**

• Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, annoying, numb, tingling, stiff, swollen, Other ______________________________________________
• Does the symptom travel/radiate? (circle): yes no If yes, where? ___________________________________
• Is it worse at certain times? (circle) Morning Afternoon Evening Night or Unaffected by time of day
What are your goals related to this symptom?_______________________________________________________

---

**Symptom 3** ________________________________________
• On a scale from 0-10, with 10 being the worst, please rate your symptom: 0 1 2 3 4 5 6 7 8 9 10
• When awake, what percentage do you experience the above symptom: 10 20 30 40 50 60 70 80 90 100
• When did the symptom begin? ______________________________________________________
• Did the symptom begin suddenly or gradually? (circle one)
• How did the symptom begin? ________________________________________________
• What makes the symptom worse? (check all that apply)

| __ Lying on back | __ Getting in/out of car | __ Housework | __ Walking | __ Standing |
|---|---|---|---|---|
| __ Lying on side | __ Gripping | __ Sleeping | __ Squatting | __ Sneezing |
| __ Turning in bed | __ Dressing self | __ Pulling | __ Bending forward | __ Coughing |
| __ Laying on stomach | __ Kneeling | __ Reaching | __ Bending backward | __ Reading |
| __ Exercise | __ Stretching | __ Computer use | __ Stress | __Sit to Stand |
| __ Moving Neck | __ Getting in/out of bed | __Moving Back | __ Sitting | __ ________ |

• What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, chiropractic, nothing, Other ____________________________________________
• Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, annoying, numb, tingling, stiff, swollen, Other ______________________________________________
• Does the symptom travel/radiate? (circle): yes no If yes, where? ___________________________________
• Is it worse at certain times? (circle) Morning Afternoon Evening Night or Unaffected by time of day
What are your goals related to this symptom?_______________________________________________________

---

**Symptom 4** ________________________________________
• On a scale from 0-10, with 10 being the worst, please rate your symptom: 0 1 2 3 4 5 6 7 8 9 10
• When awake, what percentage do you experience the above symptom: 10 20 30 40 50 60 70 80 90 100
• When did the symptom begin? ______________________________________________________
• Did the symptom begin suddenly or gradually? (circle one)
• How did the symptom begin? ________________________________________________
• What makes the symptom worse? (check all that apply)

| __ Lying on back | __ Getting in/out of car | __ Housework | __ Walking | __ Standing |
|---|---|---|---|---|
| __ Lying on side | __ Gripping | __ Sleeping | __ Squatting | __ Sneezing |
| __ Turning in bed | __ Dressing self | __ Pulling | __ Bending forward | __ Coughing |
| __ Laying on stomach | __ Kneeling | __ Reaching | __ Bending backward | __ Reading |
| __ Exercise | __ Stretching | __ Computer use | __ Stress | __Sit to Stand |
| __ Moving Neck | __ Getting in/out of bed | __Moving Back | __ Sitting | __ ________ |

• What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, chiropractic, nothing, Other ____________________________________________
• Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, stabbing, deep, nagging, annoying, numb, tingling, stiff, swollen, Other ______________________________________________
• Does the symptom travel/radiate? (circle): yes no If yes, where? ___________________________________
• Is it worse at certain times? (circle) Morning Afternoon Evening Night or Unaffected by time of day
What are your goals related to this symptom?_______________________________________________________

**Name** ______________________________ **Date of Birth** ____________ **Date** _______________________

**Medical History** (check all that apply)

| | | | |
|---|---|---|---|
| __Birth Defect | __High blood pressure | __Weakness | __Swelling |
| __Cancer | __Obesity | __Headache | ____________ |
| __High cholesterol | __Stroke | __Dizziness | ____________ |

**Surgical History** ______________________________________________________________________

______________________________________________________________________________

**Women Only**

Month or year of your last: GYN/OB Exam? ____________ Mammogram? ___________

Menses: __Regular __Irregular __Menopausal __Post-menopausal __Hysterectomy

Hormone Replacement Therapy? Current/Past/No

Are you pregnant? Yes/No ________weeks Are you trying to get pregnant? Yes/No

**Family History** _______________________________________________________________________

______________________________________________________________________________

**Social History**

Rate your quality of sleep (0 none – 10 best) _____ How many hours do you sleep on average? ____________

