

Patient Data

Date: _____

Title: Mr. Mrs. Ms Miss (check one)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Date of Birth: ____/____/____ **Sex:** Male Female **Email:** _____

Social Security Number: _____ - _____ - _____ **Marital Status:** Single Married Other

Employment Status: Employed Full Time Student Part Time Student Other (check one)

Spouse Data

Is your spouse a patient in the clinic? Yes No

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Employer Data

Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Contact Name: _____

Contact Phone: (_____) _____ - _____



Is it okay to call you at work?

- Yes No

How did you hear about our clinic? Or who referred you?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> TV Commercial | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> Other |

If you selected 'Yellow Pages' please indicate which Yellow Pages:

If you selected 'family member', 'friend', or 'physician' please enter their name below:

If you selected 'other' please describe

Medical Conditions:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |

Surgeries:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies | <input type="checkbox"/> Radical prostatectomy | <input type="checkbox"/> Transurethral prostate surgery |

Allergies:

- | | | | |
|-------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Gluten | |

Social History:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often | <input type="checkbox"/> Exercise not at all | <input type="checkbox"/> Exercise occasionally |
| <input type="checkbox"/> Exercise often | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always | <input type="checkbox"/> Wear seat belts never | <input type="checkbox"/> Wear seatbelts usually |

Family History:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent) | <input type="checkbox"/> Arthritis (sibling) | <input type="checkbox"/> Cancer (parent) | <input type="checkbox"/> Cancer (sibling) |
| <input type="checkbox"/> Cholesterol (parent) | <input type="checkbox"/> Cholesterol (sibling) | <input type="checkbox"/> Diabetes (parent) | <input type="checkbox"/> Diabetes (sibling) |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent) | <input type="checkbox"/> Psychiatric (sibling) | <input type="checkbox"/> Stroke (parent) | <input type="checkbox"/> Stroke (sibling) |
| <input type="checkbox"/> Thyroid (parent) | <input type="checkbox"/> Thyroid (sibling) | | |

Substance Use:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past) | <input type="checkbox"/> Alcohol (present) | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past) | <input type="checkbox"/> Cocaine (present) |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroine (past) | <input type="checkbox"/> Heroine (Present) |
| <input type="checkbox"/> Marijuana (past) | <input type="checkbox"/> Marijuana (present) | | |

Male Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Female Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Occupational Activities:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Daycare/childcare | <input type="checkbox"/> Executive/legal | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor | <input type="checkbox"/> Home services |
| <input type="checkbox"/> Household | <input type="checkbox"/> Light manual labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Medium manual labor |



