Financial District Chiropractic

Dr. Kai Tiltmann, DC, CAE
Dr. Kris Blum, DC
555 Front Street, San Francisco, CA 94111
Phone: (415) 781-2225, Fax: (415) 781-4115
contact@fdchiro.com
www.fdchiro.com

Personal Information

Name: _____ Today's Date: _____
Last First MI

Age: _____ Birth date: _____/_____/_____ Social Security: _____-_____-_____

Sex: __ Male __ Female Status: ___ Married ___ Single ___ Divorced

Home Address: _____
Street City State Zip Code

Home Phone: (_____)_____ Cell : (_____)_____ Work: (_____)_____

What is your preferred contact time and number? _____

Email address: _____ May we contact you via email: YES / NO

Employer: _____ Occupation: _____

Do you have medical insurance? YES / NO Insurance Company: _____

Policy #:_____ Group number #: _____

How did you hear about us? _____

Medical History

Family Physician: _____ Phone #: (____)_____

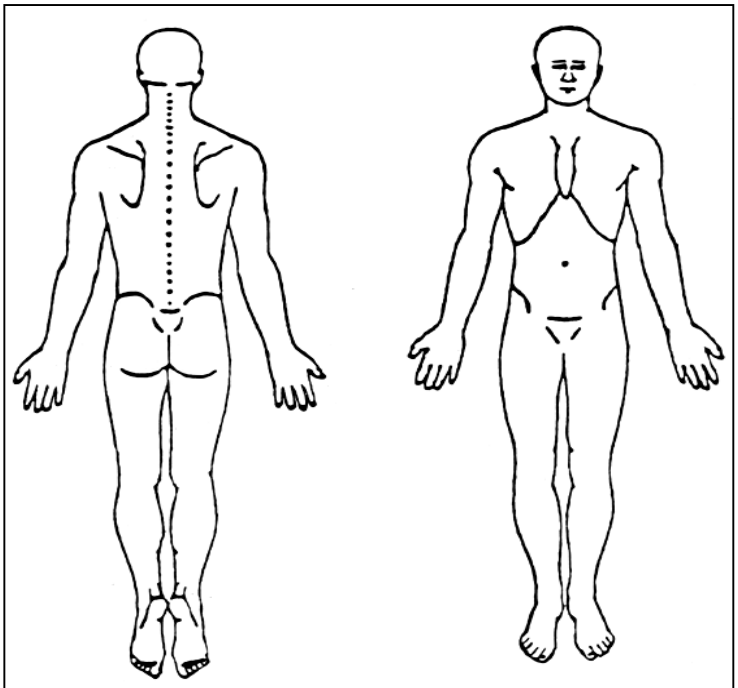
May I inform your medical doctor that we are providing you with treatment for this condition? YES / NO

Please list all surgeries and major medical condition you have had in the past: _____

_____

Please list all medications you are currently using: _____

What type of treatment have you received for this injury? _____



Date problem began: _____/_____/_____

Please describe your problem and how it began

_____

_____

_____

_____

How bad is your pain? (Circle a number)

1 2 3 4 5 6 7 8 9 10 (0 = no pain)

How often are your symptoms?

☐Intermittently (25%) ☐Occasionally (50%)
☐Frequently (75%) ☐Constantly (90-100%)

☜ *Mark the diagram where you have symptoms*

This injury is due to: automobile accident / work injury / other _____

Describe your current pain/symptoms:

☐ Sharp/Stabbing ☐ Throbbing ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness ☐ Numbness

☐ Shooting ☐ Tingling ☐ Burning ☐ Other _____

Do you have or have you experienced the following?

Abnormal Bleeding	☐Yes ☐No	Hemophilia	☐Yes ☐No
Allergies	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Anemia	☐Yes ☐No	Infection	☐Yes ☐No
Arthritis	☐Yes ☐No	Persistent Cough	☐Yes ☐No
Artificial Bones/Joints	☐Yes ☐No	Retention	☐Yes ☐No
Cancer	☐Yes ☐No	Scoliosis	☐Yes ☐No
Depression	☐Yes ☐No	Sciatica	☐Yes ☐No
Diabetes	☐Yes ☐No	Stroke	☐Yes ☐No
Glaucoma	☐Yes ☐No	Urinary/Bowel Incontinence	☐Yes ☐No
Headaches	☐Yes ☐No	Weight Loss/Gain	☐Yes ☐No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. This chiropractic office will prepare insurance forms to assist me in making collections from the insurance company. All services rendered are charged directly to me and I understand that I am personally responsible for payment. If I suspend or terminate my care, any fees for services rendered will be immediately due and payable. All deductibles and copayments are due at the time of service.

I hereby authorize Financial District Chiropractic to furnish all information required by the insurance company concerning my injury or illness.