Rate your energy level (0 none – 10 best) _____ What gives you energy? ___________________________

Rate your stress level (0 none – 10 high) _____ What gives you stress? ____________________________

How many ounces do you drink a day of: Water? _______ Soda? _______ Coffee?________ Tea?________

Alcohol use? Yes/No Type and Frequency? _____________________________________________________

Do you exercise? Yes/No What type of exercise do you do? How often? ______________________________

______________________________________________________________________________

Hobbies? _____________________________________________________________________________

How would you describe your diet? Healthy ________ So-so_______ Not good _______ Poor______________

Are you interested in nutritional counseling? Yes/No

Current weight? ____ Highest Lifetime Weight ____ Are you trying to lose weight? Yes/No

How many hours a week do you work? __________ How many hours a week do you drive? ________________

Do you engage in meditation or prayer? Yes/No

**Allergies** **Reaction**

______________________________________________________________________________

______________________________________________________________________________

**Medications** **Reason**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Vitamins, minerals, or supplements you are taking (please list brands, if known)**

______________________________________________________________________________

______________________________________________________________________________

**Name** ________________________________**Date of Birth** _____________**Date**________________________
Date of accident/incident? ____/___/___ Time?______ □ a.m. □ p.m.
Location?____________________________________________________________________________

| | | | | |
|---|---|---|---|---|
| You were the: | □ Driver | □Passenger Front | □ Passenger Back of Driver | □Passenger Back Side |
| You were hit from | □ Front | □ Rear-ended | □Driver's Side | □ Passenger's Side |
| The other car was: | □ Stopped | □ Moving. How fast? ~_______mph | | |
| You were: | □ Stopped | □ Moving. How fast? ~_______mph | | |
| Wearing a seatbelt? | □ Yes | □ No | | |
| Airbags in the car? | □ Yes | □ No | | |
| Airbags deployed? | □ Yes | □ No | | |
| Surprised by impact? | □ Yes | □ No | | |
| You were looking: | □ Forward | □Right | □ Left | □ Up □Down |
| Hit your head: | □ Yes- on windshield | □ Yes- on headrest | □ Yes- on steering wheel | □ No |
| Loss of consciousness? | □ Yes | □ No | | |
| If yes, how long: | □ Not applicable | □_________ | □ Not sure | |
| Pain immediately? | □ Yes □ No | | | |

Briefly explain what happened ________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

| | | | |
|---|---|---|---|
| Police came? | □ Yes | □ No | |
| Paramedics came? | □ Yes | □ No | |
| Recommended ER? | □ Yes | □ No | |
| Did you go? | □ Yes | □ No | |
| Traveled how? | □ Ambulance | □ Drove self | □ Someone took you |
| Saw non-ER doctor? | □ Yes □ No | | |
| When did you go? | □ Just after the accident/injury | □ The next day | □ ____ Days later |

Why did you wait to get care? _______________________________________________________________
Was medication prescribed? □ Yes □ No List._________________________________________________
Did you take the medication? □ Yes □ No If no, why not.______________________________________
Name of hospital and/or name of doctor ______________________________________________________
Were X-rays or imaging taken? □ Yes □ No
Describe any treatment received. ____________________________________________________________
Is your condition □ getting better □ about the same □getting worse

**Have you had:**

| | | | | | |
|---|---|---|---|---|---|
| Bruises/Contusions | □ Yes | □ No | Restriction of movement | □ Yes | □ No |
| Muscle spasms | □ Yes | □ No | Nausea | □ Yes | □ No |
| Dizziness | □ Yes | □ No | Vision disturbances | □ Yes | □ No |
| Radiating pain (traveling pain) | □ Yes | □ No | Depression | □ Yes | □ No |
| Headache | □ Yes | □ No | Anxiety | □ Yes | □ No |
| Have you lost time from work? | □ Yes | □ No | Fear of Driving | □ Yes | □ No |

