Back to Life Chiropractic

FAMILY AND SPORTS MEDICINE
KRYSTAL PHILLIPS D.C., M.S

PATIENT INFORMATION

NAME _____ DATE _____

ADDRESS_____CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK # _____

E-MAIL ADDRESS _____ SOCIAL SECURITY # _____

I WOULD LIKE TO RECEIVE EMAIL APPOINTMENT REMINDERS [YES] [NO] TEXT REMINDERS? [YES] [NO]

RACE:
AMERICAN INDIAN OR
ALASKA NATIVE
ASIAN
BLACK OR AFRICAN-AMERICAN
OTHER PACIFIC ISLANDER
HISPANIC OR LATINO
WHITE

ETHNICITY:
NON-HISPANIC OR NON-LATINO
HISPANIC
HISPANIC OR LATINO

HEIGHT: _____ **WEIGHT:** _____

GENDER:
FEMALE MALE OTHER

DO YOU SMOKE?
NO YES
IF YES, HOW MUCH? _____
ARE YOU A FORMER SMOKER?
NO YES

DO YOU DRINK?
NO YES
IF YES, HOW MUCH? _____

EMPLOYER _____ OCCUPATION _____

DESCRIBE DAILY DUTIES _____

HOBBIES / RECREATIONAL SPORTS _____

DATE OF BIRTH _____AGE _____ MARITAL STATUS [MARRIED] [WIDOWED] [SINGLE] [DIVORCED]

SPOUSES NAME _____ EMPLOYED BY _____

CHILDREN (NAMES/AGES) _____

PRIMARY INSURANCE COMPANY _____ ID# _____

SECONDARY INSURANCE COMPANY _____ ID # _____

PATIENT HISTORY

WHAT IS YOUR MAJOR COMPLAINT? _____

DATE OF INJURY _____ HOW DID THE INJURY OCCUR? _____

LIST OTHER DOCTOR(S)/THERAPISTS SEEN FOR THIS CONDITION? _____

WHAT ACTIVITIES MAKE THE PROBLEM WORSE? _____

WHAT ACTIVITIES MAKE THE PROBLEM BETTER? _____

IS THIS CONDITION GETTING BETTER OR WORSE? _____

IS THE PAIN CONSTANT OR DOES IT COME AND GO? _____

IS THIS CONDITION RELATED TO AN AUTOMOBILE OR ON-THE-JOB INJURY? _____

CURRENT MEDICATIONS *(OVER THE COUNTER & PRESCRIPTION)*

_____

CURRENT ALLERGIES_____

FAMILY PHYSICIAN _____ FEMALES: *ARE YOU PREGNANT, OR A CHANCE YOU MIGHT BE PREGNANT? YES / NO*

HOW WERE YOU REFERRED TO OUR OFFICE? _____

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MEDICAL HISTORY:

Please indicate (1) if previously had, OR (2) if presently have for conditions listed below:

Musculo-Skeletal:
__low back pain
__pain between shoulders
__neck problems
__arm problems
__leg problems
__painful joints
__stiff joints
__sore muscles
__weak muscles
__broken bones

Nervous System
__numbness
__loss of feeling
__paralysis
__dizziness
__fainting
__headaches
__muscle jerking
__convulsions
__forgetfulness
__confusion
__depression

Cardiovascular-Respiratory
__chest pain
__difficult breathing
__persistent cough
__coughing blood
__rapid heartbeat
__blood pressure problems
__heart problems
__lung problems

Gastro-Intestinal:
__poor appetite
__excessive hunger
__difficulty swallowing
__nausea
__vomiting food
__vomiting blood
__abdominal pain
__diarrhea
__constipation
__black stool
__bloody stool
__hemorrhoids
__liver trouble
__gall bladder problems
__weight trouble

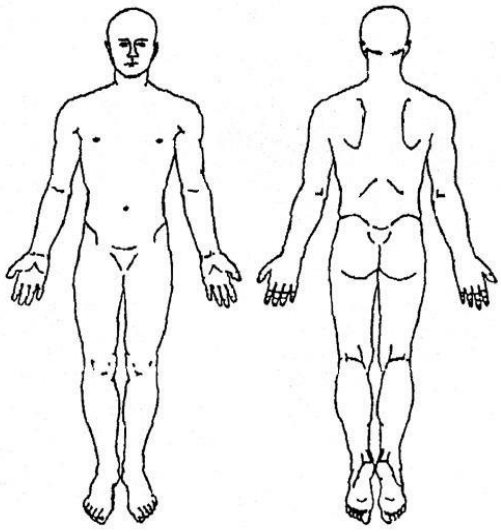
Urinary:
__bladder trouble
__excessive urine
__painful urination
__discolored urine