By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

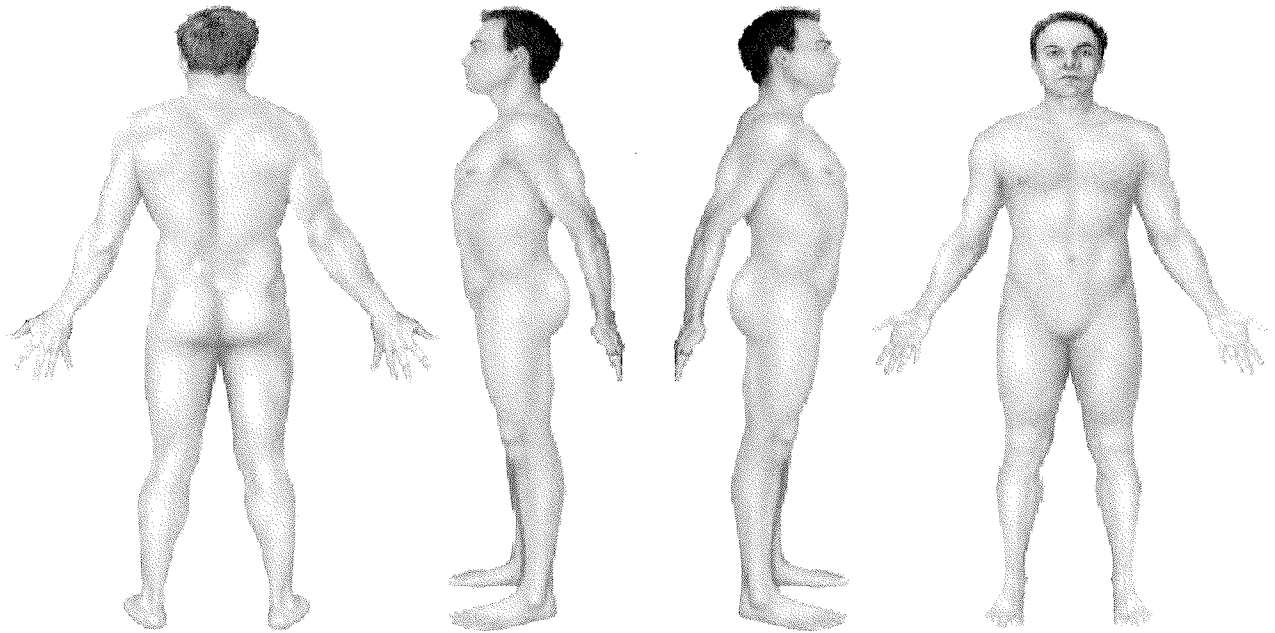
= Numbness

X = Burning

/ = Stabbing

0 = Pins & Needles

+ = Dull Ache



Describe your symptoms: _____

When did your symptoms start? Month _____ Day _____ Year _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- Sharp
- Burning
- Dull ache
- Tingling
- Numb
- Stabbing
- Shooting

How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- 0 None
- 4
- 8
- 1
- 5
- 9
- 2
- 6
- 10 Unbearable
- 3
- 7

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- Not at all
- Extremely
- A little bit
- Moderately
- Quite a bit

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- All of the time
- None of the time
- Most of the time
- Some of the time
- A little of the time



In general, would you say your overall health right now is...?

- Excellent
- Very good
- Good
- Fair
- Poor

Who have you seen for your symptoms:

- No one
- Other Chiropractor
- Medical Doctor
- Physical Therapist
- Other

What treatment did you receive for your symptoms?

- Adjustments
- Physical Therapy
- Medication
- Surgery
- Other

When did you receive this treatment?

- In the last month
- 2 – 3 months ago
- 3 – 6 months ago
- 6 months to 1 year ago
- 1 – 2 years ago
- 2 – 5 years ago
- 5 – 10 years ago

What tests have you had for your symptoms?

- X-rays
- MRI
- CT Scan
- Other

When were these tests done?

- In the last month
- 2 – 3 months ago
- 3 – 6 months ago
- 6 months to 1 year ago
- 1 - 2 years ago
- 2 – 5 years ago
- 5 – 10 years ago

Have you had similar symptoms in the past?

- Yes
- No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- This Office
- Other Chiropractor
- Medical Doctor
- Physical Therapist
- Other

What is your occupation?

- Professional/Executive
- White Collar/Secretarial
- Tradesperson
- Laborer
- Homemaker
- Full-time Student
- Retired
- Other

If you are not retired, a homemaker or a student, what is your work status?

- Full-time
- Part-time
- Self-employed
- Unemployed
- Off work
- Other

What medications/supplements/vitamins are you currently taking?

| | | |
|--|--|--|
| | | |
| | | |
| | | |
| | | |

X _____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE:

X _____
RELATIONSHIP TO PATIENT

X _____
DATE

Thank you. Please return to the front desk.



