



BRENTWOOD

spine + sport

Patient Name: _____ Birthdate: _____ Sex: M / F
 Address: _____ City: _____ State: _____ Zip: _____
 Telephone: _____ Email: _____
 Social Security #: _____ Driver's Lic. #: _____
 Occupation: _____ Employer: _____ Work Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Subscriber Name: _____ Health Plan: _____
 Subscriber ID #: _____ Group #: _____ Spouse Name: _____
 Spouse Employer: _____ City: _____ State: _____ Zip: _____

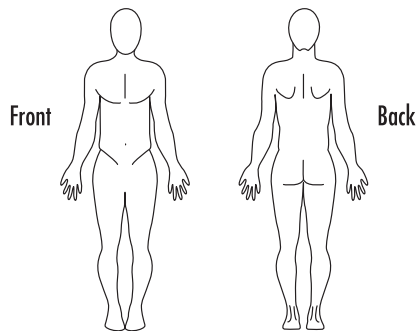
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Is this? Work Related Auto Related N/A

DATE PROBLEM BEGAN: _____

Current complaint (How you feel today?) _____

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



How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%
 Can you perform your daily activities? Yes No Describe: _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? Yes No Date(s) taken: _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you:

None Apply

- | NO | YES | CONDITION |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent fever |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV / AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (Date) |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness / Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin / Buttocks |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer / Tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma |

- | NO | YES | CONDITION |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy / Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low / Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries / Medications: _____ |
| | | _____ |
| | | _____ |
| | | _____ |

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ Date: _____

Benjamin W. Kleinbrodt, D.C., C.C.S.P.

11620 Wilshire Blvd, Suite 710
Los Angeles, CA 90025
310.826.0721

Our Financial Policy

Thank you for choosing us as your Chiropractic health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

Adult Patients

Adult patients are responsible for payment at the time of service. It is required that 100% of your first visit be paid at the time of your visit.

After payment for the initial visit, you will only be responsible for:

1. The deductible (if not met)
2. The Co-pay (if applicable)
3. Any services your insurance does not cover for every visit, including any treatments listed below.

Fees

initial

Comprehensive Initial History and Examination \$210

Chiropractic Adjustment \$75

Additional Treatment Modalities (*including Chiropractic Adjustment*) \$120

Doctor to determine the best combination of treatment modalities for your specific condition, which may include:

- Active Release Technique (approximately 15 minute treatment)
- Graston Technique
- Myofascial Release (approximately 15 minute treatment)
- Ultrasound Therapy
- Electric Stimulation / Interferential Therapy
- Therapeutic Exercise / Stretching / Rehabilitation
- Laser Light Therapy
- Nutrition Consultation*
- Fitness Consultation

**additional fee dependent on complexity of condition*

Charges for re-examination, orthotics, support braces, pillows, or other adjunct therapy are additional.

Service Charge and Rebilling Fees

Any account not paid in full at the time services have been rendered will be subject to a 2% service fee per month on any portion of the month thereof. If the account is not paid in full within 30 days of the initiation of treatment, it may also be subject to a \$10 rebilling charge.

Missed Appointments and Fees

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments, barring emergencies (e.g. illness, earthquake, fire, flood, mudslide, riot), at a rate that directly reflects the amount of time reserved for treatment.

In the event of a default of payment, you will be health responsible for collection costs and/or reasonable attorney fees.

Thank you for your understanding of our Financial Policy. Please let us know if you have any further questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____
Signature of Patient / Responsible Party

Date _____



BRENTWOOD

spine + sport

310.826.0721

drben870@gmail.com

www.brentwoodspineandsport.com

Credit Card Authorization Form

I authorize Brentwood Spine and Sport to keep my signature and credit card information on file and to directly charge my credit card for:

- charges I incur directly.
- appointments not cancelled within 24 hours of my appointment time (*with the exception of notifying the doctor of an emergency*).
- services not covered by my insurance.

I understand my Chiropractor's time is valuable (and he feels the same about your time). Please, whenever possible, cancel an appointment at least 24 hours in advance of your appointment time. This provides us the opportunity to offer the appointment to another patient.