Female
__vaginal bleeding
__vaginal discharge
__breast pain
__breast augmentation
__lumps in breast

Other:
_____
_____

Family History:
__Diabetes
__Thyroid disease
__ Kidney Disease
__ High Blood Pres.
__ Heart Disease
__ Cancer
__ Lung Disease
__ Arthritis
__ Seizure

Using the symbols given below, mark the areas on your body where you feel the described sensations, include a



Numbness ---------- **Pins & Needles** 000000000000000 **Burning** XXXXX

Aching ******* **Stabbing** ////////////

********Please List all Hospitalizations and / or Surgeries:_____

_____

_____

Signature _____ Date _____

(If patient is a minor, signature of parent or guardian)

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Payment Policies

1. Patient Portions / Payments:

Are collected after **EACH** visit. We accept: Cash, Personal Check, Visa, MasterCard, American Express and Discover. **RETURNED CHECKS** will incur a $25.00 service charge.

All patient responsible balances that remain delinquent after 60 days, with no response to our requests for payment, may be referred to a collection agency. Patients whose accounts are referred to a collection agency may be responsible for attorneys' and/or collections fees, the amount of which shall not exceed that allowed under Missouri Law.

2. Health Insurance:

We **DO** accept most insurance plans, and most insurance plans **DO** cover Chiropractic care. It is **YOUR** responsibility to give to the correct information about your insurance company, and is **YOUR** responsibility to follow the rules outlined by your insurance company. E.g. referrals

We will call your insurance company to verify your chiropractic coverage. We will collect any co-payment and/or deductible amounts quoted by your insurance at the time services are rendered. If there are any discrepancies when the claims are processed, you may be responsible for any additional monies. We advise you to contact your insurance company to verify your benefits. If you are told different benefits, please advise our office.

We will submit all claims for services rendered in our office to your insurance company. We feel all procedures performed in our office are medically necessary. However, some insurance companies in an attempt to save cost, will consider some services as "non-covered", or "not medically necessary." Any services, which are denied, will be your responsibility.

3. Auto Accidents:

The patient **MUST** select which entity (personal health insurance, personal auto, med pay, party at fault auto insurance) will be responsible for reimbursement of services rendered by the conclusion of the first visit. (Please direct questions regarding the selection to the Doctors during your consultation.)

If you are dealing with an auto insurance company or involved in a lawsuit that affects the payment of the services rendered, please be advised that payment is due no later than **30 days** of discharge from our office, whether or not your case has settled. It is **YOUR** responsibility to stay on top of your case with the party at fault auto insurance, and/or your attorney.

4. Medicare:

We **DO** accept Medicare assignment. Medicare will be billed at the time services are rendered. You will be responsible for the portion of charges that Medicare does not pay. It is **YOUR** responsibility to make our staff aware if you have a secondary insurance and if you are set up for "cross-over."

I have read the above terms and hereby assume full responsibility.

_____ _____

Patient / Responsible Party Date

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Consent to Chiropractic Services

I. ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Back to Life Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

_____
Responsible Party Signature

_____ _____
Relationship Date

II. CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic manipulations and other procedures including various modes of physical therapy, and/or diagnostic tests by Back to Life Chiropractic and staff who now or in the future treat me while employed by this office. I have had an opportunity to discuss with the doctor named above and/or with other clinic personnel the nature and purpose of the treatment indicated. I understand that results are not guaranteed 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 wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

Signed _____ Date_____

Witness_____ Date_____

III. APPOINTMENT CHANGE NOTIFICATION

I have read and understand the appointment change notification policy and understand that if I change my appointment time with less than 24 hours notification, I will subsequently be charged a $40.00 fee.

Signed _____ Date_____

IV. CONSENT TO TREATMENT OF A MINOR CHILD

I authorize the licensed doctor to administer chiropractic care as deemed necessary to my _____(relationship), _____(name).

_____ _____
Responsible Party Signature Date

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)