Dr. Mark A. Kendall, DC, PC

Certified Spinal Disability Evaluator
Phone: 248 363 1775
Fax: 248 363 1776

Patient Information *Please complete all sections of this form*

First Name: ________________________________ **M. I.:** _____ **Last Name:** _________________________________ **Suffix:** ________

Address: ____

City: ____ **State:** _________________ **Zip:** ____________________________

D.O.B: _______________________ **S.S.N.:** ____ **Gender: MALE FEMALE**

Marital Status: Married Single Divorced Widowed Separated Preferred Method of Contact: ___________________________

Phone No.: __________________________ **Work No.:** ______________________________ **Cell No.:** _____________________________

Email Address: ____

(will not share your email with any third party. We will only use your email to contact you in relation to your care.)

How did you find our office? Doctor Patient Other: Friend Advertisement Insurance Co. Website Drive By

If referred by a patient, who may we thank: ____

Is the patient a minor? YES NO If, yes I authorize treatment of my child (initial here)____

Primary Care Physician: ____

Address: ____ **City:** ____________________________ **State:** _______**Zip:** __________

Phone No.: _______________________ **Fax No:** _____________________ **Email:** ____

Responsible Party if other than yourself: Parent Guardian Other

First Name: ________________________________ **M. I.:** _____ **Last Name:** ________________________________ **Suffix:** _______

Address: ____

City: ____ **State:** _________________ **Zip:** ___________________________

Phone No.: ___________________________ **Work No.:** ___________________________ **Cell No.:** _____________________________

Email Address: ____

Emergency Contact Info Name: ____ **Phone:** ______________________________

Race: Asian Black or African American Native Hawaiian or Other Pacific Islander White Other Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined

Employer: ____ **Occupation:** ____

Address: ____ **City:** ________________________ **State:** _________ **Zip:** __________

Insurance Company: ____ **Relation to Insured: Self Spouse Child Other**

Insured's D.O.B.: ______________________________ **Type of Insurance Medicare Medicaid BCBSM Comm Insurance Auto W/C**

Secondary Ins. Co.: ____ **Relation to Insured: Self Spouse Child Other**

Insured's D.O.B.: ______________________________ **Type of Insurance Medicare Medicaid BCBSM Comm Insurance Auto W/C**

Patient Signature:____ **Date:**__________________________

9555 Commerce Rd. Suite 1, Commerce, MI 48382 www.BPChiro.com Email: Drk.BPChiro@gmail.com

ASSIGNMENT OF INURANCE BENEFITS

I understand that health and accident insurance policies are an agreement between the insurance company and me the insured. I am responsible for payment of all services rendered to me. I direct my insurance/health care benefit company, to pay Dr. Mark Kendall, D.C., P.C, d/b/a Bay Pointe Chiropractic, a legally qualified doctor, upon receipt of his clean claim submitted electronically or via First Class Mail for services rendered out of indemnity due me under the terms of my policy listed above. This policy was in full force and in effect at the time these services were rendered. Payment of this amount is herein directed, by whole or in part, shall be the same as if paid to me. I hereby direct the above listed insurance company to pay by check made out and mailed directly to: Bay Pointe Chiropractic, 9555 Commerce Rd., Suite 1, Commerce, MI 48382. If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct my insurance company to make out the check to me and mail it as follows: c/o 9555 Commerce Rd., Suite 1, Commerce, MI 48382. A photo-copy of this assignment shall be considered as effective and valid as the original.

H.I.P.A.A. PRIVACY POLICY AND CONSENT

I understand I have a right to review Bay Pointe Chiropractic's Notice of Privacy Practices prior to signing this acknowledge that Bay Pointe Chiropractic's "Notice of Privacy Practices" will be provided to me upon my request. Bay Pointe Chiropractic's Notice of Privacy Practices has been made available to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bay Pointe Chiropractic. The Notice of Privacy Practices for Bay Pointe Chiropractic's is also provided on request at the main administration desk of this practice and on Bay Pointe Chiropractic's website at www.BPChiro.com This Notice of Privacy Practices also describes my rights and Bay Pointe Chiropractic's duties with respect to my protected health information. Bay Pointe Chiropractic's reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Bay Pointe Chiropractic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature: ____ Date: ____________________________

YOU, The Patient are RESPONSIBILE" for DEDUCTIBLES and Co-Payments

We do not offer unsecured credit for your chiropractic care. You must authorize direct payment for deductibles and co-pays or any unpaid balance directly with your Health Savings Account, credit or debit card.

