

Date: ____/____/____

PATIENT REGISTRATION

**UNDER THE “FED. PRIVACY ACT” – ID IS REQUIRED TO:
REGISTER AS A PATIENT, PROVE INSURANCE, OR LEGALLY CHANGE NAME**

Patient Name:

(Last) (First) (Initial) (Maiden)

Guarantor Name:

(If not patient)

(Last) (First) (Initial) (Maiden)

LOCAL Patient Address :

(City) (State) (Zip) () (Phone) -

OUT OF STATE Address :

(Guarantor's if Different)

(City) (State) (Zip) () (Phone) -

Patient Date of Birth:

____/____/____

Sex: Male ☐ Female ☐ Patient's SS#: ____/____/____

Driver's Lic# ID

#: _____ Issued from State of: _____

Patient/Guarantor's

Marital Status

☐ Married ☐ Divorced ☐ Single ☐ Widowed

(Spouse Name: _____) Work# () _____ - _____

Email Address: _____

/____/Patient's Employer, or

/____/(Guarantor Employer):

____ Full Time

____ Part-Time

____ Retired

____ Student

(Employer's Name) (Occupation)

(Employer Address)

(City) (State) (Zip) () (Phone) -

In Case of Emergency - (Someone other than at same address or phone number) – Notify the following

Name:

Relationship

Address:

(City) (State) (Zip) () (Phone) -

Were you Injured:

☐ No ☐ Yes ☐ At Work ☐ In/Around an Auto ☐ At Home ☐ On Another's Property

Do you have an Attorney:

☐ No ☐ Yes Name: _____

Address: _____

Phone Number: _____

Are you covered by:

☐ Medicare ☐ Supplement ☐ Group Health Insurance ☐ Individual Health Policy ☐ HMO

☐ Medicaid (We are not a participating provider and do not file claims to Medicaid)

IMPORTANT!! PLEASE READ CAREFULLY

Payment Agreement:

I agree to be responsible to pay in full for services rendered **OR** to assist with any action required by me for my insurance to pay. Filing my insurance is a service provided by the office of Jason B. Kaster, D.C. on my behalf. I remain responsible to call my insurance (if I have not heard from them) regarding payment within 30 (thirty) days after my appointment. **I agree to pay my co-pay or coinsurance portion promptly and any amount my insurance (including medicare) indicates as “my responsibility. As a medicare patient, I understand this office has not verified my supplemental benefits and I agree to be responsible to file a copy of my medicare summary along with any “duplicate non-assigned” claims provided by _____ (Insurance is to reimburse me for all non-assigned claims)**

Guarantor/Patient Signature

Date

CONSTITUTIONAL:

	NO	YES
Good General Health Lately?		
Recent weight: Gain? Loss?		
Fever?		
Fatigue?		
Frequent Headaches?		
Other:		

EYES:

	NO	YES
Eye disease? or injury?		
Wear glasses? Contacts?		
Blurred vision? Double vision?		
Glaucoma?		
Other:		

EARS/NOSE/MOUTH/THROAT

	NO	YES
Hearing loss? Ringing? Pain?		
Chronic sinus problem/s?		
Frequent: nose bleed? Bleeding gums?		
Mouth sores?		
Frequent sore throat? Recent voice change?		
Swollen glands in neck?		
Other:		

CARDIOVASCULAR

	NO	YES
Heart problem?		
Chest pain?		
Irregular heart beat?		
Shortness of breath? Walking? Lying flat?		
Swelling of: Feet? Ankles? Hands?		
Other:		

MUSCULOSKELETAL

	NO	YES
Joint pain in		
Joint stiffness? Swelling?		
Weakness of: Muscle? Joints?		
Muscle: Pain? Cramps?		
Frequent back pain?		
Difficulty walking?		
Other:		

GENIROURINARY

	NO	YES
Urination: Frequent?		
Cuts? Burning? Painful?		
Incontinence? Dribbling?		
Kidney Stones?		