I give permission and authorize Financial District Chiropractic and Dr. Kai Tiltmann, DC or Dr. Kris Blum DC or associates to render examination and treatment of my condition.

_____/_____/_____

Signature Print Date

Financial District Chiropractic

Dr. Kai Tiltmann, DC, CAE
Dr. Kris Blum, DC
555 Front Street, San Francisco, CA 94111
Phone: (415) 781-2225, Fax: (415) 781-4115
contact@fdchiro.com
www.fdchiro.com

PATIENT PRIVACY NOTICE

THIS ABBREVIATED NOTICE BRIEFLY DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to personnel who are involved in taking care of you.
For Payment: We may use and disclose health information about you so that the services you receive from us may be billed to insurance carriers and payments collected.
For Health Care Operations: We may use and disclose health information about you for operations that are necessary to run our practice.
Threat to Health or Safety: We may use and disclose health information about you when it is necessary to prevent a serious threat to your safety, the health and safety of the public, or another person.
Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs.
Worker's Compensation: We may release health information about you for workers compensation or similar programs. These programs provide benefits for work related injuries or illness.
Health Oversight Activities: We may disclose health information to a health oversight agency as authorized by law.
Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order etc…
Law Enforcement: We may release health information if asked to do so by a law enforcement official.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care.
Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information
Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment and health care operations as previously described.
Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations.
Right to Request Confidential Communication: You have the right to request that we communicate with you about health matters in a certain way or at a certain location.
Right to Paper Copy of This Notice: You have the right to obtain a paper copy of the entire PHI Privacy Notice at any time.

We reserve the right to change this notice at any time. We will post a copy of the current notice in our facility

_____/_____/_____
Signature Print Date

Financial District Chiropractic

Dr. Kai Tiltmann, DC, CAE
Dr. Kris Blum, DC
555 Front Street, San Francisco, CA 94111
Phone: (415) 781-2225, Fax: (415) 781-4115
contact@fdchiro.com
www.fdchiro.com

FINANCIAL POLICY AND INFORMED CONSENT

We would like to welcome you to our office and thank you for choosing Financial District Chiropractic for your health care needs. We appreciate your trust and look forward to keeping you healthy and happy.

As part of our service, we try to contain the ever rising cost of health care. In an effort to do this we have implemented a Financial Policy which we ask you to read and sign.

INSURANCE BENEFITS AND COVERAGE

We request that you provide us the necessary information on your insurance card before the time of your visit so we can verify coverage. As a courtesy to you, our staff will contact your insurance company to verify your coverage regarding chiropractic care. If we are unable to contact your insurance company before our visit, full payment is expected at the time of service. We will hold your payment and reimburse you if your insurance coverage is authorized.

We will make every effort to advise you if certain treatments are not covered by your plan. In doing so, we must rely on the information provided to us by our insurance company representative. Verification of coverage and eligibility is **not** a guarantee that payment will be made by your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that company directly. If you have any questions regarding your coverage, please feel free to contact your insurance company directly. Ultimately, **you** are responsible for all costs incurred during treatment.

CO-PAYMENTS, DEDUCTIBLE, UNINSURED, AND NON COVERED SERVICES

All co-payments and unpaid yearly deductibles are to be paid prior to treatment. All patients without verified insurance are required to provide payment in full at the time of service. We accept cash, checks, Visa and MasterCard. Payments of all non-covered services and supplies are due at the time of service.

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to chiropractic adjustments and other chiropractic procedures. I have had an opportunity to discuss the nature and procedure of chiropractic adjustments and procedures with the Chiropractor.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatments. Although these complications are rare, they may include: fractures, disc injuries, strokes dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks or complications. I wish to rely on the doctor to exercise judgment during the course of the procedures, allowing the doctor to provide treatments which he/she feels are in my interest, based upon the facts known at the time of treatment.

I have read the above Financial Policy and Informed Consent. I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____/_____/_____

Signature Print Date

Financial District Chiropractic

Dr. Kai Tiltmann, DC, CAE
Dr. Kris Blum, DC
555 Front Street, San Francisco, CA 94111
Phone: (415) 781-2225, Fax: (415) 781-4115
contact@fdchiro.com
www.fdchiro.com

Dear Patients,

We are pleased to let you know that we are minimizing your wait time by not overbooking appointments. In order to make this effective for all patients, we ask you to be on time for your appointment and call us 24 hours in advance to reschedule your appointment if you are unable to keep it.

The missed appointment fee is $50.00
and is not covered by insurance.

.

Sincerely,
Kai Tiltmann, D.C. and staff

I have read this notice and understand that I will be charged
$50.00 for an appointment cancelled without 24 hours notice.

Name: _____

Signature: _____

Date: _____