Are your work activities restricted as a result of this injury? □ Yes □ No
Please describe:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
To whom have you made a report of your injury?
□ Auto Insurance □ Employer □ Attorney □ Other ___________________
What is your attorney's name and number? _______________________________________________

**Name** ________________________________**Date of Birth** _____________**Date**________________________
**Review of Systems: Please note to mark "None" in each section if applicable.**

**Pulmonary (Lung)** □ Allergies □ Asthma □ Difficulty breathing □ COPD □ Emphysema
□ Other ____________ □ **None**

**Cardiovascular (Heart)** □ Heart surgeries □ Congestive heart failure □ Murmurs or valve disease □ Heart attacks □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ Other ___________ □ **None**

**Neurological (Nerve)** □ Loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _______________ □ **None**

**Endocrine (Hormone)** □ Thyroid disease □ Hormone replacement therapy □ Steroid replacements □ Diabetes
□ Other ________________ □ **None**

**Renal (Kidney)** □ Renal stones □ Blood in the urine □ Loss of bladder control □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _________________ □ **None**

**GI (Stomach)** □ Nausea □ Difficulty swallowing □ Ulcerative disease □ Abdominal pain □ Hernia
□ Constipation □ Diarrhea □ Pancreatic disease □ Irritable bowel □ Liver disease □ Bloody stool □ Vomiting
□ Loss of bowel control □ Heartburn □ Other _________ □ **None**

**Blood** □ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV
□ Abnormal bruising □ Sickle-cell □ Enlarged lymph nodes □ Hemophilia □ Blood clots □ Blood thinners
□ Regular aspirin use □ Other _______________ □ **None**

**Dermatological (Skin)** □ Significant burns □ Significant rashes □ Psoriasis □ Other __________ □ **None**

**Musculoskeletal (Bone/Muscle)** □ Osteopenia □ Osteoporosis □ Rheumatoid □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis □ Scoliosis □ Metal implants
□ Jaw pain □ Other ______________ □ **None**

**Psychological** □ Alcohol Abuse □ Drug Abuse □ Anxiety □ Depression □ Suicidal □ Bipolar □ Schizophrenia □ Psychiatric diagnosis
□ Psychiatric hospitalizations □ Other ____________ □ **None**

To what extent are you open to changes to help you improve your health and wellness?
(circle) Eager/ Receptive/ Resistant/ Other ________________________________________________________

Do you have any other concerns about your visit today?_________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