After our office receives your insurance companies E.O.B. (explanation of benefits), the insurance portion of your claim has been completed. We will charge to the card listed in this agreement, the **Patient Responsibility amount** as stated by your insurance company. If payment is not received from your insurance company in a timely fashion (45 days) it will be treated as a completed claim and we will charge to the card listed here the approved amount for the service rendered.

[ ] *I authorize direct payment to Dr. Mark Kendall, DC, PC*

Card Number: ________________________________ Exp. Date______________________ Security Code: __________

Patient Signature:____ Date: ___________________________

BAY POINTE CHIROPRACTIC FINANCIAL POLICY

We would like to have open communication with our patients by informing them of our policies. We feel that this provides a positive physician-patient relationship and we strive for this in our practice. Please read carefully below regarding our billing and insurance policies and if you have any questions, do not hesitate to call. Upon arrival, please present your current insurance card and photo ID. This is the verification of the correct insurance and consent to bill them on your behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU COULD BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND SUBMIT THE CHARGES TO THE CORRECT PLAN.

1. According to your insurance plan, ***you are responsible for any and all co-payments, deductibles and co-insurances.***
2. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or Prior Authorization is required to see a specialist (Chiropractors are specialists) or have a specific treatment or procedure.
3. If our physicians do not participate in your insurance plan, payment in full is expected for you at the time of your office visit. For scheduled appointments, prior balances must be paid before you are seen for your visit.
4. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
5. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 20 business days of your receipt of your bill.
6. Any balance over 90 days will be forwarded to our Collections Department and you will be charged an additional fee, which is 30% of the balance.
7. A fee will be charged for missed or cancelled appointments without 24-hour notice at the discretion of the practice. You will be informed when you make your appointment of the policy and cost if this occurs.
8. A $35 fee will be charged for any check returned for insufficient funds, plus any bank fees incurred.
9. Advance notice is needed for all referrals. Please contact your primary care physician which typically takes 3 to 5 business days. It is your responsibility to know if the physician you will be seeing in this practice participates with your plan. Your primary care physician must approve your request before issuing a referral. If you choose to see the physician here without a referral you will be responsible for the total cost of the visit including any cost for x-rays, adjustments etc. that are performed without a referral from your doctor. You may also reschedule.
10. Not all services provided by our office are covered by every plan. Any service determined not to be a covered benefit or medically necessary by your plan will be your responsibility.
11. A $30 late fee will be assessed for all past due balances over 60 days.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Signature: ____ Date: ________________

INFORMEND CONSENT

CHIROPRACTIC health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of Dr. Kendall's procedure often depends on environment, underlying causes and spinal conditions. It is important to understand what to expect from chiropractic health services.

ANALYSIS: Dr. Kendall conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complex (VCS). When such Vertebral Subluxation Complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS: Although Dr. Kendall is an expert in chiropractic diagnosis of the Vertebral Subluxation Syndrome and Complex, he is not an internal medical specialist. Every chiropractic patient should be mindful of his/her symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition. Dr. Kendall may express an opinion as to whether or not you should take this step, but you are responsible for the final decision**.**

RESULTS: The purpose of chiropractic treatment is to promote natural healing through the reduction of Vertebral Subluxation Complex. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the chiropractic procedure. Sometimes response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, conditions, which do not respond to chiropractic care, may come under control or be helped through medications or surgery. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

INFORMED CONSENT FOR CHIROPRACTIC CARE: A patient, in coming to Dr. Kendall, gives permission and authority to care for the patient in accordance with the chiropractic test, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. Dr. Kendall, of course will not give a chiropractic adjustment, or health care if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness or deformity which would otherwise not come to the attention of Dr. Kendall. The patient should look to the correct specialized, non-duplicating health service. Dr. Kendall is licensed and holds special training as a spinal disability evaluator and is available to work with other types of providers in your health care regime.

