244 E US Hwy 69, Suite 202
Kansas City, MO 64119
P 816.453.1198 * F 816.453.0381
www.ahckc.com E-Mail: info@advancedhealthchiro.com
Dr. Cheryl Golladay and Dr. Noelle Van Meter

PATIENT NAME: ____ DATE: __________________________

Chiropractic Case History/Patient Information

Name: ____ Social Security # _______________________

Age: _____ Birth date:____________ Marital: M S W D

Address: _____________________________ City: ___________ State: _________ Zip: ___________

Email Address: ______________________________ (Note: Your email address will remain private and will only be used to send AHC specials, health tips, e-Cards and office news. You can unsubscribe anytime using the link at the bottom of every email. You will receive an opt-in email to confirm your approval.)

Home Phone: ____________________ Cell Phone: ______________________

Can we leave a message on both of the #'s listed above? ☐ Yes ☐ No

Occupation:__________________________ Employer: _______________________________

Spouse: __________________________ Occupation/Employer:__________________________________

Emergency Contact: _________________________________ Phone: ________________________

How were you referred to our office?

Referral, if so who can we thank? _______________________________ Insurance Directory

Online Search Yellow Pages Signage Facebook Twitter Other : _______________________

Chief Complaint: Purpose of this appointment: ____

Date symptoms appeared or date of accident: ____

Is this due to: Auto___ Work____ Other____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

Skin, hair or nail problems	Swollen Extremities	Urinary Problems	Fatigue	Eye Problems
Weight Change Unplanned	Swallowing Issues	Dizziness/Vertigo	Weakness	Ear Problems
Menstrual Problems	Digestive Issues	Sinus/Allergies	Bowel Issues	Breast Pain
Heartburn/Indigestion	Abdominal Pain	Heart Problems	Clumsiness	

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Have you had Chiropractic care before? Yes No When? ____________________

Have you had these symptoms before? Yes No When? _____________________

Are you symptoms: Improving About the Same Getting Worse Comes & Goes

Who is your Medical Doctor? ____

List all Hospitalizations and Surgical Operations: ___________________________

____

____

List all Prescription Medications: ____

____

List all Non Prescription Medications/Supplements: _________________________

____

What are your habits?

Tobacco	Alcohol	Caffeine	None

What is your exercise activity level?

None	Light	Moderate	Strenuous

Stress Level

None	Minimal	Moderate	Greatly

Physical Activities

Sitting 50% of the time	Light Labor	Manual Labor	Repetitive Motions	Heavy Labor

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PATIENT NAME: ____ DATE: __________________________

Indicate any conditions you have been treated for (Past/Present)

High Blood Pressure	Epilepsy/Seizures	Sinus / Allergy issues	Heart Issues	Liver Issues	Lung Problems	Stroke
Low Blood Pressure	Thyroid Issues	Kidney Issues	Spinal Disc Disease	Cancer/Tumor	Numbness in Groin/ Buttock	Fainting
Aortic Aneurysm	Vertigo	Breast Issues	Pacemaker	Mental/Emotional Issues	Diabetes	Arthritis
Abnormal Weight Change	Menstrual Issues	Osteoporosis	Visual Issues	Prostate Issues	Scoliosis	

List any bone fractures/breaks (list and dates): ______________________________

____

Family History

(circle if applicable, indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, **M**aternal Grand**m**other or **G**rand**f**ather, **P**aternal **G**rand**m**other or **G**rand**f**ather)

Arthritis	HBP	Cancer	Diabetes	Stroke
Osteoporosis	Cardiovascular Disease	Back Problems	Other	Other

Please write the number down next to the function if you feel it is occuring:

1. No Limitations are being experienced
2. Mild/slight (Infrequent breaks)
3. Moderate (frequent breaks)
4. Severe (cannot perform)

Sitting	Yard Work	Carrying Objects	Putting on shoes	Dressing	Sleeping	Pulling Objects
Extended Computer	Standing	Driving	Concentrating	Reaching Overhead	Walking	Squatting

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Use						
Pushing Objects	Stand/Sit for long periods of time	Reaching	Kneeling	Household Chores	Using the Bathroom	Grooming
Bending	Using Stairs	Caring for Family	Hobbies	Pet Care	Lifting Objects	

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company (if any): ____

Dr. Cheryl Golladay DC, Dr. Noelle Van Meter DC, Advanced Health Chiropractic

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above 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 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.

I have had the opportunity to request a copy of the HIPPA NOTICE before signing this consent and understand and agree with how my records will be used and agree to these policies and procedures.

Patient Signature__________________________ 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.

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, including but not limited to the New Patient Exam.

WORKERS COMPENSATION: It is your responsibility to provide all necessary billing information to this office before or the day of your initial visit. 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, 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 before or the day of your initial visit. 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.**

CANCELLATION/NO SHOW POLICY FOR APPOINTMENTS: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
First No Call/No Show - $0
Second (and beyond) No Call/No Show - $25 fee; this will not be covered by your insurance company.

COLLECTIONS FEE: If your account goes 90 days + with no payment and payment arrangements are not made your account will be sent to collections and a $25 fee will be added to cover costs.

I understand the information above and agree to the financial policy

PATIENT SIGNATURE: ________________________________
PRINTED NAME: ____________________________________
DATE: __________________

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