***I certify that I have answered truthfully and to the best of my ability.***

***Printed Name*** ____________________________________________________ ***Date***____________________

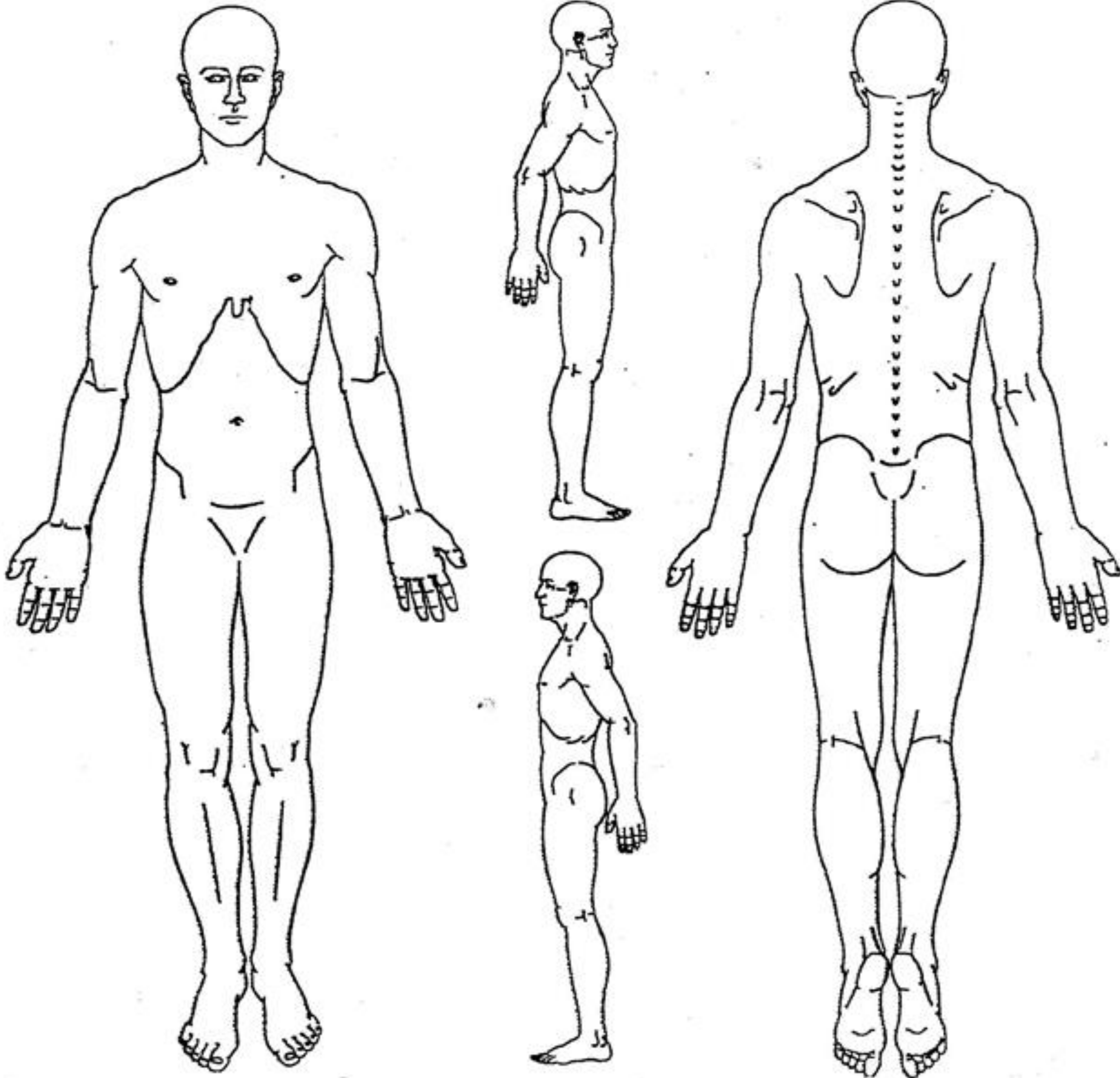
***(sign)***____________________________________ ***(parent/guardian sign)***_____________________________

Name ______________________________Date of Birth ____________Date______________________

# Discomfort Diagram

Use the letters below to indicate the type and location of your sensations right now:

**A = Achy**
**D = Pins and Needles**
**B = Burning**
**S = Stabbing**
**N = Numbness**
**T = Throbbing**
**O = Other**



______________________________________________________________________________

**Name ________________________________Date of Birth _____________Date_________________________**

## Pain Dysfunction Questionaire (Spine 2004)

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by **MAKING AN "X" ALONG THE LINE** to rate how much your pain problem has affected you from 0 to 10 (from having no problems at all to having the most severe problems you can imagine).

**BE SURE TO ANSWER ALL QUESTIONS.**

**0 1 2 3 4 5 6 7 8 9 10**

F1. Does your pain interfere with your normal work inside and outside the home?
]______________]______________]______________]______________]______________]
Work Normally — Unable to work at all

F2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
]______________]______________]______________]______________]______________]
Take care of my self completely — Need help with personal care

F3. Does your pain interfere with your traveling?
]______________]______________]______________]______________]______________]
Travel anywhere I like — Only travel to see doctors

F4. Does your pain affect your ability to sit or stand?
]______________]______________]______________]______________]______________]
No problems — Cannot sit/stand at all

F5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
]______________]______________]______________]______________]______________]
No problems — Cannot do at all

F6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
]______________]______________]______________]______________]______________]
No problems — Cannot do at all

F7. Does your pain affect your ability to walk or run?
]______________]______________]______________]______________]______________]
No problems — Cannot walk/run at all

P8. Has your income declined since your pain began?
]______________]______________]______________]______________]______________]
No decline — Lost all income

P9. Do you have to take pain medication every day to control your pain?
]______________]______________]______________]______________]______________]
No medication needed — On pain medication throughout the day