I have read and understand the foregoing.

Signature: ____ **Date:** ______________

__________________________________ ____

Name of patient or personal representative **Description of personal representative's authority**

Name: ____ Date: _______________

Patient Medical History

Any previous accident(s)?: ____

Any previous hospitalizations / serious illnesses?:________________________________

Do you now or have you ever had any of the following conditions?:

[ ] anemia	[ ] arthritis	[ ] asthma	[ ] cardiovascular problems
[ ] cancer	[ ] COPD	[ ] currently pregnant	[ ] diabetes
[ ] depression	[ ] dislocation	[ ] dizziness / fainting	[ ] Fractures
[ ] headaches	[ ] pacemaker	[ ] heart disease	[ ] hepatitis / HIV
[ ] hi blood pressure	[ ] halter monitor	[ ] seizures	[ ] kidney problems
[ ] low blood pressure	[ ] respiratory problems	[ ] systemic problems	[ ] thyroid problems

If 65 years or older, have you recived a pneumococcal vaccine? [ ] yes [ ] no

Have you ever had general anesthesia? [ ] yes [ ] no **Any problems with anesthesia?** [ ]yes [ ]no

Any other medical problems?: ____

Any pain management?: ____

Past Chiropractic care?: ____

Past treatments?: ____

Family Medical History

Is mother deceased? [ ] yes [ ] no **Cause of death**:________________________________

Mother has a history of: [ ] unremarkable [ ] unknown

[ ] anemia	[ ] arthritis	[ ] asthma	[ ] cardiovascular problems
[ ] cancer	[ ] COPD	[ ] currently pregnant	[ ] diabetes
[ ] depression	[ ] dislocation	[ ] dizziness / fainting	[ ] Fractures
[ ] headaches	[ ] pacemaker	[ ] heart disease	[ ] hepatitis / HIV
[ ] hi blood pressure	[ ] halter monitor	[ ] seizures	[ ] kidney problems
[ ] low blood pressure	[ ] respiratory problems	[ ] systemic problems	[ ] thyroid problems

Is father deceased? [ ] yes [ ] no **Cause of death:** ________________________________

Father has history of: [ ] unremarkable [ ] unknown

[ ] anemia	[ ] arthritis	[ ] asthma	[ ] cardiovascular problems
[ ] cancer	[ ] COPD	[ ] currently pregnant	[ ] diabetes
[ ] depression	[ ] dislocation	[ ] dizziness / fainting	[ ] Fractures
[ ] headaches	[ ] pacemaker	[ ] heart disease	[ ] hepatitis / HIV
[ ] hi blood pressure	[ ] halter monitor	[ ] seizures	[ ] kidney problems
[ ] low blood pressure	[ ] respiratory problems	[ ] systemic problems	[ ] thyroid problems

Comments: ____

____

Name: ____ Date: _______________

Social History:

Marital Status: [ ] single [ ] married [ ] divorced [ ] separated [ ] widowed

Employed? [ ] yes [ ] no **Occupation?:** ____

Employer?: _____________________________________ **Work from home?** [ ] yes [ ] no

Do you have children? [ ] yes [ ] no **How many children?** __________________________

Exercise? [ ] yes [ ] no **How often?** [ ] daily [ ] weekly [ ] monthly [ ] rarely [ ] never

What type of exercise? ____

Patient smoking status: [ ] current every day smoker [ ] current some day smoker [ ] former smoker
[ ] never smoker [ ] heavy tobacco smoker [ ] light tobacco user

Do you drink alcohol? [ ] yes [ ]no

Alcohol quantity [ ] 1-2 per week [ ] 1-2 per day [ ] 2 or more per day [ ] socially