INSURANCE INFORMATION

Insurance Company _____ Insurance ID# _____
Insured's Name _____ Sex: M F
Insured's Date of Birth _____ Insured's SS# _____
Insured's Employer _____ Employer's Phone () _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Decker Chiropractic staff will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Decker Chiropractic Walk-In-Care will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DECKER CHIROPRACTIC WALK-IN-CARE

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to DECKER CHIROPRACTIC WALK-IN-CARE as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to Decker Chiropractic Walk-In-Care, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

DECKER CHIROPRACTIC WALK-IN-CARE, P.A.
13025 S MUR-LEN SUITE 100
OLATHE, KS 66062
(913) 829-5111

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Insured

Date

Witness

Date

FINANCIAL AND INSURANCE DISCLAIMER

FINANCIAL POLICY

Payment in full is expected at the time service is rendered. If you have insurance coverage for chiropractic care in our office, you will be responsible for your co-payment, deductible, or co-insurance payment at the time of each visit. If you do not have insurance coverage for chiropractic care, you will be responsible for payment in full at the time service is rendered. We provide the convenience of accepting all major credit cards, as well as cash, personal check, bank card, or money order. We understand that it may not be possible to pay in full on occasion, and we are willing to establish a payment schedule with you; however, the balance can not exceed \$250.00, and the full balance must be paid within 30 days. Delinquent accounts may be handled by an attorney for collection. Costs of collections will be added to your account and will be your responsibility.

INSURANCE POLICY

Our office accepts most insurance coverage. If you have insurance, please provide us with your insurance card so we may make a copy of the card for your file. Our staff will call the insurance company to verify your insurance coverage and will explain to you what information was obtained. **NOTE:** Verification is not a guarantee of benefits. Benefits are subject to the terms of the contract on the date benefits are quoted. Actual benefits and coverage will be paid once submitted and a review at the time of process. Upon receipt of payment and Explanation of Benefits (EOB) from your insurance company, we will know your final patient responsibility. We will then notify you of any changes or differences to the original verification quoted to us. **NOTE:** We will verify your insurance coverage for chiropractic care in our office, but we assume no responsibility for the information we receive being correct concerning how much or for what your insurance company will cover and pay.

Some insurance companies require a referral from your Primary Care Provider (PCP) before your visit to our office so your care can be covered under their plan. If your insurance company requires you to have a referral in order to be treated in this office, it is your obligation to obtain the referral BEFORE service is rendered. Your PCP is not allowed by law to back date a referral, so you must have one before service is rendered in our office. We cannot do this for you. Should you not have a referral at the time of service, you must be prepared to pay in full for the service at the time the service is rendered.

Decker Chiropractic Walk-In-Care, P.A., does not accept responsibility for information given to us by the insurance company or by the patient. The final financial responsibility is yours. In no case can insurance be guaranteed. Should you have any questions at any time, do not hesitate to contact the staff or Office Manager.

I understand that Decker Chiropractic Walk-In-Care, P.A., will submit services rendered for my care for payment under the contract I have with my health and/or accident insurance carrier. However, I understand and agree that verification of insurance is not a guarantee of benefits on all services rendered me, and I am ultimately responsible for payment. I also understand if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient and/or Insured

Date

Witness

Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustment and any other chiropractic procedures, including examination tests, diagnostic x-rays(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for, the Doctor of Chiropractic named below.

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also understand and agree that the amount paid to the doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest. I understand that the results are not guaranteed.

I have read the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. 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.

Decker Chiropractic Walk-In-Care

Dr. George D. Decker, D.C

Dr. Sara M. Mitchell, D.C.

Dr. William H. Thomas, D.C.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient

Signature of Patient

Date

Signature of Patient's Representative (if minor or physically incapacitated)

Date

Witness to Patient's Signature

Date

Welcome to Our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Discuss your case with family
- Collect payment
- Do research
- Run our office
- Include you in care classes
- Inform you about other services
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to worker's compensation
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings

You have the right to:

- Request a copy of your health record
- Request confidential communications
- Request a list of whom we share your health information with
- Amend your protected health information
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated

These privacy practices are effective: 4/1/2003

For further information please contact: De-Anna Binkley

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

patient or guardian signature

date

ADDENDUM TO NOTICE OF PRIVACY PRACTICES - HIPAA

I give permission to release information to the following person or persons. He and/or she may inquire in person, by phone, or mail about my account or records and speak with the doctor on my behalf.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I give permission to release information about my Chiropractic care and my progress to the Medical Doctor listed below.

Doctor name _____

Office address _____

City & zip _____

Office phone # _____

Signature _____

Date _____