Confidential Patient Information for
Restore Family Chiropractic

Today's Date ___________________________________

Name ____Sex ______ Marital Status ______Date of Birth ____/_____/____ Age _____
First Name, Middle Initial and Last Name — M or F — S or M — Mo/Day/Yr

Address ____Apt #______ City ____________________ State _____ Zip___________
Include Street type such as St., Ave., etc.

Home Phone____________________________Work Phone___________________________Cell Phone_____________________________
Area Code/Number — Area Code/Number — Area Code/Number

____
Patient's Occupation — Company Name — Location

Email Address____

Is your visit due to an accident? __ No __ Yes What type? ☐ Auto ☐ Work ☐ Other (if auto, please see receptionist for an injury report)

Name of Primary Care Physician:________________________________Address:____

Who referred you to/how did you hear about our office?____

Reason for consulting our office?____

Emergency Contact:

Full Name____ __________________________
First Name , Last Name — Phone Number

Relationship to you:____

Do you have insurance? ☐ Yes ☐ No Company ____

I.D. No. ____Policy Group No. ____

Are you the primary insured? ☐ Yes ☐ No If not, please tell us who is: ☐ Spouse ☐ Significant Other ☐ Parent ☐ Guardian

Name of insured if not yourself____Employer of Insured_______________________________

Do you have a secondary insurance policy? ☐ Yes ☐ No Company ____

I.D. No. ____Policy Group No. ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charges directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Restore Family Chiropractic extends credit to me and 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 unless prior arrangements are made. I hereby authorize the doctors at Restore Family Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above is true and correct.

Patient's Signature ____**Date**________________________

Parent or Guardian Signature (if patient is a minor)____**Date**_______________

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT…

As a full spectrum Wellness office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Did you have any childhood illnesses? Y / N

Did you take/use any drugs? Y / N

Did you have any serious falls as a child? Y / N

Did you have any surgery? Y / N

Did you play youth sports? Y / N

Were you vaccinated? Y / N

Have you fallen/jumped from a height over three feet? (i.e.: crib, bunk bed, trees) Y / N

Were you involved in any accidents (i.e.: car, bike, skateboard, sports, etc) as a child? Y / N

Was there any prolonged use of medicine such as antibiotics or an inhaler? Y / N

Did you suffer any other traumas? (physical or emotional) Y / N

As a child, were you under regular chiropractic care? Y / N

ADULT (18 TO PRESENT)

Do/did you smoke? Y / N

Do/did you drink alcohol? Y / N

Have you been in any accidents? Y / N

Have you had any surgery? Y / N

Do/did you play any adult sports? Y / N

Do/did you participate in extreme sports? Y / N

Are you pregnant? Y / N

If yes, how far along? ___________Est Due date___________

On a scale of 1-10, describe your stress level: (0=none / 10=extreme)

Occupational Stress _____

Personal Stress _____

On a scale of Poor, Good, Excellent describe your:

Diet __________ Sleep __________

Exercise __________ General Health __________

▪*Addressing the Issues That Brought You to the Office*

If you have **no symptoms**, and are here for wellness services, please check here_____ "Wish to Have Chiropractic Wellness Services" and skip to the next page. **Others need to briefly describe the chief area of complaint, including the effect it has had on your life**.

____

____

If you are experiencing pain, is it… (circle all that apply)

sharp dull comes and goes constant travels

Since the problem started, it is…(circle all that apply) about the same getting better getting worse

What makes it worse:____

Yes, the pain interferes with…(circle all that apply)

work sleep walking sitting hobbies leisure driving other

Other Doctors seen for this problem (please list): Chiropractor ______________________________

Medical Doctor ______________________________

Other ______________________________

Personal Medical History (if any of the following are relevant to your medical history, please check the accompanying box:)

- ☐ Cancer
- ☐ Polio
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Concussion
- ☐ Hepatitis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Nervousness
- ☐ Asthma
- ☐ Dizziness
- ☐ German Measles
- ☐ Digestive Disorders
- ☐ Sinus Trouble
- ☐ Backaches
- ☐ Numbness
- ☐ Arthritis
- ☐ Venereal Disease

Please check all of the symptoms you have now, even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Pins/Needles in arms
- ☐ Dizziness
- ☐ Numbness in fingers
- ☐ Fatigue
- ☐ Sleeping problems
- ☐ Diarrhea
- ☐ Cold sweats
- ☐ Mood swings
- ☐ Loss of smell
- ☐ Pins/Needles in legs
- ☐ Buzzing in ears
- ☐ Numbness in toes
- ☐ Depression
- ☐ Neck stiffness
- ☐ Constipation
- ☐ Light sensitivity
- ☐ Menstrual pain
- ☐ Fainting
- ☐ Back pain
- ☐ Ringing in ears
- ☐ Loss of taste
- ☐ Irritability
- ☐ Cold hands
- ☐ Fever
- ☐ Problem urinating
- ☐ Menstrual irregularity
- ☐ Neck pain
- ☐ Loss of balance
- ☐ Nervousness
- ☐ Stomach upset
- ☐ Tension
- ☐ Cold feet
- ☐ Hot flashes
- ☐ Heartburn
- ☐ Ulcers

Please list any medications you are taking:______________________________

How does this condition currently interfere with your life and ability to function? Place "✔" or "X" in box.

	no affect	mild affect	moderate affect	severe affect			no affect	mild affect	moderate affect	severe affect
sitting						household chores				
rising out of a chair						lifting objects				
standing						reaching overhead				
walking						showering / bathing				
lying down						dressing myself				
bending over						getting to sleep				
climbing stairs						staying asleep				
using a computer						concentrating				
getting in / out of car						exercising				
driving a car						yard work				
looking over shoulder						work / career				
caring for family						recreational activities				
grocery shopping						personal relationships				

Short Term Health Goals	**Long Term Health Goals**

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature______________________________ Date______________

Parent or Guardian Signature (if patient is a minor)______________________________ Date______________

RESTORE FAMILY CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Restore Family Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

<u>Disclosure of Your Health Care Information</u>

<u>Treatment</u>

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

> "*On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Restore Family Chiropractic."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Restore Family Chiropractic, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

<u>Payment</u>

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Restore Family Chiropractic for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

<u>Workers' Compensation</u>

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

<u>Emergencies</u>

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

<u>Public Health</u>

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with and reactions to medication, and reporting disease or infection exposure.