Comments:____

____

Medication Allergies: [ ] yes [ ] no

If yes, list: ____

Height: ____________ **Weight:** ______________

NAME: ______________________________ DATE: ______________

IF YOU HAVE NECK COMPLAINT PLEASE COMPLETE

The "Neck Disability Index" is a questionnaire that indicates the extent to which a person's functional level is restricted by pain. It is intended for clinical use and is completed by the patient. It is divided into 10 sections, each containing six items. The sections cover the disabling effect of increasingly severe levels of pain on daily activities: pain intensity, personal care, lifting, reading, headaches, concentration, work, driving, sleeping and recreation. This questionnaire therefore concentrates on the effects rather than the nature of pain.

Section 1- Pain Intensity

[ ] A. No pain at the moment.
[ ] B. Mild pain at the moment.
[ ] C. Moderate pain at the moment.
[ ] D. Fairly severe pain at the moment.
[ ] E. Very severe pain at the moment.
[ ] F. Worst imaginable pain at the moment.

Section 2-Personal Care

[ ] A. Personal care is normal without extra pain.
[ ] B. Personal care normal with extra pain.
[ ] C. Personal care painful/slow and careful.
[ ] D. Manage most personal care with some help.
[ ] E. Needs help every day in most aspects of care.
[ ] F. Difficulty dressing and washing/stay in bed.

Section 3- Lifting

[ ] A. Lifts heavy weights with no pain.
[ ] B. Lifts heavy weights with pain.
[ ] C. Can lift heavy weights from a table.
[ ] D. Can lift light weights from a table.
[ ] E. Can lift only very light weights.
[ ] F. Cannot lift or carry anything.

Section 4-Reading

[ ] A. No pain while reading.
[ ] B. Slight pain while reading.
[ ] C. Moderate pain while reading.
[ ] D. Moderate pain prevents reading.
[ ] E. Severe pain prevents reading.
[ ] F. Cannot read at all.

Section 5- Headaches

[ ] A. No headaches.
[ ] B. Slight, infrequent headaches.
[ ] C. Moderate, infrequent headaches.
[ ] D. Moderate, frequent headaches.
[ ] E. Severe, frequent headaches.
[ ] F. Constant headaches.

Section 6- Concentration

[ ] A. Can concentrate without difficulty.
[ ] B. Can concentrate with slight difficulty.
[ ] C. Can concentrate with fair difficulty.
[ ] D. Can concentrate with a lot of difficulty.
[ ] E. Can concentrate with extreme difficulty
[ ] F. Cannot concentrate at all.

Section 7-Work

[ ] A. Work is unrestricted.
[ ] B. Can do usual work but no more.
[ ] C. Can do most usual work, but no more.
[ ] D. Cannot do usual work.
[ ] E. Can hardly do any work.
[ ] F. Cannot do any work.

Section 8- Driving

[ ] A. Can drive without pain.
[ ] B. Driving causes slight neck pain.
[ ] C. Driving causes moderate neck pain.
[ ] D. Cannot drive long due to the moderate pain.
[ ] E. Can hardly drive due to severe pain.
[ ] F. Pain prevents driving.

Section 9- Sleeping

[ ] A. No difficulties sleeping.
[ ] B. Sleep is mildly disturbed.
[ ] C. 1-2 hours' loss of sleep.
[ ] D. 2-3 hours' loss of sleep.
[ ] E. 3-5 hours' loss of sleep.
[ ] F. 5-7 hours' loss of sleep.

Section 10-Recreation

[ ] A. Recreation is not affected.
[ ] B. Some neck pain but does not affect activity.
[ ] C. Some activity is affected by pain.
[ ] D. Most activity is affected by pain.
[ ] E. Activity severely restricted by pain.
[ ] F. Cannot do any activity.