SKIN AND BREAST

	NO	YES
Unusual Rash? Itch?		
Change in: Skin color? Hair? Nails?		
Frequent breast pain?		
Breast Lumps? Discharge?		
Other:		

NEUROLOGICAL

	NO	YES
Headaches? Frequent? Recurrent?		
Light headed? Dizzy? Fainting?		
Convulsions? Seizures?		
Other:		

PSYCHIATRIC

	NO	YES
Frequent: Memory Loss? Confusion?		
Frequent: Nervousness? Depression?		
Other:		

ENDOCRINE

	NO	YES
Glandular? Hormone problems?		
Throid disease?		
Diabetic?		
Excessive: Thirst? Urination?		
Heat or cold intolerance?		
Other:		

RESPIRATORY

	NO	YES
Cough: Chronic? Frequent?		
Spitting up blood?		
Shortness of breath?		
Asthma? Wheezing?		
Other:		

GASTROENTESTINAL

	NO	YES
Loss of appetite?		
Change in bowel moements?		
Frequent: Nausea? Vomitting?		
Rectal bleeding? Blood in stool?		
Black tarry stool?		
Peptic Ulcer disease?		
Other:		

HEMATOLOGIC/LYMPHATIC

	NO	YES
Slow to heal		
Tendency to: Bleed? Or, bruise easily?		
Anemia?		
Phlebitis?		
History of blood transfusions?		
Enlarged glands?		

Jason B. Kaster, D.C.

Jason B. Kaster, D.C. • 1791 Boy Scout Drive, Suite 6 • Fort Myers, FL 33907
Naples Chiropractic Associates • 9955 Tamiami Trail North, Suite 1 • Naples, FL 34108

SURGERY HISTORY

	NO	YES	
Appendix Removed?			When? ____/____/____
Biopsy of?			When? ____/____/____
Gall Bladder Removed?			When? ____/____/____ Why?
Heart Surgery?			When? ____/____/____ Kind?
Hysterectomy?			When? ____/____/____ Why?
Ovaries Removed?			When? ____/____/____ Why?

Others: _____

Medications/Supplements: _____

FAMILY HISTORY

Father	Living	_____	Age: _____	Problems: _____
	Deceased	_____	Age: _____	Cause of Death: _____
Mother	Living	_____	Age: _____	Problems: _____
	Deceased	_____	Age: _____	Cause of Death: _____
Siblings	Living	_____	Age: _____	Problems: _____
		_____	Age: _____	Problems: _____
		_____	Age: _____	Problems: _____
	Deceased	_____	Age: _____	Cause of Death: _____
	Deceased	_____	Age: _____	Cause of Death: _____
	Deceased	_____	Age: _____	Cause of Death: _____
Children	Living	_____	Age: _____	Problems: _____
		_____	Age: _____	Problems: _____
		_____	Age: _____	Problems: _____
	Deceased	_____	Age: _____	Cause of Death: _____

Any one in your family has/had: Colon Cancer? No: _____ Yes: _____ Breast or Ovarian Cancer? No: _____ Yes: _____

Who? _____

Kaster Inc. (Jason B. Kaster, D.C.) • 1791 Boy Scout Drive, Suite 6 • Fort Myers, FL 33907
Naples Chiropractic Associates • 9955 Tamiami Trail North, Suite 1 • Naples, FL 34108

Patient Name (print): _____ Date of Birth: _____

FINANCIAL RESPONSIBILITY

I understand that I may be financially responsible for any charges incurred at this office and I accept any responsibility for charges, which may not be approved. The insurance company will review any/all documentation submitted by **Kaster Inc. (dba Jason B. Kaster, D.C.)** for review for medical necessity and base their approval/denial upon this documentation.

I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my care is not approved by the insurance company. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

This office may seek payment from you for any services your health insurance plan determines not to be medically necessary.

I have read and understand my obligations for payment in the absence of insurance coverage.

Patient's initials: _____

ASSIGNMENTS OF BENEFITS & DIRECTION TO PAY

I hereby authorize my insurance company from whom I may be entitled to personal injury and/or medical payments benefits to make said payments otherwise payable to me for services rendered by Kaster Inc. (dba Jason B. Kaster, D.C.), but not to exceed to charges of those services, payable to and mailed directly to:

Kaster Inc., 1791 Boy Scout Drive, Suite 6, Fort Myers, FL 33907

Furthermore, I hereby irrevocable assign to Kaster Inc. (dba Jason B. Kaster, D.C.) the rights and benefits, including the right to file and prosecute a lawsuit for the collection of personal injury and/or medical payments benefits, under and policy of insurance, including those policies of insurance from which I may be entitled to personal injury and/or medical payments benefits, indemnity agreement, or any other collateral source as defined in Florida statutes for any service and or charges provided by Kaster Inc. (dba Jason B. Kaster, D.C.). I understand that in exchange for this assignment of said rights and benefits. I will receive medical treatment from Kaster Inc. (dba Jason B. Kaster, D.C.).