<u>Judicial and Administrative Proceedings</u>

We may disclose your health information in the course of any administrative or judicial proceeding.

<u>Law Enforcement</u>

We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

<u>Deceased Persons</u>

We may disclose your health information to coroners or medical examiners.

<u>Organ Donation</u>

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

<u>Research</u>

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

<u>Public Safety</u>

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health and safety of a particular person or to the general public.

<u>Specialized Government Agencies</u>

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes of fundraising purposes, as described below: (example)

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*
>
> *"It is our practice to participate in charitable events to raise awareness, food donation, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Restore Family Chiropractic sponsored fund-raising events."*

Change of Ownership

In the event that Restore Family Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights:

- *You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however that Restore Family Chiropractic is not required to agree to the restrictions that you requested.*
- *You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.*
- *You have the right to inspect and copy your health information.*
- *You have a right to request that Restore Family Chiropractic amend your protected health information. Please be advised, however, that Restore Family Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with and explanation of our denial reason(s) and information about how you can disagree with the denial.*
- *You have a right to receive an accounting of disclosures of your protected health information made by Restore Family Chiropractic.*
- *You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.*

Changes to this Notice of Privacy Practices

Restore Family Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Restore Family Chiropractic is required by law to comply with this Notice.

Restore Family Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any of this notice or if you want more information about your privacy rights, please contact: Lacey Allen by calling this office at (913) 393-2222. If Lacey Allen is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about our Privacy rights or how Restore Family Chiropractic has handled your health information should be directed to Lacey Allen by calling this office at (913) 393-2222. If Lacey Allen is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S. W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Restore Family Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient's Name (print)

____ _________________________
Patient's Signature or Guardian Signature Date

____ _________________________
Authorized Facility Signature Date

Restore Family Chiropractic

14645 W 95th Street Lenexa • Kansas 66215 • (913) 393-2222

Payment and Insurance Policy

Restore Family Chiropractic will try to assist in obtaining insurance benefits whenever possible. It must be understood, however, that

1. The patient is responsible for full payment of all services rendered on their behalf or on behalf of their dependent.
2. We will call to verify benefits. However, we cannot be responsible for errors in the quoting of benefits. We suggest that you become aware of your own benefits, deductibles, and maximums, etc.
3. Insurance is a contract between you, the Insurance Company and/or your employer. Restore Family Chiropractic is not a party to that contract. Assisting you in trying to obtain payment is a courtesy and may be withdrawn at any time.
4. Insurance carriers are billed daily by Restore Family Chiropractic. Insurance payments are generally received within 30 days. The maximum time limit that Restore Family Chiropractic extends is 60 days. Thereafter, the patient must pay the fees in full.
5. If we are requested to fill out additional forms, a clerical fee of $5.00 per form is due in advance.
6. Patients must stay current with the full amount of their percentage responsibility (e.g. if insurance is expected to pay 80% of the bill, the patient must pay at least 20% of their charges). This must be paid at time of service or when other arrangements have been made with the doctor.
7. If the patient discontinues care for any reason other than discharge by the doctor, the patient must pay the outstanding balance in full, immediately-regardless of any claims submitted.
8. If the patient fails to keep regular appointments, they will be discharged. The patient must pay the outstanding balance in full, immediately.
9. All deductible amounts must be paid prior to submission for insurance benefits.
10. If there is any balance due after the Statement of Benefits is received from the insurance carrier, that balance is due from the patient immediately.
11. If the patient fails to pay off the balance due or make consistent payments, the account will be turned over for collection after 45 days of no payment. The patient will also be responsible for any collection fees acquired in the collection process.
12. Any refunds made to patients will be based on the full account balance, without presuming further insurance benefits that may be payable.

I have read and I agree to the above. Further, I hereby authorize and request that insurance companies pay directly to Restore Family Chiropractic, any insurance benefits for medical care, health related service and durable medical equipment that would otherwise be payable to me.

____________________________________ ____________________

Patient or Guardian Signature Date

RESTORE FAMILY CHIROPRACTIC

NO SHOW/LATE CANCELLATION POLICY

Restore Family Chiropractic is committed to providing exceptional service in a timely manner. Unfortunately, when a patient cancels without giving enough notice, it prevents another patient from being treated. For that reason, Restore Family Chiropractic has implemented a no show/late cancellation policy that will be strictly observed.

CANCELLATIONS & NO SHOW:

- Effective May 01, 2022 any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 8 hours notice** will be considered a No Show and charged a **$30.00** fee.
- The fee is charged to the patient, not the insurance company, and is due at the time of missed appointment.
- As a courtesy, we send out reminder texts for upcoming appointments. If you do not receive a reminder text, the above policy will remain in effect.

______________________________________ ___________________________

Patient/Guardian Signature Date