



**1995 N Cedar St., Suite #3  
Holt, MI 48842  
Office: (517) 699-3000  
Fax: (517) 699-3610  
www.volzchiro.com**

CASE # \_\_\_\_\_

DATE \_\_\_\_\_

1<sup>ST</sup> APPT. \_\_\_\_\_

2<sup>ND</sup> APPT. \_\_\_\_\_

**NEW PATIENT LOG**

NAME \_\_\_\_\_ "NICKNAME" \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT. / LOT NO. \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ GENDER \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ HOME PHONE \_(\_\_\_\_\_) \_\_\_\_\_

E-MAIL \_\_\_\_\_ CELL PHONE \_(\_\_\_\_\_) \_\_\_\_\_

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

NUMBER OF CHILDREN \_\_\_\_\_ OCCUPATION \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_

COLLEGE STUDENT:  Full Time  Part Time Name of School \_\_\_\_\_

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

INSURANCE:  Medicare  Medicaid  Blue Cross  PHP  None  Other \_\_\_\_\_

Insured Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship \_\_\_\_\_

Insured ID # \_\_\_\_\_ Group # \_\_\_\_\_

Coverage: Deductible \_\_\_\_\_ Met? Yes / No Co pay \_\_\_\_\_

X-Rays \_\_\_\_\_ # of visits \_\_\_\_\_ Calendar / Fiscal Year \_\_\_\_\_

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

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRESENT PROBLEM \_\_\_\_\_

HOW LONG HAVE YOU HAD THIS PROBLEM? \_\_\_\_\_ HAVE YOU HAD IT BEFORE? \_\_\_\_\_

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? \_\_\_\_\_

THE PAIN IS  SHARP  DULL  ACHY  BURNING  SHOOTING  NUMBNESS  TINGLING

IS CONDITION GETTING WORSE?  YES  NO  CONSTANT  COMES & GOES

IS CONDITION INTERFERING WITH YOUR  WORK  SLEEP  DAILY ROUTINE  OTHER

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

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

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

DIAGNOSIS \_\_\_\_\_ RESULTS \_\_\_\_\_

ARE YOU TAKING ANY MEDICATION? IF SO WHAT KIND? \_\_\_\_\_

OPERATIONS? / EXPLAIN \_\_\_\_\_

HOSPITALIZED? \_\_\_\_\_

EVER HAD ANY BAD FALLS? / EXPLAIN \_\_\_\_\_

BROKEN BONES? \_\_\_\_\_

AUTO ACCIDENTS? / EXPLAIN \_\_\_\_\_

ARE YOU PREGNANT? / IF SO, DUE DATE? \_\_\_\_\_

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

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

**Family History**

Heart Disease       Arthritis       Cancer       Diabetes       Other \_\_\_\_\_

**Daily Habits**

Exercise       None       Light       Moderate       Heavy       Daily

Work Habits     Sitting     Standing     Repetitive Motions     Light Labor     Heavy Labor

Sleep Positions     Side       Stomach       Back

Do You Smoke?       Yes       No      Packs / Day \_\_\_\_\_

Do You Drink Alcohol?       Yes       No      Drinks / Week \_\_\_\_\_

Coffee / Caffeine Drinks?       Yes       No      Cups / Day \_\_\_\_\_

Do You Have High Stress?       Yes       No      Reason \_\_\_\_\_

What Vitamins / Nutritional Supplements do you take? \_\_\_\_\_

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

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

**CONSULTATION** (For Doctor’s Use Only)

Onset \_\_\_\_\_

Palliative \_\_\_\_\_

Provocative \_\_\_\_\_

Quality of Pain \_\_\_\_\_

Region/Radiating \_\_\_\_\_

Site/Severity \_\_\_\_\_

Time \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



1995 N. Cedar Street, Suite #3  
Holt, MI 48842  
Phone #: (517) 699-3000  
Fax #: (517) 699-3610  
[www.volzchiro.com](http://www.volzchiro.com)

## **HIPAA Privacy Papers**

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

The full disclosure forms are available in the waiting room.

---

Print PATIENT Name

---

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

---

Date



1995 N. Cedar Street, Suite #3  
Holt, MI 48842  
Phone #: (517) 699-3000  
Fax #: (517) 699-3610  
www.volzchiro.com

### **OFFICE, FINANCIAL AND CANCELLATION POLICIES**

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

#### **Office and Financial Policies**

- We require you to pay any remaining deductible and the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. For your convenience, we accept cash, check, Visa, Mastercard, American Express and Discover.
- We cannot emphasize too strongly that the extent of your insurance benefits is a contract between you, your employer and your insurance company. We are not a party to that contract. We had no input into any of the decision-making. As your chiropractic health care provider, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claim form and sending it in promptly, however, we highly recommend that you know your specific chiropractic benefits before your care begins by calling your insurance company, as you are ultimately responsible for any of the monies not covered by your insurance.
- *Your personal balance may not exceed \$100 at any time or your care may be terminated.*

#### **Cancellation Policy**

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

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

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

**I have read and understand the above conditions.**

---

Patient's Name (Please Print)

---

Date

---

Signature of Responsible Party



1995 N. Cedar Street, Suite #3  
Holt, MI 48842  
Phone #: (517) 699-3000  
Fax #: (517) 699-3610

## **TO OUR PATIENTS**

There are over 1000 insurance plans in America. Therefore, it is IMPOSSIBLE for our office to know the covered benefits of YOUR insurance plan. As a courtesy, we try to verify what coverage you may have to inform you of your benefits before starting care. However, it is the RESPONSIBILITY of the PATIENT to know and understand the policies and benefits of their insurance plan. These include but are not limited to:

1. Required referrals obtained and presented PRIOR to services being rendered.
2. Deductibles, Co-payments and Co-insurances as they are different.
3. Covered exams, re-exams, x-rays, spinal manipulations (aka adjustments), mechanical traction, and massage therapy
4. Necessary prior authorization for procedures (MRI, CT) or specialists
5. Current claim address and phone numbers

SHOULD YOU HAVE ANY QUESTIONS REGARDING YOUR BENEFITS YOU WILL NEED TO CONTACT YOUR INSURANCE COMPANY. THE NUMBER TO REACH CUSTOMER SERVICE IS USUALLY PRINTED ON YOUR INSURANCE CARD OR MAY BE OBTAINED FROM YOUR HUMAN RESOURCES DEPARTMENT OR A PREVIOUS EXPLANATION OF BENEFITS!

---

Patient Signature

---

Date



1995 N. Cedar Street, Suite #3  
Holt, MI 48842  
Phone #: (517) 699-3000  
Fax #: (517) 699-3610  
www.volzchiro.com

## **PATIENT CONSENT**

### **CONSENT FOR CARE:**

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

### **RELEASE OF INFORMATION:**

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

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

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

### **MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:**

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

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

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

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

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Signature

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

\_\_\_\_\_  
Witness