P10. Does your pain force you to see doctors much more often than before your pain began?
]______________]______________]______________]______________]______________]
Never see doctors — See doctors weekly

P11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
]______________]______________]______________]______________]______________]
No problem — Never see them

F12. Does your pain interfere with recreational activities and hobbies that important to you?
]______________]______________]______________]______________]______________]
No interference — Total interference

F13. Do you need the help of your family and friends to complete everyday tasks (both housework and outside work) because of your pain?
]______________]______________]______________]______________]______________]
Never need help — Need help all the time

P14. Do you now feel more depressed, tense, or anxious than before your pain began?
]______________]______________]______________]______________]______________]
No depression/tension — Severe depression/tension

P15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
]______________]______________]______________]______________]______________]
No problems — Severe problems

FSC__________ PC__________ Total___________

**Name ________________________________Date of Birth _____________Date_________________________**

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Kuty Chiropractic LLC's Notice of Privacy Practices, which has an effective date of 9/21/13 and which describes how my health information may be used and disclosed.

I understand that Kuty Chiropractic LLC has the right to change the Notice of Privacy Practices at any time, that a copy of any updated version will be available on the website, and that I may contact you at any time to request a current Notice of Privacy Practices.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

__________________________________________ ____________________

Signature of Patient or Patient's Representative Date

____________________________________________________

Print Name

____________________________________________________

Relationship to Patient (If not signed by the Patient)

**Name** ________________________________**Date of Birth** _____________**Date**_________________________

**Responsibility for Payment**
I understand that I am responsible to verify my insurance eligibility and coverage. If my insurance company denies any portion of my bill, denies visits or medical necessity, applies an unexpected portion to deductible, or does not pay for another reason not here listed, the following applies: I understand that the terms of coverage conveyed to me by this office or by a representative/website from my insurance carrier do not guarantee payment or accuracy. Final payment determination is made by my insurance company upon receipt of the claim and review of documents. I agree to pay any unpaid charges.
________________ Initial to accept

**Assignment of Benefits**
I hereby authorize and direct my insurance company to pay directly to Kuty Chiropractic such sums as may be due for services rendered. Any funds I receive as payment for services, I agree to promptly direct to Kuty Chiropractic. Any overages may be applied to any non-covered charges.
________________ Initial to accept

**Insurance Follow-Up**
I understand that it is my responsibility to follow up with my insurance company on incorrectly applied payments, underpayments, and denied charges. I agree to pay the difference between contracted amounts and payments provided to Kuty Chiropractic from my insurance company. As a courtesy Kuty Chiropractic may make an attempt to correct my insurance company's errors, but I understand that I am responsible to coordinate appeals with the insurance company with whom I have contracted.
________________ Initial to accept

**Failure to Pay**
If I suspend or terminate my treatment, any fees for services will come immediately due and payable. I understand that I am fully responsible for any costs to collect my bill. Costs may include, but are not limited to collection agency fees, attorney's fees, and court costs deemed necessary by Kuty Chiropractic to collect my bill. I understand that I will be charged a $30 late fee per month for any balances due past 30 days. I additionally understand that I will be charged interest of 5% per year on any unpaid balances.
________________ Initial to accept

**Designation of Authorized Representative**
I designate Dr. Jolene Kuty and Kuty Chiropractic 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 health care expenses incurred as a result of the services I receive at Kuty Chiropractic. These rights include acting 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 health care reimbursements.
________________ Initial to accept

**Contacting You**
I agree to update Kuty Chiropractic with any contact changes. I give permission to Kuty Chiropractic to send me mail and send emails. I understand that Kuty Chiropractic may call. Financial statements will be sent to my address on file. I understand I am responsible to update the office with changes to address, phone, and email. I further understand if I fail to update my information, my insurance company may deny my bill and I will be responsible for charges.
________________ Initial to accept

**Informed Consent: Permission to Treat**
I hereby authorize Kuty Chiropractic, including Dr. Kuty and staff, to treat my conditions as deemed appropriate. I certify that the information given to Kuty Chiropractic is correct and complete to the best of my knowledge. I will not hold Kuty Chiropractic responsible for any pre-existing medically diagnosed conditions or any errors or omissions that I may have made in the completion of any documents.
________________ Initial to accept

