Social Security Number: ___________________________

History of Present Illness:

Chief Complaint: Purpose of this appointment: ______________________________________
Date symptoms appeared or date of accident: ______________________________________
Is this due to: Auto___ Work____ Other____
Have you ever had the same or similar condition? Yes No If yes, when and describe:
____
____
Days lost from work: ____________ How did you treat it? _____________________________
Date of last physical exam? ______________________
What do you hope to get out of your Chiropractic visit(s)? ______________________________

Past Medical History:

Have you ever been diagnosed as having or have suffered from: (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__Excessive Bleeding
__High/Low Blood Pressure
__Osteoarthritis
__Epilepsy
__Pace Maker
__HIV Positive
__Depression
__Eating Disorder
__Alcoholism
__Drug Addiction
__Ruptures
__Coughing Blood
__Stroke
__Cancer
__Gall Bladder
__Congenital Disease
__Ulcers

Do you have a history of stroke or hypertension? _____________________________________
Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (including dates):___________________________________
____
Have you been treated for any health condition by a physician in the last year: Yes No If yes, please describe what and the outcome: ____
____
What medications or drugs are you taking?____
____
Do you have any allergies to any medications or latex? Yes No If yes, describe __________
____
Do you have any allergies of any kind? Yes No If yes, describe: ______________________
Please list any other health problems you have, no matter how insignificant they may be:_______
____
____
Is there anything you feel we should know about you &/or your condition?___________________
____
____

Social History:

Do you drink alcoholic beverages?______ If so, how much per week? __________________
Do you use any tobacco products?_______ Do you smoke? ____ If so, packs per day_________
Do you take vitamin supplements? _____ If so, please list ______________________________

Do you consume caffeine? _____ If so, how much per day ________________________________
Do you exercise? ____ If yes, what is the frequency and type of exercise?___________________
What percentage of time during the day (at home or at your job) do you spend
Lifting _______ Sitting _______ Bending _______ Working at at computer _______

Family History:

Parents:
Father: Living___ Deceased___ Current age if living: ____ Cause of death and age at death if deceased:
____
Mother: Living___ Deceased___ Current age if living: ____ Cause of death and age at death if deceased:
____
If applicable: ____ Adopted as a child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? If so, please list:
____
____
Family Diseases (check if applicable and indicate whether family member is Father, Mother, Sister, Brother)
Tuberculosis___ Cancer___ Mental Illness___ Diabetes___ Asthma___ Heart Disease___ Stroke___ Kidney Disease___
Lung Disease___ Arthritis___ Liver Disease___ Other______________________

Please check any and all insurance coverage that may be applicable in this case:
Major Medical___ Workers Compensation ___ Medicare ____ Auto Accident ____
Medical Savings Account & Flex Plan ____ Other ____

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if any): ____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy 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 have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature__________________________ Date __________________

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____

Name of Patient   Date

Advanced Health Chiropractic
FINANCIAL POLICY

CASH PATIENTS: Patients without the benefit of chiropractic coverage on their insurance are **responsible to pay 100%** of their charges as services are rendered. If care becomes extensive, a **payment agreement** can be provided which will spell out a monthly amount. Your balance may **never exceed $250.00** at any time unless you have been **set UP** on a payment plan.

GENERAL INSURANCE: As a courtesy to you we will bill your insurance company and wait for payment. The insured is responsible for knowing their insurance benefit coverage. Every attempt will be made to determine an estimate of the insured's coverage, but because the insurance policy is a unique agreement between your employer and the insurance company, **we can make no guarantees**. **We cannot become involved in disputes between you and your insurance company** regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, coinsurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc., other than to supply factual information when necessary. Each guest is ultimately responsible for the timely payment of their account.

Your obligation is to pay any and all deductibles and co-payments as you go. You are also responsible for any "non-covered" services. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and after 90 days you will be responsible for payment in full for any outstanding balance. Remember, the care and services were provided to *you* and not your insurance company. You are responsible for all cost incurred in this office.

MEDICARE: As a participating provider with Medicare, we will accept what Medicare approves for your adjustments. Please be aware that **Medicare covers only chiropractic adjustments**. Medicare does not pay for any other services performed at our office.

WORKERS COMPENSATION: It is your responsibility to provide all necessary billing information to this office within five working days of your initial visit. Failure to do so will make you a cash patient and payment in full will be required on day five. If you have retained an attorney, you are also further required to provide this office with all attorney information. If you are a Missouri Workers Compensation patient, the laws require you, in your state, to get your employer's approval to come to this office. Without this approval, Missouri Workers Compensation will not pay for your care.

PERSONAL INJURY: All patients involved in a personal injury, such as a motor vehicle accident, are required to provide all necessary billing information and attorney information to this office within 5 working days of your initial visit. Failure to do so will make you a cash patient and payment in full of any outstanding balance will be required on day five. If you have retained an attorney you will be asked to sign a lien to protect any outstanding balance in this office at the time of settlement. **Any outstanding balance not paid at the time of settlement is YOUR responsibility.**

PATIENT SIGNATURE: ________________________________
PRINTED NAME: _____________________________________
DATE: __________________