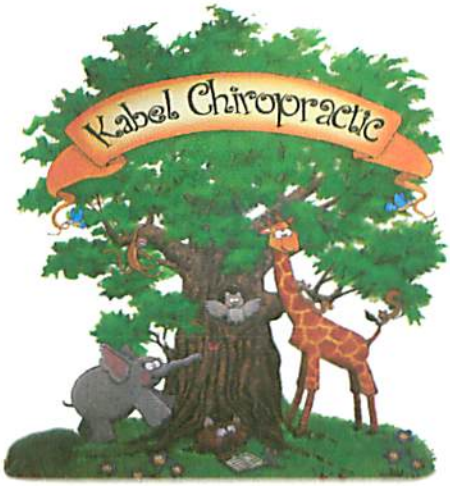

Kabel Chiropractic

Denver's Premiere Wellness Center

Welcome to our office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you.
Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

About the Patient

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____

Cell Phone (_____) _____

Birthdate _____ Age _____

Gender ❒M ❒F Number of Children _____

Employer _____

Work Address _____

Work Phone _____

Type of Work _____

Marital Status ❒ Married ❒ Single ❒ Divorced
❒ Separated ❒ Widowed

Email Address _____

Social Security # _____

Credit Card number to be put on file for outstanding balances. This card WILL NOT be charged before informing you first.

Credit Card# _____

Exp: _____

Reason For This Visit

Describe the purpose of this visit: _____

_____

_____

Is the purpose of this appointment related to:

❒ Sports ❒ Chronic Discomfort ❒ Injury ❒ Other

Please Explain: _____

_____

When did this condition begin? _____

Is it: ❒ getting worse ❒ staying constant ❒ off & on

Does this condition interfere with:

❒ work ❒ sleep ❒ daily routine ❒ other activities

Please Explain _____

Has this condition occurred before? ❒ Yes ❒ No

Explain _____

What level is your pain?

_____

0 No Pain 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Have you seen other doctors for this? ❒Yes ❒No

Dr.'s Name (s) _____

Type of treatment _____

Results _____

Experience With Chiropractic

Who referred you to this office? _____

Have you been adjusted by a chiropractor before? ❒ Yes ❒ No

Reason for those visits? _____

Doctor's Name _____

Approximate date of last visit? _____

Has any *adult* in your family seen a chiropractor? ❒ Yes ❒ No

Has any *child* in your family seen a chiropractor? ❒ yes ❒ No

Awareness of Chiropractic Principles

Were you aware that .....

Doctors of chiropractic work with the nervous system? ❒ Yes ❒ No

The nervous system controls all bodily functions and systems? ❒ Yes ❒ No

Chiropractic is the largest natural healing profession in the world? ❒ Yes ❒ No

If chiropractic care starts at birth, you can achieve a higher level of health throughout life? ❒ Yes ❒ No

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies (wellness 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: Symptomatic relief of pain or discomfort
- ❒ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms.
- ❒ Wellness Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ❒ I want the doctor to select the type of care appropriate for my condition.

_____

Patient 's Signature Date

Medications I Now Take

- ❒ Nerve Pills
- ❒ Pain Killers (including Aspirins)
- ❒ Muscle Relaxers
- ❒ Blood Pressure Medicine
- ❒ Insulin
- ❒ Stimulants
- ❒ Blood Thinners
- ❒ _____
- ❒ _____
- ❒ _____

Health Habits

	No	Yes
Do you smoke?	❒	❒
Do you drink alcohol?	❒	❒
Do you drink coffee?	❒	❒

Do you exercise regularly? ❒ No ❒ Moderate ❒ Daily

Do you wear ❒ Heel Lifts ❒ Sole lifts ❒ Inner Soles ❒ Arch Supports

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ❒ Severe or Frequent Headaches
- ❒ Sinus Problems
- ❒ Dizziness
- ❒ Cancer
- ❒ Loss of Sleep
- ❒ Hepatitis
- ❒ Pain Between the Shoulders
- ❒ Frequent Neck Pain
- ❒ Numbness or Pain in
- ❒ Arms/Legs/Hands
- ❒ Lower Back Problems
- ❒ Digestive Problems
- ❒ Ulcers/Colitis
- ❒ Heart Attack/Stroke
- ❒ Thyroid Problems
- ❒ Kidney Problems
- ❒ Congenital Heart Detect
- ❒ Heart Surgery/Pacemaker
- ❒ High/low Blood Pressure
- ❒ Psychiatric Problems
- ❒ Difficulty Breathing
- ❒ Rheumatic Fever
- ❒ Asthma
- ❒ Arthritis
- ❒ Alcohol/Drug Abuse
- ❒ Venereal Disease
- ❒ HIV/AIDS
- ❒ Diabetes
- ❒ Tuberculosis
- ❒ Shingles
- ❒ Chemotherapy
- ❒ Anemia

FOR WOMEN ONLY:

Are you pregnant?
❒ Yes ❒ No

Are you nursing?
❒ Yes ❒ No

Are you taking birth control?
❒ Yes ❒ No

Do you experience painful periods?
❒ Yes ❒ No

Do you have irregular cycles?
❒ Yes ❒ No

Do you have breast implants?
❒ Yes ❒ No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

_____ _____

Patient Signature Date Guardian or Spouse/s Signature Date

Who should receive bills for payment on account?

