Dr. Kenneth Best, D.C.
Sports & Holistic Chiropractor
650 N. La Peer Drive, West Hollywood, CA 90069

Welcome To Our Office!

Initial Visit:

On your first visit, a complete history will be taken and an examination performed as needed. Appropriate services will then be offered.

Emergencies:

If an emergency situation arises, please call the office **immediately** and you will be seen ASAP.

Personal Injury:

If you get injured in a car accident, notify the office. We will provide the necessary paperwork for you, and refer you to one or our specialized lawyers if needed. We recommend adding a **'MedPay'** of at least $5000 to your existing insurance policy if you do not have it. This is relatively inexpensive for the year and covers your medical expenses regardless of who is at fault.

Financial Arrangements:

Payment is required at the time the treatment is rendered. Fee schedule is based on face-to-face time with Kenneth Best, D.C. in 15-minutes increments. A standard initial intermediate office visit (50 to 60 min.) is $165 and subsequent intermediate office visits (25 mins.) are $85, this fee is subject to additional charges incurred in the performance of additional procedures for a specific treatment (e.g. laser treatment time 10 min at $40). Personal injruy and other complex issues require a more complete (60 min.) or complex (90 min) physical exam and treatment that are billed accordingly. Cash payments are required for all nutritional supplements received. If you are covered by insurance for chiropractic care, we will assist you with billing your insurance. This service is provided as an office courtesy, and we do not guarantee payment by insurance companies. **You are ultimately responsible financially for services rendered.**

We accept as forms of payment: cash, personal checks, Visa, Mastercard and American Express.

Appointments:

Please be on time for your appointment. Tardiness may have an effect on the length of your treatment time. **24 hours notice is required** to cancel or change an appointment. **Missed appointments or late cancellations will be subject to a full visit charge.**

I have read, understand and agree to the policy of this office and agree to pay for services rendered and for any missed appointments or for cancellation with less than 24 hours notice.

Print Name Signature Date

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Patient Name: ______________________________ Date:____________

Address:______________________City:____________ State:______ Zip:________

{only for P.I.}

☐ Home or ☐ Cell:____________ Work: ____________ Soc Sec #:____________

Email address:____

Date of Birth:______________ Age:______ Sex: ☐ M or ☐ F Weight ______ Height ______

Marital Status ☐ single, ☐ married, ☐ separated, ☐ divorced, ☐ widowed Spouse Name:______________

Referred by: ________________ Emergency Contact:____________ Phone:________

Insurance Co. ____________________ ID#________________Gr#________

Main Complaint(s) - [Are you interested in just Pain Relief ☐ or Total Wellness ☐ ?]

Main complaint(s that brought you to this office? ________________________

When did the problem start? ______________ Did it come on gradually? ☐ or suddenly? ☐

Describe how the injury/problem occurred? ______________________

What makes it feel better? ______________ What makes it feel worse? ____________

Does the pain travel anywhere? If so where? ______________________

Do you have any numbness or tingling in your arms or legs? If so where?______________

How would you describe it? (sharp, dull, electric, etc)______________________

How severe is it? (0 is no pain, 10 is unbearable pain) ______ Is it constant? ☐ or intermittent ? ☐

Is it worse in the A.M.? ☐ or P.M.? ☐ or all day? ☐ Has your sleep been affected? ☐ Yes ☐ No

It is getting better? ☐ or worse? ☐ or no change? ☐ Is it better with rest? ☐ Yes ☐ No

Have you had any trouble controlling bodily or daily functions? If so what? ______________

Do you have any other symptoms that seem to be associated? If so what? ______________

Has this condition caused you to avoid doing things that you enjoy doing? If so what? ___________________

List any doctors you have seen for this condition? ___________________

Have you ever had any Chiropractic care? ☐ Yes ☐ No. If so who? ___________________

Past Medical History

Do you have allergies? ☐Yes ☐No If yes, what? ___________________

Are you taking any medication/supplements for any reasons? ☐ Yes ☐ No If yes, please list: ___________________

Have you had any surgeries in the past? ☐Yes ☐No If yes, when was the surgery and what was it for?

Have you had any previous accidents? ☐Yes ☐No If yes, please describe the accident, any injuries, and any care received. ___________________

Family Health History

Associated health problems/deaths of immediate family (i.e. heart disease, cancer, stroke): please list relation to yourself and cause of death___________________

Social and Occupational History:

Recreational activities:___________________

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): ___________________

Review of Systems:

Do you have any problems with your: Eyes, Ears, Nose, Throat, Skin, Muscles, Digestive System, Vascular, Skeletal, or Urinary/Genital Systems? ___________________

Do you have any other illnesses or health problem that I need to be aware of: ☐ yes ☐ no
If yes, explain: ___________________

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

___________________ Patient/Guardian Signature/Date

___________________ Doctor's Signature

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, laser and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I will discuss with the doctor of chiropractic, Kenneth Best, D.C., and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that specific results are not guaranteed. I understand that during the initial phases of healing and treatment I may feel some discomfort or pain as my body returns to a balanced state.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form

*** DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS! ***

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Kenneth and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interests to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name: ______________________________
(Print Name)

Patient Signature: ___________________________ Date ___________________

Witness Signature: ___________________________ Date ___________________

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Health Insurance

Health Insurance Info: Please provide a copy of your insurance card and ID to the front desk. Insurance Manager will inform you of your benefits.

Financial Agreement:
I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges from the services provided by Dr. Kenneth R. Best, D.C. which are not paid by my health insurance or other payer. By signing this form I agree to pay for any services that are denied in whole or in part due to incomplete or inaccurate information given by me or my guardian. Also I agree to pay any co-pays, deductibles or non-covered services determined by my insurance plan and reimburse within 5 days any payments made directly to me by insurance for services of Dr. Best.

All charges are due and payable when I receive the bill. If payment is not made with in 90 days from the date the bill was mailed from the office of Dr. Kenneth R. Best, D.C. I understand that a delinquent charge of 1.5% interest per month or 18% per annum may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with the office of Dr. Kenneth R. Best, D.C.

Insurance/HIPPA Assignment
Thank you for providing our office with your complete insurance information. This notice is to inform you of your obligation to this office regarding the filing of your insurance claim. We will file your claim as a courtesy to you. By filing your claim we are in no way releasing you of your financial obligations and responsibilities.

Assignment of Benefits/Records Release Authorization:
I hereby authorize and direct any insurance benefits to be paid directly to Dr. Kenneth R. Best, D.C. I hereby give permission to Dr. Kenneth R. Best, D.C. to release information from my medical records including the financial ledger to any person or corporation (1) which is or may be liable or under contract to Dr. Kenneth for reimbursement for services rendered, and (2) any health care provider for continued patient care. This includes the legal guardian of patients over the age of 18 who are covered under the guardian's health/automobile insurance.

Acknowledgement of Receipt of Notice of Privacy Practices
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Print Name	Signature	Date