**Informed Consent: Understanding the Risks**
Chiropractic, along with other types of health care, is associated with potential risks. There are also risks of non-treatment by Kuty Chiropractic or other health care providers and delay of other services. Chiropractic is generally considered remarkably safe though I understand that, as in practice of all health care, there are some risks to treatment. Sometimes patients experience post treatment soreness. I will tell the doctor if I experience soreness. Occasionally treatment may aggravate or cause an injury, for example to a joint, ligament, tendon, or other soft tissue. Adjustments, in rare cases, may cause a fracture. Care is taken to minimize these risks. All X-rays are harmful radiation and have associated radiation risks. Ice or heat may cause minor skin burns. Based on the latest research, stroke is not considered a side effect of chiropractic care. Please tell Dr. Kuty all your symptoms, even those you deem unrelated. Any side effects to treatment should be reported to Kuty Chiropractic promptly. 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 exam and procedures based the doctors opinions at the time, based on the facts then known, and acting in my best interest. I understand that when appropriate Dr. Kuty or Kuty Chiropractic may refer me to another provider and I agree to follow up on these referrals. I understand that Kuty Chiropractic does not promise any cure for any symptom, condition, or disease as a result of this treatment. I understand that Kuty Chiropractic attempts to provide me with their very best care.
________________ Initial to accept

**File Property**
All health care files are the property of Kuty Chiropractic and will remain on the property of this office.
________________ Initial to accept

**Keeping my Appointments- Rescheduling and No-Show Fees**
I understand that keeping my appointments is important to the success of my prescribed treatment plan. I agree to pay **$20 for rescheduling without 24 hours notice** and **$35 if I do not show up** for my appointment.
________________ Initial to accept

**Copy of This Agreement for your Records**
I understand that Kuty Chiropractic is offering me a copy of these agreements including HIPAA Notice of Privacy Practices and I have let them know if I would like a copy for my records. Further, I understand that this information is available to me by request at a later date.
________________ Initial to accept

**I read and understood this entire document. I, ______________________, ______________accept and consent to all of the above.** (**Patient printed name**, **Date of birth**)

| ____________________________ | _____ | _________________________ | _____ |
|---|---|---|---|
| **Signature of patient** | **Date** | **Signature of staff** | **Date** |

I hereby authorize Dr. Jolene Kuty, Kuty Chiropractic LLC, and whomever she may designate as assistants to administer examinations and treatment as deemed necessary to the minor of which I am parent or legal guardian.

| ____________________________ | _____ | _________________________ | _____ |
|---|---|---|---|
| **Signature of guardian if applicable** | **Date** | **Printed name of guardian** | **Date** |

## Accident Injury Statement of Responsibility at Kuty Chiropractic, LLC

**Name ________________________________Date of Birth _____________Date_________________________**

**Deciding How to Pay for Treatment When You Have Been Injured**

When you've been in an accident, both the State of Arizona and Kuty Chiropractic want you to be able to seek out and afford to receive health care. Under Arizona's Collateral Source Rule you may bill: 1) private insurance 2) MedPay (medical payments under your car insurance **AND/OR** 3) a 3rd party liability (the person's insurance who hit you) and/ or that person. You also have the right to self pay for care and seek reimbursement after the fact. We try to make the process of getting paid for your health bills easier for you. First we ask that you let us know if you want us to bill 1, 2, AND/OR 3 of the above choices, or none.

**Private Insurance**:

Sometimes people choose to bill their private insurance to make sure someone pays the bill in case the liability company does not pay or accept liability. Some choose not to bill their health insurance because they have limited chiropractic visits per year or a managed plan, and they want to save those visits for after the accident coverage to be used later. Some insurance companies will not pay if injuries are due to an auto accident and some one else is at fault. If your insurance, post-payment, denies your bill for being due to an accident, you are responsible for the entire bill. If you choose to only bill your private insurance for payment, you are responsible to pay your co-pays, co-insurance, and deductibles at the time of your visit.