❒ Patient ❒ Spouse ❒ Parent ❒ Worker 's Comp.

❒ Medicare ❒ Personal Health Insurance ❒ Auto Insurance

Ownership of X-Ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-Rays only. The X-Ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Emergency Contact

Name _____

Relationship _____

Work Phone _____

Home Phone _____

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor 's Office will provide any necessary reports and forms to assist me in collecting 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.

Signature: _____ Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

I therefore accept chiropractic care on this basis.

_____ _____

(signature) (date)

Kabel Chiropractic 2209 Wildcat Reserve Pkwy E-3 Phone: 720-489-1450 Fax: 720-489-1890

Office Fee Schedule and Financial Policy

Service	Regular Fee	Time of Service Discounted Fee
Consultation	No charge	No charge
Initial Exam with Computer Scans	$85	$50
X-Rays (per view)	$108-130	$50-100
Periodic Dynamic Exam	$65	$45
Adjustment	$45-90	$45
Wellness Adjustment Plans	Not applicable	$82 - $165 / month

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include Corrective Adjustment Plans (CAP) and Wellness Adjustment Plans (WAP). Details of these plans will be discussed with you during your chiropractic report. Please choose one of the following fee options:

- ☐ **Regular Fees:** If you have health insurance that covers chiropractic and choose to use it, you will be charged the regular fees listed above. We will file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to you. Please note that insurance may not be used for Wellness Adjustment Plans.

- ☐ **Time of Service Discounted Fees:** If you do not have health insurance, choose not to use your health insurance or are participating in a Wellness Adjustment Plan, you will be eligible for the time of service discounted fees above. You will be given a receipt for tax purposes or a health savings account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

  If a special situation arises, such as an auto accident or a worker's compensation injury, you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims. Once the claim is complete, you can begin to pay the discounted fees again.

I, (name) _____ have read and I understand the above policies. I have checked the fee option that applies to me.

_____

Patient signature Date

Kabel Chiropractic 2209 Wildcat Reserve Pkwy E-3 Phone: 720-489-1450 Fax: 720-489-1890

Patient Authorization

The Chiropractic Office of Dr. James M. Kabel

Patient Authorization regarding chiropractic care being provided in an "open adjusting" environment.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Kabel or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (printed)	Signature	Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Kabel Chiropractic, Dr. James M. Kabel, D.C.
2209 Wildcat Reserve Pkwy, Unit E3, Highlands Ranch 80129
(720) 489-1450 fax: (720) 489-1890

The New Federal HIPPA Laws

How your health information may be used:

TO PROVIDE TREATMENT – We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

TO OBTAIN PAYMENT – We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

TO CONDUCT HEALTH CARE OPERATIONS – Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, inters, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

IN PATIENT REMINDERS – Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or service that may of interest to you or your family.

ABUSE OR NEGLECT – We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

PUBLIC HEALTH AND NATIONAL SECURITY – We may be required to disclose to federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

FOR LAW ENFORCEMENT – As permitted or required be State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstance, if you are a victim of a crime or in order to report a crime.

FAMILY, FRIENDS AND CAREGIVERS – we may share your health information with those you tell us will be helping you with you home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergence, where you are unable to tell us what you want we will use out very best judgment when sharing your information only when it will be important to those participating in providing your care.

TO CORONERS, FUNERAL DIRECTORS AND MEDICAL EXAMINERS – We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

MEDICAL RESEARCH – Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

AUTHORIZATION TO USE OR DISCLOSE HEATLH INFORMATION – Other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization, in writing at any time.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS – You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

CONFIDENTIAL COMUNICATIONS – You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family member present or through mail communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION – You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a coy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

AMEND YOUR HEALTH INFORMATION – You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

DOCUMENTATION OF HEALTH INFORMATION – You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

REQUEST A PAPER COPY OF THIS NOTICE - You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by low to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or to the Secretary of Health and Hyman Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Privacy Policy Acknowledgement

I have received the Notice of Privacy Policies and I have been provided with an opportunity to review it.

Name: _____ DOB: _____

Signature: _____

Date: _____