Elite Chiro Care

7121 W. 95th St Overland Park, KS, 66212 Phone (913) 499-1027

Confidential Patient Information

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!

Date: _____ Patient's Full Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone & Provider: _____ E-Mail: _____

Date of Birth:_____/_____/_____ □ Male □ Female Spouse's Name: _____

□ Married □ Single □ Widowed □ Separated □ Divorced Number of Children/Ages: _____

Social Security # _____ - _____ - _____ Referred by (Friend, Relative, Physician or Newspaper): _____

Status: □ Employed □ Full Time Student □ Part Time Student □ Retired □ Unemployed □ Occupation: _____

Employer: _____ Work Phone: _____

Primary Insurance Company: _____ ID: _____ Group #: _____

Insured's Name: _____ Birth Date: _____ Employer: _____

Secondary Insurance Company: _____ ID: _____ Group#: _____

Insured's Name: _____ Birth Date: _____ Employer: _____

Relationship to Insured: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Family Physician: _____ May we contact your physician regarding your case? □ YES □ NO

Physician's Phone #:_____

Previous Chiropractic Care: □ Yes □ No If yes, for what problem: _____

Doctor's Name: _____ City: _____ State: _____

What type of care are you interested in: □ Pain relief only □ Healing of current condition □ Optimizing your health □ All three

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1) You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2) I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3) I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.
4) I further agree that this Authorization and Assignment is irrevocable until all moneys owed to Elite Chiro Care are **paid in full**.

Patient Signature: _____ Date: _____

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In general, would you say your health is (check one): ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

GOALS, EXPECTATIONS, LIMITATIONS:

What type of care are you seeking?: ☐ Pain relief only ☐ Healing of current condition ☐Optimizing your health ☐All three
What are your GOALS for seeking treatment in our office? _____
Where do you expect to be 3 weeks from now? _____
…6 weeks from now? _____
What limitations do you currently have as a result of your complaint(s)? _____
_____

PAST HEALTH HISTORY:

1) Have you ever experienced your present problem before for which you are consulting us: ☐ Yes ☐ No If YES, when: _____
   Was treatment provided: ☐ Yes ☐ No If yes, by whom: _____ Outcome: _____
2) Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss** or **blood loss**? ☐ Yes ☐ No If yes, explain:
   _____
3) Have you ever:
   - Broken a bone? ☐ Yes ☐ No If yes, please explain: _____
   - Had major sprains/strains? ☐ Yes ☐ No If yes, please explain: _____
   - Been knocked unconscious? ☐ Yes ☐ No If yes, please explain: _____
   - Been hospitalized? ☐ Yes ☐ No If yes, please explain: _____
   - Had surgery? ☐ Yes ☐ No If yes, please explain: _____
   - Had an eating disorder? ☐ Yes ☐ No If yes, please explain: _____
   - Been in an accident? ☐ Yes ☐ No If yes, please explain: _____
4) Please circle any of the following that you currently have or have had in the past:

Allergies	Emotional/Mental Disorders	Lung Disease
Anemia	Epilepsy	Macular Degeneration
Arteriosclerosis	Eye Pain	Migraines
Arthritis	Fatigue	Nosebleeds
Asthma	Frequent Urination	Pacemaker
Autoimmune Disease	Gallbladder Disease	Polio
Bleeding Disorder	Glaucoma	Prostrate Problems
Breast Lump	Gout	Seizures
Bronchitis	Headaches	Shortness of Breath
Cancer	Hepatitis	Sinus Infections
Congestive Heart Failure	High Blood Pressure	Sleep Problems/Insomnia
Cold hands/feet	Irregular Heart Beat	Skin Sensitivity
Constipation	Irregular Menstrual Cycle	STDs
COPD/Emphysema	Kidney Infection/Stones	Stroke
Dementia/Alzheimer's	Liver Disease	Swollen Ankles
Depression	Loss of Balance	Swollen Joints
Diabetes	Loss of Memory	Thyroid Conditions
Digestive Problems	Loss of Smell	Tuberculosis
Dizziness	Loss of Taste	Ulcers
HIV/AIDS	Varicose Veins	NONE OF THE ABOVE

Other Not Listed: _____

Social Health History:

How frequently do you:

Exercise:
□Never □Rarely □Occasionally □Frequently □Daily
Type: _____

Use Tobacco:
□Never □Rarely □Occasionally □Frequently □Daily
Type/Amount per day? _____

Consume Alcohol:
□Never □Rarely □Occasionally □Frequently □Daily

Use Drugs:
□Never □Rarely □Occasionally □Frequently □Daily

Eat Healthy:
□Never □Rarely □Occasionally □Frequently □Daily

Drink Caffeine:
□Never □Rarely □Occasionally □Frequently □Daily

Get adequate sleep:
□Never □Rarely □Occasionally □Frequently □Daily

Feel Stressed:
□Never □Rarely □Occasionally □Frequently □Daily

How much water do you drink daily? _____

FAMILY HISTORY:

Please list any family history of disease or illness in blood relatives (i.e. cancer, diabetes, heart attack, etc.):

MEDICATIONS:

Please list all medications you are taking including prescription and over the counter.