**Medpay (Medical Pay):**

Some people have a MedPay plan on their car insurance policy. This is an additional item that you PAY for to cover you if you are injured in an accident. Usually these policies cover $5000-$10000 in care and may bridge the gap on your insurance deductible, cover you if you are injured by an uninsured or underinsured motorist, or pay for care in offices that don't accept you on lien. We can help you look at your declarations page of your insurance to see if you have MedPay. Some choose not to bill MedPay thinking it may raise policy costs; please check with your car insurance carrier or agent. When billing MedPay, we wait for payment until the end of your case and usually you are not responsible for any payments along the way.

**3rd Party Liability:**

Billing the insurance of the person who hit you or that person directly gives them the responsibility to pay for injures sustained in an accident. Most people choose to have us assist them in billing their liability insurance. While it may sometimes require some effort, most still choose to use this option alone or along with another option. When billing a 3rd party liability, we wait for payment until the end of your case and usually you are not responsible for any payments along the way.

**Self Pay:**

You may pay for treatment out of pocket. Some people want to pay upfront and handle all the settlement themselves. You may use this option to take advantage of our pay at the time of service discounts. Most people choose not to use this option due to the high out-of-pocket costs. It may take a few months up to 2 years to be reimbursed by insurance or 3rd party liability. Patients and insurance carriers may take advantage of Pay at Time of Service discounts. If payments are not made at the time of service, they are subject to full fee.

**Overpayment:**

If you choose to use more than one method of payment and there is an overpayment for the total of your account balance, the overpayment will be refunded to you as part of your settlement.

Name ________________________________Date of Birth _____________Date________________________

**Lien Acceptance for Billing 3rd Parties:**

When Kuty Chiropractic bills a 3rd party liability on your behalf, we assign a **medical lien.** This is a legal binding document filed with the Maricopa County Recorder's Office to protect that Kuty Chiropractic receives payment for your claim.

In consideration of Kuty Chiropractic, LLC (known from here on as Kuty Chiropractic) undertaking to treat me, I agree to the following:

**Authorization to Release Information**

Kuty Chiropractic is authorized to release any information that they deem appropriate concerning my judicial condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges by me as a result of professional services rendered by Kuty Chiropractic. I hereby release Kuty Chiropractic of any consequence thereof.

_______________ Initial to accept

**Authorization to Pay Directly to the Doctor**

I authorize a direct payment to Kuty Chiropractic of any sum I now or hereafter owe Kuty Chiropractic by my attorney our of the proceeds of any settlement of my case and/or by any insurance company obligated to reimburse me for the charges of your services in whole or in part. I also give this office power of attorney to endorse checks made out to me in regards to this case to be credited to my account.

_______________ Initial to accept

**Authorization of Lien Assignment**

I hereby knowingly grant authorization and give my permission to Kuty Chiropractic to record and serve a lien assignment upon myself and all parties who may be liable to me for damages arising from the claim from which I am about to receive care. I understand that by doing so I have entered into a contractual obligation with Kuty Chiropractic that guarantees payment of service by assigning to said provider any and all 1st party or 3rd party benefits and the monies that I may be entitled to by reason of the injuries I have sustained in such amount as is necessary to pay the providers bill.

_______________ Initial to accept

I understand that payment will include an administrative expense with processing my claim to include the charges by Kuty Chiropractic for recording and serving a lien assignment upon any liable parties and their insurance companies.

_______________ Initial to accept

I further understand that as part of the process of recording a public record, I will receive certified mail with a copy of the lien assignment enclosed and that this copy is for my own records and does not require a response.

_______________ Initial to accept

**Acceptance of Fee Schedule**

A list of fees is available for your inspection upon inquiry with Kuty Chiropractic. You are being given the opportunity to review the listed fees for reasonableness, and for being customary within the geographical vicinity, and that by accepting services I agree that the listed fees are reasonable and customary and waive the right to argue otherwise later.

_______________ Initial to accept

________________________ ___________________________________ _____

Printed Name Signature Date

**Name ________________________________Date of Birth _____________Date_________________________**

**Acknowledgement and Understanding**

I hereby acknowledge that I am receiving (or about to receive) health care services at Kuty Chiropractic and that I have been advised that the doctors providing services are willing to wait for payment of these services provided that there continues to be a responsible chance that payment will be made either by insurance proceeds or out of the settlement of the 3rd party liability claim.