NAME: ________________________________ **DATE:** ______________

IF YOU HAVE LOW BACK COMPLAINT PLEASE COMPLETE

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** Which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1- Pain Intensity

[ ] Pain comes and go and is mild.
[ ] Pain is mild and does not very.
[ ] Pain comes and goes is moderate.
[ ] Pain is moderate and does not very much.
[ ] Pain comes and goes and is severe.
[ ] Pain is severe and does not very much.

Section 2- personal Care

[ ] Does not change habits to avoid pain.
[ ] Does not change habits/ some pain
[ ] Does not change habits/ increase pain.
[ ] changes habit/increase pain.
[ ] Unable to do some personal care without help.
[ ] Unable to wash or dress without help.

Section 3- Lifting

[ ] Lift heavy weights with no pain.
[ ] Lifts heavy weight with pain.
[ ] Cannot lift heavy weights off the floor.
[ ] Can lift heavy weights from a table.
[ ] Can lift light weight from a table.
[ ] Can lift only very light weight.

Section 4- Walking

[ ] Pain Does not prevent walking .
[ ] Cannot walk more than a mile.
[ ] Cannot walk more than ½ mile.
[ ] Cannot walk more than ¼ mile.
[ ] I can only walk using a stick or crutches.
[ ] Bedridden and must crawl to the toilet.

Section 5- Sitting

[ ] I can sit in any chair as long as I like.
[ ] Can sit only in the favorite chair as desired.
[ ] Pain prevents me from sitting more than one hour.
[ ] Pain prevents me from sitting more than 30 minutes.
[ ] Pain prevents me from sitting more than 10 minutes
[ ] Pain prevents me from sitting almost all the time.

Section 6- Standing

[ ] Can stand for unlimited time without pain.
[ ] Some pain standing/ doesn't increase with time.
[ ] Cannot stand more than 1 hour.
[ ] Cannot stand more than 1/2 hour.
[ ] Cannot stand more than 10 minutes.
[ ] Cannot stand at all.

Section 7- Sleeping

[ ] No pain in bed.
[ ] Gets pain in bed, but sleeps well.
[ ] Normal sleep reduced by 1/4.
[ ] Normal night sleep reduced by 1/2.
[ ] Normal night sleep reduced by 3/4
[ ] Cannot sleep at all due to pain.

Section 8- Traveling

[ ] I can travel anywhere without pain.
[ ] Travel causes some pain but not made worse.
[ ] Causes extra pain/no change in form.
[ ] Causes pain/uses alternative travels.
[ ] Pain restricts all forms of travel.
[ ] Pain prevents me from traveling except lying down

Section 9-Social Life

[ ] Normal and causes no pain.
[ ] Normal but causes extra pain.
[ ] Limit energetic interests.
[ ] Pain limits/doesn't go out as
[ ] Pain restricted social life to home.
[ ] Pain restricts all social life.

Section 10- Changing Degree of

[ ] Pain is rapidly improving
[ ] Pain fluctuates but is improving.
[ ] Improvement is slow.
[ ] Pain level is unchanged.
[ ] Pain is gradually worsening.
[ ] Pain is rapidly worsening.

Complete this page if you have been in an Auto Accident

ATTORNEY'S LEIN

I, ____do hereby authorize Mark A.

Kendall, D.C., to furnish you, ____,
my attorney, with prepaid copies of medical records relevant to my injury or accident for which he is representing me.

I further authorize and direct my attorney to pay directly to Dr. Mark Kendall, D.C.P.C., such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment. I hereby grant Dr. Mark Kendall, D.C., P.C., a lien on my claim against any and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services before proceeds are disbursed to myself or any other individual, attorney or company.

I fully understand that I am directly and fully responsible to the above health care provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for their additional protection and in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, as to the appropriateness of services rendered and/or fees charged. Alternate third-party payment, if accepted, is done as a courtesy provided by Dr. Mark Kendall, D.C., P.C.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that this agreement shall be governed by the laws of the State of Michigan.

Patient: ____ Date: ___________________

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

Attorney's Signature:____

Date:______________________________ Bar #:____

Attorney address:____

City:____ State:_________ Zip:________________