Patient initial _____ Date _____

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Current Health History:

Please answer the following as thoroughly as possible:

Where is your chief complaint? (one complaint per section) _____

When did it begin and what were you doing at the time? _____

What makes it feel better? _____

What makes it feel worse? _____

Describe your pain (Check all that apply):

Type of discomfort: □ Sharp □Dull □ Aching □ Burning □ Numbing □ Shooting □ Tightness □ Throbbing □ Diffuse □ Tingling

Quality of discomfort: □ Continuous □ Intermittent □ Occasional □ Frequent

Changes with movement: □ Decreases □ Same □ Increases

Intensity: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Amount of time: □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Does the pain/altered sensation radiate or travel to another part of your body? □Yes □ No If so, where? _____

Does it wake you up at night? □ Yes □ No

Please rate the severity of your pain (i.e. 0 = no pain . . . 10 = gunshot): 0 1 2 3 4 5 6 7 8 9 10

no pain unbearable

Have you noticed any difference in when you feel the problem (such as the time of day, specific activities, etc.)? □ Yes □ No

If yes, explain: _____

Where is your second complaint? (one complaint per section) _____

When did it begin and what were you doing at the time? _____

What makes it feel better? _____

What makes it feel worse? _____

Describe your pain (Check all that apply):

Type of discomfort: □ Sharp □Dull □ Aching □ Burning □ Numbing □ Shooting □ Tightness □ Throbbing □ Diffuse □ Tingling

Quality of discomfort: □ Continuous □ Intermittent □ Occasional □ Frequent

Changes with movement: □ Decreases □ Same □ Increases

Intensity: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Amount of time: □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Does the pain/altered sensation radiate or travel to another part of your body? □Yes □ No If so, where? _____

Does it wake you up at night? □ Yes □ No

Please rate the severity of your pain (i.e. 0 = no pain . . . 10 = gunshot): 0 1 2 3 4 5 6 7 8 9 10

no pain unbearable

Have you noticed any difference in when you feel the problem (such as the time of day, specific activities, etc.)? □ Yes □ No

If yes, explain: _____

Where is your third complaint? (one complaint per section) _____

When did it begin and what were you doing at the time? _____

What makes it feel better? _____

What makes it feel worse? _____

Describe your pain (Check all that apply):

Type of discomfort: □ Sharp □Dull □ Aching □ Burning □ Numbing □ Shooting □ Tightness □ Throbbing □ Diffuse □ Tingling

Quality of discomfort: □ Continuous □ Intermittent □ Occasional □ Frequent

Changes with movement: □ Decreases □ Same □ Increases

Intensity: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Amount of time: □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Does the pain/altered sensation radiate or travel to another part of your body? □Yes □ No If so, where? _____

Does it wake you up at night? □ Yes □ No

Please rate the severity of your pain (i.e. 0 = no pain . . . 10 = gunshot): 0 1 2 3 4 5 6 7 8 9 10

no pain unbearable

Have you noticed any difference in when you feel the problem (such as the time of day, specific activities, etc.)? □ Yes □ No

If yes, explain: _____

Patient initial _____ Date _____

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Where is your fourth complaint? _____

When did it begin and what were you doing at the time? _____

What makes it feel better? _____

What makes it feel worse? _____

Describe your pain (Check all that apply):

Type of discomfort: □ Sharp □Dull □ Aching □ Burning □ Numbing □ Shooting □ Tightness □ Throbbing □ Diffuse □ Tingling

Quality of discomfort: □ Continuous □ Intermittent □ Occasional □ Frequent

Changes with movement: □ Decreases □ Same □ Increases

Intensity: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Amount of time: □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Does the pain/altered sensation radiate or travel to another part of your body? □Yes □ No If so, where? _____

Does it wake you up at night? □ Yes □ No

Please rate the severity of your pain (i.e. 0 = no pain . . . 10 = gunshot): 0 1 2 3 4 5 6 7 8 9 10

no pain ⟷ unbearable

Have you noticed any difference in when you feel the problem (such as the time of day, specific activities, etc.)? □ Yes □ No

If yes, explain: _____

Where is your fifth complaint? _____

When did it begin and what were you doing at the time? _____

What makes it feel better? _____

What makes it feel worse? _____

Describe your pain (Check all that apply):

Type of discomfort: □ Sharp □Dull □ Aching □ Burning □ Numbing □ Shooting □ Tightness □ Throbbing □ Diffuse □ Tingling