If I do not cancel my appointment time with in the 24 hour cancellation period, I agree to pay for the missed appointment. _____

initial

If my insurance does not cover the services provided, I agree to pay for services not reimbursable by my insurance. _____

initial

I have read fully, understand and agree to the above. _____

initial

Name as appears on credit card: _____

Credit Card Type: __ Visa __ MasterCard __ Discover __ AmExCredit __ Other

Card Number: _____ Expiration Date: _____

Card identification Number/CVC#: _____ (3 digits on the back of the card/ 4 digit on front of Amex)

Print Patient Name: _____

Guardian Name: _____

Patient or Guardian's Signature: _____

Date: _____

Brentwood Spine and Sport
Benjamin Kleinbrodt, D.C., C.C.S.P.

INFORMED CONSENT FOR TREATMENT

My signature below certifies that I, _____, have read (or have read to me) this informed consent. I have had an opportunity to personally discuss it with a doctor or staff member and understand the following:

- In this office the chiropractic practice is augmented with the use of physiotherapy and rehabilitative exercise therapy. Although they might not be specifically licensed or degreed, the staff is skilled in the use of these adjunctive therapies. I personally request and consent to examination, diagnostic x-rays, and chiropractic treatments by the clinic's doctor. Further, I agree to any modality, manipulation, or rehabilitative exercises that the doctor feel is necessary in my case. I hereby give permission for clerical as well as health care staff to have access to my personal health records both during and after the time of treatment.
- When necessary, and with this document acting as proper realize thereof, I hereby give (clinic and all staff) permission to release my records to legal and/or other health care professionals who present their request in a written and legal form.
- I knowingly and willingly accept treatment, understanding that although rare, there may be certain risks inherent with physical medicine, chiropractic, physiotherapy, and rehabilitative exercises and other clinical procedures. These risks rarely involve, but are not limited to, sprains/strains, spinal disc irritation, or in very rare incidents (with certain high-risk patients) stroke. I do not expect the doctor to anticipate, nor explain all of the risks, and/or complications that are possible. I will rely on the doctor's training and education or exercise professional judgment during the course of any procedure or protocol which he/she feels necessary based on the fact and diagnosis in my case, knowing that he/she will act in my best interests.
- This consent noted herein will remain in effect throughout my active treatment program until personally revoked by me.

Patient's Signature _____ Date:

Print Name _____

Brentwood Spine and Sport
Benjamin Kleinbrodt, D.C., C.C.S.P.

ALL INSURANCE PATIENTS, PLEASE READ

Dear Valued Patient:

We would like to share the following policies with you so that you understand your responsibility regarding charges for the services rendered to you by our office:

Dr. Benjamin Kleinbrodt is a participating provider with most commercial U.S. insurance plans. We will gladly bill your primary and secondary insurance carriers, as a courtesy, for services rendered.

However, please be aware that you will be responsible for the payment of:

- A. The annual deductible**
- B. Co-payments and/or co-insurance amounts for your plan**
- C. Charges for non-covered services such as:**
 - i. Graston, Laser Therapy, or Active Release Technique**
 - ii. Functional Evaluation**
 - iii. Nutritional supplements, exercise equipment and/or orthopedic supplies if necessary**

If your insurance company denies coverage for a charge you thought was covered by your plan, you will be billed for the charge after we obtain denial from your insurance company.

Most insurance plans have a “co-insurance” amount, which you will be billed for once we receive the Explanation of Benefits (EOB) from your insurance carrier for services rendered. Most insurance companies do not pay 100% of the contracted/allowed amounts, leaving a co-insurance balance to be paid by the patient. We recommend you contact the Member Services Department of your insurance company if you have questions about what is covered and amounts you will be responsible for.

In the event that your insurance carrier fails to pay for services rendered within the 90 days, you will be billed for any unpaid charges.

Patient due balances over 30 days will be assessed a 1.5% monthly (18% annual) service charge, unless other payment arrangements have previously been made with the office.

Your signature below signifies that you understand our financial policy and your responsibility regarding the charges incurred in this office. It also serves as an authorization for our office to charge the credit card you have placed on file for any outstanding balances.

For insurances that allow maximum dollar amount per visit, such as Guilds, MPIH, and SAG, your non-covered responsibility is different between the paid amount and the office minimum charge.

Patient/Responsible Party Signature

Date