CHIROPRACTIC
WELLNESS CENTER

PATIENT INFORMATION

Date: ____/____/____

Last Name: _____ First Name: _____ MI: ____ Gender: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

Cell #: _____ Email: _____ Date of Birth: ____/____/_____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____

How did you hear about us?: _____

Do you smoke? YES NO If yes, how often/how much:_____

Height: _____ Weight:_____ LBS Are you currently pregnant? YES NO

PRESENT CONDITION

List any conditions, in order of concern, rate your level of pain (10 being extreme)

1. _____ ____/10 How long? _____
2. _____ ____/10 How long? _____
3. _____ ____/10 How long? _____

CURRENT SYMPTOMS: *Please check any of the following that apply to you:*

	Headaches		Sinus Problems		Dizziness
	Neck Pain		Digestive Issues		Depression
	Arm Pain		Allergies		Loss of Balance
	Shoulder Pain		Asthma		Vertigo
	Mid Back Pain		Osteoporosis		Blood Pressure
	Lower Back Pain		Pregnancy		Shortness of Breath
	Knee/Ankle Pain		Shortness of Breath		Muscle Spasms
	Ringing in Ears		Tingling in Legs/Feet		Sleep Problems
	Sciatic Pain		Tingling in Arms		Pace Maker

Please share any surgeries or traumas you've experienced:

_____

_____

WHAT MAKES THE PAIN BETTER? _____

WHAT MAKES THE PAIN WORSE? _____

Who have you seen for your symptoms and when?

Chiropractor: _____ Physical Therapist: _____

Medical Doctor: _____ Other: _____

CHIROPRACTIC
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PATIENT HISTORY

NAME: _____ DOB: _____/_____/_____

MEDICAL HISTORY- *PLEASE CHECK ANY ISSUES EXPERIENCES BY YOU OR FAMILY MEMBERS.*

	SELF	MOM	DAD	GP'S
ALCOHOL				
ALLERGIES				
ARTHRITIS				
BLOOD PRESSURE				
CANCER				
CHOLESTEROL				
CHRONIC FATIGUE				
COLITIS				
CONVULSIONS				
DEPRESSION				
DIABETES				
DRUGS				
FIBROMYALGIA				
GASTRIC/REFLUX				
HEADACHES				
HEART DISEASE				
HEPATITIS				
HIV/AIDS				

	SELF	MOM	DAD	GP'S
IBS				
IMMUNE SYSTEM				
LUNG DISEASE				
LUPUS				
MENTAL ILLNESS				
MULTI. SCLEROSIS				
MUSC. DYSTROPHY				
OSTEOPOROSIS				
RHEUM FEVER				
SCARLET FEVER				
SEIZURES				
SHINGLES				
SKIN DISORDERS				
SLEEP DISORDERS				
STROKE				
THYROID DISEASE				
VARICOSE VEINS				
WEIGHT- GAIN/ LOSS				

PLEASE PUT AN X ON THE ACTIVITES YOU PARTICIPATE IN:

	ACTIVITY	HOW OFTEN?			ACTIVITY	HOW OFTEN?
	DRIVING LONG DISTANCE				SLEEP COMFORTABLY	
	EXERCISE				SLEEP ON STOMACH	
	LIFT WEIGHTS				TALK ON PHONE	
	PLAY SPORTS				TRAVEL	
	YOGA/STRETCH				SIT AT DESK	

PLEASE LIST ALL CURRENT MEDICATIONS, INCLUDING VITAMINS AND SUPPLEMENTS:

_____ _____

_____ _____

_____ _____

_____ _____

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

INSURANCE AND FINANCIAL INFORMATION

Patient Name: _____ DOB: _____

☐ Check here if you are not using insurnace for your appointments.

Insurance Information (Please present insurance card(s) to the front desk so a copy can be included in your file.)

Primary Insurance: _____ Insurance ID: _____

Name of Insured: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Other: _____

Secondary Insurance: _____ Insurance ID: _____

Name of Insured: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Other: _____

1. The fees for our professional services are based upon usual and customary charges in this area.
2. We recognize that our patients often must seek Chiropractic services when the patient is least able to bear the expense, however, the responsibility for paying for care will be placed upon those who receive services, other than some of the exceptions listed below.
3. If your insurance company does not pay the physician directly, a payment of $60 will be requested at the time of service. We will be happy to discuss our charges with you If necessary, financial arrangements can be made by discussing this with the office management prior to your appointment.
4. We bill all primary insurance companies when billing information and a billing address is provided. We are a partricipating Medicare provider and bill Medicare as well as your secondary insurance
5. Patients covered by worker's compensation or motor vehicle claims must provide the office with all the necessary information.
    a. Claim numbers and date of injury as well as mailing address.
    b. Patient who are covered under worker's compensation claims must provide the office with their insurance information if your claim is denied.
    c. If you cannot provide us with the necessary information for billing, it may be necessary to reschedule your appointment.
6. We do not feel that a liability action against someone else is a reason to delay payemnt of your bill.
    a. Payment is the responsibility of the individual who has received the treatment, not the individual being sued.
    b. For this reason, as well as the fact that lawsuits may go on for an extended period, we expect our bill to be paid promptly.
    c. Without insurance coverage, payment in full will be expected at the time of service, unless other arrangements are made.
7. Past due account will be turned over to an outside collection agency. Patients whose accounts have been assigned for collection may be seen in the future on a cash basis only.
8. We will be happy to complete disibility form for you; however, this also requires time and a normal charge per form is required prior to information being completed.
    a. As a curtosy we will complete one (1) disability form for you at "No charge".
    b. All subsequent disability forms will be assessed a minimum charge of $25.00 each.