Patient's initials: _____

INSURANCE ASSIGNMENT DISCLAIMER

Our office is pleased to accept your insurance assignment. However, it must be understood that the contract with your insurance company is between you and your insurance company. We will make every effort to file your insurance claim form and assist you in obtaining your rightful benefits. Please understand that you are fully responsible for any fees incurred by you and not reimbursable or collectable from your insurance carrier.

Naturally, you are responsible for any deductible or co-insurance payments you have contracted for with your insurance company. Most insurance companies cover care provided within this office. However, some companies have limits on their coverage. We will try to confirm your coverage and determine which services will be covered, what your deductible is, and what you are responsible for. Once we obtain the information we will discuss it with you. Payment of co-insurance / co-pay will be expected the day services are rendered. You are welcome at any time to review your current charges and receive copies of your bills and records.

Patient's initials: _____

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 that 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.

Patient's initials: _____

Patient signature: _____ Witness: _____

Date: _____

INFORMED CONSENT

Dear Patient,

Every type of health care is associated with some risk of a potential problem; this includes chiropractic care. Should we accept your case, although extremely rare, we want you to be informed about potential problems with chiropractic health care before consenting to treatment.

Manipulations: Chiropractic manipulation is the moving of the bones with the doctor's hands or with the use of a device. Frequently manipulation creates a "pop" or "click" sound/sensation in the area being treated. A manipulation is the specific application of gentle forces to facilitate the body's correction of vertebral fixation. In the office we used trained staff and personnel to assist the doctor with portions of your exercise instruction, physiotherapy, etc.

Vertebral Fixation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes a joint and/or nerve inflammation sometimes complicated by a muscle spasm. We do not offer to treat any systemic disease or conditions not related to the musculoskeletal system. However, if during the course of a chiropractic examination or during treatment, we encounter non-chiropractic, medical or unusual findings we will inform you and we may refer you to the appropriate healthcare provider.

Soft Tissue Injury: In the context of this office soft tissue primarily refers to muscles, nerves, ligaments, tendons and discs. Muscle moves bones and ligaments limit joint movement. Rarely a chiropractic manipulation may tear some muscles or ligament fibers. The result is a temporary increase in pain or discomfort and necessary treatment for resolution, but there are no long-term effects for the patient. These problems occur so rarely that we are not aware of any available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle of the back. They extend from your back to the front chest area; rarely a chiropractic manipulation will crack a rib bone. This occurs only in patients that have weakened bones from such things as osteoporosis. If Osteoporosis is discovered in your x-rays we carefully alter our technique. These problems occur so rarely that we are not aware of any statistics to quantify their probability.

Soreness: It is not uncommon to be temporarily sore after a chiropractic manipulation in the region that was being treated. It is temporary but not dangerous; you can notify your chiropractor of any long-term soreness.

Stroke: On very rare occasion, a chiropractic manipulation has been associated with a stroke. The stroke arises from the vertebral artery only, because the vertebral artery is found in the neck. Techniques used in this office are specifically practiced to limit the risk of stroke. The average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniation that creates pressure on a spinal nerve or on the spinal cord are frequently successfully treated by chiropractic manipulation and various therapies. This includes both in the neck and back. Occasionally chiropractic treatment will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic manipulation may also cause a disc problem if the disc is in a weakened condition such as degenerative disc disease. These problems occur so rarely that we are not aware of any available statistics to quantify their probability.

Patient Signature: _____

Patient Name: _____ Date: _____



JASON B KASTER
Chiropractic Physician

1791 Boy Scout Drive, Suite 6, Fort Myers, Florida 33912
9955 Tamiami Trail North, Suite One, Naples, Florida 34108
Ph: 239.332.2555 Fax: 239.332.2556
info@drkasters.com | www.drkasters.com

Date: _____

I _____ give Permission to:

Jason B. Kasters Chiropractic to discuss my health history and any diagnostics performed with

_____. Furthermore, I understand that HIPPA protects my health history and

Records from being viewed by anyone other than the staff and the doctor.

Signed _____