

Utterback Chiropractic, LLC

Kirkwood Spine & Rehab

REASON FOR VISIT

What is/are your complaints? _____

When did these symptoms begin (most recent episode)?: _____

Have you had these symptoms in the past? Yes No If So, Explain: _____

How did the symptoms begin: Auto Accident Work Accident Fall
 Other (please explain): _____

Is this condition interfering with your: Work Sleep Daily Routine
 Other (please explain): _____

How often do you experience your symptoms?

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

What best describes your symptoms?

- Sharp Dull Ache Numb Burning Shooting Tingling

Since your symptoms began, have they been:

- Getting Worse Getting Better No Change

How do you rate your overall health?:

- Excellent Very Good Good Fair Poor

Have you seen any other healthcare professionals for this condition?: Yes No

If so, Who?: _____ Phone Number: _____

What treatment did you receive? _____

Were X-rays/MRI/Tests etc. performed? Yes No If So, Where?: _____

PAIN DRAWING

Patient Name: _____ Acct: _____ Date: _____

Draw location of your pain on body outlines and mark how bad it is on pain line.

PAIN SCALE

1 = Mild 10 = Severe

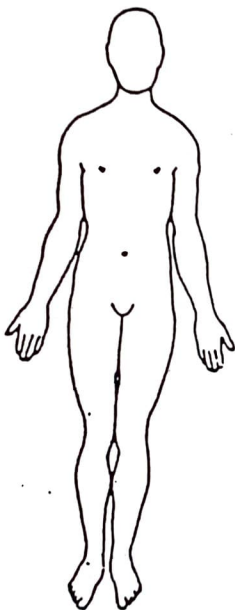
PAIN DRAW

Pain =

Numbness = ++++++

Ache = *****

Burning = //////////////



HANDS.

FEET

Tops

Palms

Tops

Soles



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HEALTH HISTORY

Do you currently or have you had in the past any of the following (Please check and explain below, if necessary):

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Alcohol / Drug Abuse |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Back Pain | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers / Colitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Diseases | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Shingles | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Artificial Bones / Joints |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Birth Defects |

Please list any other serious medical conditions you have had or provide explanation for above: _____

Are you taking any medications?: Yes No

If Yes, Please List: _____

Do you have any allergies?: Yes No

If Yes, Please List: _____

Please list any previous surgeries: _____

Please list any past accidents/falls/trauma with dates: _____

Family health history (i.e. cancer, anemia, diabetes, high/low blood pressure): _____

Do you take supplements or vitamins? No Yes, list: _____

Do you exercise? Yes No If Yes, how often? _____

Are you on a special diet? Yes No If Yes, Please Explain _____

Do you smoke? Yes No How Much? _____ For how long: _____

Do you wear: Heel Lifts Orthotics Arch Supports Other: _____

For women: Are you pregnant? No Yes/How long? _____; Nursing Yes No

Are you taking birth control? Yes No

• I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE: _____ DATE: _____

Adult Patient Parent or Guardian Spouse

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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

This PHI Consent will be part of your medical record at this facility.

Accidents – Auto/Other

1. If you are being treated for injuries sustained in an accident (automobile/other) you agree that your personal med pay and/or party at fault insurance company will be responsible for reimbursement of treatment provided.
2. A signed lien is REQUIRED for treatment in this office.
3. 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 90 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 insurance and/or your attorney.

Medicare

We do not accept Medicare assignment. Medicare members must pay in full at the time services are rendered. We will submit claims to Medicare and any reimbursement they make will be sent directly to you. It is your responsibility to make our staff aware if you have a secondary insurance and if you are set up for cross over.

Overdue Accounts

Any patient portion unpaid after 90 days from the date of service will be subject to an 18% charge. If your balance remains unpaid it will be sent to a collection agency or an attorney for nonpayment.

Missed Appointments

A missed appointment fee of \$10 will be charged for no shows and appointments cancelled without 24 hour notice.

By your signature below, you agree to the terms set out in this registration.

Signature _____ Date _____

01/15/14

NEW PATIENT REGISTRATION

Name _____ Age _____ Sex _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Phone (H) _____ (W) _____ (C) _____
SS # _____ Marital Status: () Married () Divorced () Single Spouses Name _____
Employer _____ Spouses Employer _____
Family Dr. _____ Doctors Phone # _____
In Case of Emergency Call _____ Phone # _____ Relation _____
Email Address _____ Can we send info to your email address? Yes ___ No ___
Referred by: _____

Welcome to the Utterback Chiropractic, LLC, dba Kirkwood Spine and Rehab clinic. Our highly trained staff is always willing to help you and your family. Our practice grows from referrals and we appreciate you in a very special way when you recommend your family and friends to our office.

Office hours allow our patients the convenience to schedule appointments before and after work as well as during lunch. We are usually available to see new patients the same day or through our 24 hour- 7 day emergency service.

The doctor will discuss your health history, perform an examination and discuss recommendations with you today. There are no guarantees or promises of improvement or complete recovery. Please give the doctor as much information as you can remember. By this registration you authorize the doctor to perform such examinations, diagnostic tests and/or treatment as he may consider medically necessary and you authorize us to release all information to your health insurance company and/or all applicable parties on your behalf.

Payment

1. Patient payments are collected at time of visit, including copays, co-insurance, deductibles and all non-covered charges. Due to the variations among insurance companies, we will estimate your portion to the best of our ability. We will collect a minimum of \$45 if you have a deductible that has not been met for the year. Any balances due will be expected at the time of billing.
2. We accept cash, personal check, Visa, MasterCard and Discover.
3. Returned checks, debit and credit charges due to insufficient funds, stopped payments or other reasons of non payment will be assessed a \$30 charge.

Health Insurance

1. We do accept most insurance plans and most insurance plans do cover chiropractic care. It is YOUR responsibility to give the correct information about your insurance accompany and YOUR responsibility to follow the rules outlined by your insurance plan (i.e. Referrals).
2. We will call your insurance company to verify your chiropractic coverage. We will collect any copayment 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. Please look at your explanations of benefits sent to your home from your insurance company. We advise you to contact your insurance company to verify your benefits. If you are told different benefits, please advise our office.
3. We will submit all claims for services rendered in our office to your insurance company.
4. 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.