By signing this document you are acknowledging that you fully understand and accept the terms in this policy.

Patient Name: _____ Date: _____

Patient Signature: _____

CHIROPRACTIC
WELLNESS CENTER

FINANCIAL POLICY

We are pleased to accept your insurance assignment subject to verification of your coverage. We will file your claims as a courtesy to you. However, it must be fully understood that the contract is between you and your insurance company and **you are fully responsible for any amount not paid by your insurance.**

I accept assignment of benefits for medical payments to be made directly to Chiropractic Wellness Center.

I authorize the release of medical information necessary in the processing of my insurance claims.

I agree that I will pay the percentage of charges not covered by my insurance company at the time of service as deductible, coinsurance, copays.

I agree that I will pay in full for charges or services rendered by Chiropractic Wellness Center for either self-pay accounts or services that will not be covered by my insurance company, at the time they are incurred and, if for any reason my insurance company do not cover charges or a claim is denied, I will make payment arrangements immediately.

I agree that if my insurance company refuses to accept assignment of benefits or for some reason sends the payment to me, I will bring or send those payments to Chiropractic Wellness Center.

I understand and agree that Chiropractic Wellness Center will not enter into any dispute with my insurance company regarding a claim and that this is my responsibility and obligation.

I agree that a copy of this document can be considered the same as an original when used for insurance billing purposes.

I understand that I may be charged **$10 for no show appointments**. I will not be charged if I inform the office that I need to reschedule or cancel my appointment, by end of business day of my scheduled appointment. In our desire to be effective and fair to all of our clients and out of consideration to our doctor's time, we have adopted this following policy. The **$10** fee will be due before your next appointment.

By signing this document I certify that I have read and understand the financial policy of Chiropractic Wellness Center and agree it is true and accurate to the best of my knowledge. I authorize this office and its staff to examine and to treat my condition as the doctors see medically necessary. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment unless prior arrangements have been made.

Name of patient: _____ **Date:** _____

Patient's Signature: _____

PHOTO RELEASE

Social media is a great way to spread the word about chiropractic care. Through photos and videos, we are able to share with others what exactly goes on here at Chiropractic Wellness Center.

If you are comfortable with us snapping photos of you occasionally and sharing on our social media, please sign the statement below. Please know that only your first name will be used and we promise to only use "flattering" pictures.

I give permission for Chiropractic Wellness Center to take pictures of my treatments and use on Chiropractic Wellness Center's social media pages.

Name of patient: _____

Patient's Signature: _____ **Date:** _____

CWCKCMO

CHIROPRACTIC
WELLNESS CENTER

CHIROPRACTIC INFORMED CONSENT

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both the chiropractor and the patient to be working toward the same objective. Chiropractic has only one goal, to detect and reduce/correct misalignment. It is important that each person understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, cryotherapy, decompression therapy, hydro massage and therapeutic exercises. Risks may include but are not limited to cardiovascular, muscle ligament, joint or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. Any increase in the current levels of discomfort should be immediately reported to a staff member.

There are expected benefits associated with participation in a treatment program. They include: *increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.*

We do not offer to diagnose or treat any disease or condition other than misalignment. If during the course of a chiropractic evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider specializing in that area.

Name of patient: _____ **Date:** _____

Patient's Signature: _____

PATIENT COMMUNICATION CONSENT

I agree to allow CHIROPRACTIC WELLNESS CENTER and staff to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize CHIROPRACTIC WELLNESS CENTER to leave detailed messages for me when I am unavailable.

Please select your preferred method of contact from our office where we can leave a detailed message.

☐ Home Phone ☐ Cell Phone (Texting requires that you give us your cell number and for you to have a text enabled cell phone plan.)

☐ Work Phone ☐ Email

I authorize CHIROPRACTIC WELLNESS CENTER and staff to discuss my healthcare information (which may be history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name: _____

Relationship to patient: _____

By my signature below I acknowledge that I have read and understand the Guidelines to Patient Communication and information provided on this consent form. I understand the risk associated with the different methods of communication and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that CHIROPRACTIC WELLNESS CENTER may impose.

Name of patient: _____ **Date:** _____

Patient's Signature: _____

CHIROPRACTIC WELLNESS CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Chiropractic Wellness Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Chiropractic Wellness Center."

"It is our policy to provide a substitute health care provider, authorized by Chiropractic Wellness Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Chiropractic Wellness Center for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes of fundraising purposes, as described below: (example)

"As a courtesy to our patients. it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time or your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, food donation, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Chiropractic Wellness Center sponsored fund-raising events."

Change of Ownership

In the event that Chiropractic Wellness Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however that Chiropractic Wellness Center is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Chiropractic Wellness Center amend your protected health information. Please be advised, however, that Chiropractic Wellness Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Chiropractic Wellness Center.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Chiropractic Wellness Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Chiropractic Wellness Center is required by law to comply with this Notice.

Chiropractic Wellness Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact our office at (816)-561-7035.

Complaints

Complaints about your Privacy rights or how Chiropractic Wellness has handled your health information should be directed to our office by calling (816)-561-7035. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights 200 Independence Avenue, S.W. Room 509F HHH Building Washington, DC 20201

This notice is effective April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Chiropractic Wellness Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient's Name (print)

_____ _____

Patient's Signature Date

_____ _____

Authorized Facility Signature Date