Dr. Ken Best, D.C

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.

Financial Arrangements:

Payment is required at the time the treatment is rendered. *A* ***PROMPT PAY CASH DISCOUNT*** *is already included in the listed prices and does not apply to patients with insurance*.

Initial Intermediate Office Visit .....$165 (55-60 min.)
Follow-Up Visits

- Minimal Office Visit .....$85 (25-30 min.)
- Intermediate Office Visit .....$125 (40-45 min.)
- Extended Office Visit .....$165 (55-60 min.)

Treatment fees are subject to additional procedures. Cash payments are required for all nutritional supplements received. If we are a preferred insurance provider we bill directly and collect coinsurance payment at the time of service. If you are covered by another insurance, as a courtesy, we will assist you with billing your insurance. We do not guarantee payment by insurance. **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**.

Emergencies: Call 911

Personal Injury:

If you get injured in a car accident, notify the office. Personal injury cases require a more complex physical exam and treatments are billed accordingly. We may 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.

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

6135 Lindenhurst Avenue, Los Angeles, California 90048 – (323) 655-5515

Dr. Ken Best, D.C

Patient Name: _____ Date:_____

Address:_____City:_____ State:_____ Zip:_____

☐ Home or ☐ Cell:_____ Work: _____

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

Dr. Ken Best, D.C.

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. Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness, disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you may have, including osteoporosis, heart disease, cancer, stroke, fracture or previous severe injury. 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 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