Quality of discomfort: □ Continuous □ Intermittent □ Occasional □ Frequent

Changes with movement: □ Decreases □ Same □ Increases

Intensity: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Amount of time: □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Does the pain/altered sensation radiate or travel to another part of your body? □Yes □ No If so, where? _____

Does it wake you up at night? □ Yes □ No

Please rate the severity of your pain (i.e. 0 = no pain . . . 10 = gunshot): 0 1 2 3 4 5 6 7 8 9 10

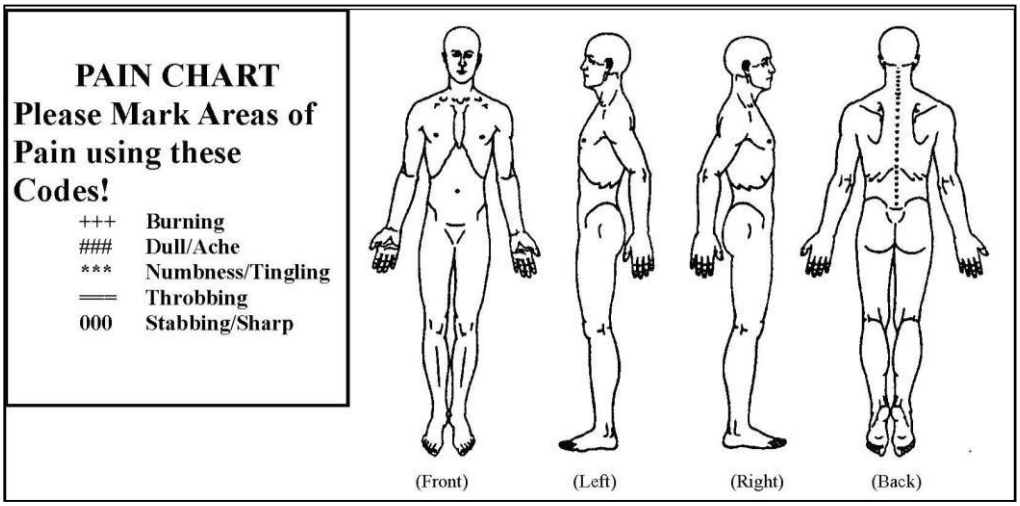
no pain ⟷ unbearable

Have you noticed any difference in when you feel the problem (such as the time of day, specific activities, etc.)? □ Yes □ No

If yes, explain: _____

(<u>If needed, use back or attach additional pages to list more complaints in same format as complaints 1-5</u>.)

<u>OPTIONAL</u>: If you feel like it is difficult to accurately describe where your pain is, please <u>ALSO</u> use the diagram below:



Patient initial _____ Date _____

Elite Chiro Care
Patient Informed Consent

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical rehabilitation and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Current medical research suggests there is no increased risk of stroke from spinal manipulation. However, some poorly constructed studies in the past suggested that there is a very slight incidence (one in about 10 million) that chiropractic manipulation can contribute to stroke.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks. Functional Dry Needling® (FDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity and is another treatment that is used at our office. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. The doctor performing this treatment will have met or exceeded the minimum training requirements set forth by the State Board.

FDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks**:** The most serious risk with FDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a very rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I understand there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient's Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Elite Chiro Care

Patient Financial/Privacy Policy and Disclaimer

Insurance Verification
Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

Deductible Payments
It is our policy to collect at time of service. Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance
Co-payments and Co-insurance is the patient's responsibility and will be **collected at the time of service**.

If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. **Payment is due within 30 days** of receipt of the bill.

In the event a bill is disputed, you must notify use within 30 days. If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue **interest at the rate of 18% per annum**. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.

All balances remaining **unpaid after 30 days may be reported to a credit bureau** and affect your credit rating.

Returned Checks
It is our policy to collect **$25.00 for checks that are returned to us**. This is to cover any fees that apply from the transaction.

Appointments
If you are unable to keep an appointment, as a courtesy to other patients and our staff, please **call before 3 pm the business day prior.** We reserve the right to apply a **$25 charge** towards your account for each cancellation that does not honor this request. We also reserve the right to apply a **$50 charge** towards your account for each appointment missed when we did not receive prior notice (no call, no show). The patient will be responsible for payment regardless of future appointment schedule.

Financial Policy Questions
We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator.

HIPAA Privacy Policy
Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you**.**

By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

I authorize this office to allow family and friends looking for me to be given information as to my arrival or departure of the premises, and or leave a message for me if I have not arrived or am in with the doctor.

Designation of Authorized Representative I do hereby designate Elite Chiro Care to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Elite Chiro Care. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

IRREVOCABLE Power of Attorney I do hereby authorize Elite Chiro Care to act on my behalf to pursue claims and exercise all rights in order to collect insurance payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Elite Chiro Care.

Patient's Signature: _____ Date: _____