_______________ Initial to accept

I understand that IF: 1) There is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge assignment to the doctor or make other provisions for the protection of the doctor; or 2) A liability claim exists and my attorney refuses to protect the interests of the doctor or if I have not engaged the services of any attorney; THEN: I am responsible for payment of services rendered by Kuty Chiropractic. Payment will made on a current basis and my bill paid in full as soon as my liability payment is settled or the passage of 3 months from last treatment, whichever occurs first. If I fail to pay my bill, Failure of Payment fees will apply.

_______________ Initial to accept

________________________ ____________________________________ _____

Printed Name Signature Date

**Attorney Agreement**

The undersigned being attorney of record or authorized representative for the above patient does herby acknowledge the above claim and does agree to honor the same to protect adequately Dr. Jolene Kuty and Kuty Chiropractic.

________________________________ ___________________________________ _____

Attorney/Representative Printed Name Signature Date

**Name _______________________________Date of Birth _____________Date________________________**

**1. Private Insurance: __________________________**
a) Per Calendar Year or Per Year Other _______to_________
b) Deductible $_____ Total Met $_______
c) Exam co-pay $_______ Co-pay per visit $________ Co-insurance per visit ______%
d) Max payment per treatment $_______ Max Total pay $_________ Max number of treatments #________
Max out of pocket $ _________ Out of Pocket met? Yes or No
5) Does this policy need a referral? Yes or No
6) Your policy is authorized by CHIROSOURCE or ACN or AXIA? Yes or No
□ If checked your insurance does not cover your physiotherapy, this is an additional $30 charge per visit.
7) We can not bill Medicare, Medicaid, or AHCCCS for your injuries services.

**CHOOSE ONE:**
1) _______________ I would like Kuty Chiropractic to bill my private health insurance for my visits.
2) _______________ I do not want Kuty Chiropractic to bill my private health insurance for my visits.

**2. MedPay (Medical Payment) from Your Car Insurance Policy**:_________________________
a) Benefit $______________
b) Other______________________________________________________________________

**CHOOSE ONE:**
1) _______________ I would like Kuty Chiropractic to bill my MedPay for my visits.
2) _______________ I do not want Kuty Chiropractic to bill my MedPay for my visits.

**3. 3rd Party Liability : __________________________**
a) We will bill the party at fault in the accident on your behalf. Typically your bill is paid from the settlement total. Typically, your settlement will cover the entirety of your bill.
b) Other______________________________________________________________________

**CHOOSE ONE:**
1) _______________ I would like Kuty Chiropractic to bill the 3rd party liability for my visits.
2) _______________ I do not want Kuty Chiropractic to bill the 3rd party liability for my visits.

**4. Pay at Time of Service Discounts- Self Pay or No Insurance Coverage:**
a) You pay up front or at the time of service for treatment.

**CHOOSE ONE:**
1) _______________ I will be responsible for my bill and pay at the time of service, not options 1, 2, or 3.
2) _______________ I do not want to use the time of service, self-pay discount. I choose options 1, 2, &/or 3.

I choose (circle all that apply): Insurance, Medpay, and /or 3rd Party Liability, **OR** Time of Service
Estimate for today's visit: $_______ Estimate for additional visits: $_______
Other:_________________________________________________________________

I understand that the above estimations are a courtesy based on knowledge to date by Kuty Chiropractic, LLC (referred to as Kuty Chiropractic for the remainder of the document). This is not a guarantee of benefits or coverage. I understand that billing may vary per treatment day depending on the care required.
**Whether by self-pay or by insurance, I agree to pay for my bill in full.**

_______________________ __________________________________ _____
Printed Name Signature Date

**Please bring the following items with you to your appointment:**

- **Copy of the police report**
- **Your car insurance policy declarations page**
- **The name and insurance information of the at fault party(ies)**
- **Incident Claim Number (if you have one already)**
- **Any Xrays or MRIs you may have had at Emergency or Urgent Care**

**Thank you.**