Mills Chiropractic & Wellness Center, P.A.

13795 S. Mur-Len Rd. Ste. #203 Olathe, KS 66062
(913) 764-5900
www.millswellness.com

New Patient Intake Form

Patient Data

Name: _____ Date of Birth: _____ Sex: ____

Address:_____ Home #: _____

City: _____ State: _____ Zip: _____ Cell # _____

E-Mail: _____ Preferred Contact Method? _____

- ☐ I want to receive appoint reminders via text message (standard carrier rates/fees may apply).
- ☐ I want to receive appointment reminders via email.
- ☐ I want to receive wellness information via email to help me get better faster.

Emergency Contact: _____ Phone #: _____

Whom may thank for referring you? _____

Primary Care Physician: _____

Address/Facility: _____

"I authorize Mills Chiropractic & Wellness Center to share their findings, treatments, outcomes, and other relevant information from my care here with the physician listed above." If YES, please sign below.

Signature: _____ Date: _____

Guarantors Information (person carrying insurance)

Name: _____ Date of Birth: _____ Sex: M / F

Address:_____ Relationship: _____

City: _____ State: _____ Zip: _____ Phone #:_____

Insurance Company: _____ Member #: _____

Policy Name: _____ Group #: _____

"I authorize Mills Chiropractic & Wellness Center to bill my insurance company for the charges incurred. I agree to abide by the rules and regulations set forth by my policy." If so, please sign below.

Signature: _____ Date: _____

Medical History:

Have you ever had chiropractic treatment before?	No	Yes, last treatment was:_____
Do you wear orthotics?	No	Yes, and they're about _____ years old
Do you currently use alcohol?	No	Yes. Frequency: _____
Do you use other recreational drugs?	No	Yes. Frequency: _____
Do you exercise?	No	Yes. Frequency: _____

What is your current smoking status?

- ☐ Current every day smoker – Amount per week: _____
- ☐ Current some day smoker – Amount per week: _____
- ☐ Former smoker – Date stopped: _____
- ☐ Never smoker

Have you been abused?	No	Yes
Are you currently being abused?	No	Yes
Are you hard of hearing?	No	Yes, and I need services: _____
Females: Are you currently pregnant?	**No**	**Yes, and I'm _____ weeks along.**

Allergies:

Do you have any medication allergies?

- ☐ No, I have no known medication allergies.
- ☐ Yes: _____

Other Allergies:

- ☐ Chemical _____
- ☐ Environmental_____
- ☐ Seasonal_____
- ☐ Other_____
- ☐ Food_____
- _____

Sensitivities:

- ☐ Chemical _____
- ☐ Environmental_____
- ☐ Seasonal_____
- ☐ Other_____
- ☐ Food_____
- _____

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Surgeries:

Please circle all surgeries you have had in the past.

Abdominal exploration	Abdominoplasty	Abortion	ACL reconstruction
Adenoid removal	Angioplasty	Appendectomy	Bone fracture repair
Breast lump	Bunion removal	Carotid artery surgery	Cataract surgery
Cervical spine surgery	Cholecystectomy	Cosmetic breast	C-Section
Facelift	Gallbladder Removal	Gastric Bypass	Heart Bypass
Heart Surgery	Hemorrhoid	Hernia Repair	Hip Joint Replacement
Hysterectomy	Kidney Transplant	Knee Arthroscopy	Knee Replacement
LASIK eye	Liposuction	Lumbar Spine	Mastectomy
Prostate Removal	Rotator Cuff	TMJ	Vasectomy
Tonsillectomy			

Other: _____

Injuries:

Please list any major injuries which you have had in your lifetime. You may use the space below if needed.

Injury: _____ Year of Injury: _____

Injury: _____ Year of Injury: _____

Injury: _____ Year of Injury: _____

Injury: _____ Year of Injury: _____

Injury: _____ Year of Injury: _____

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Conditions:

Please check whether YOU or a close relative are currently experiencing or have previously experienced any of the following conditions.

Head & Neck Conditions

Me	Family	Condition
		Headaches
		Hearing Problems
		Eye Problems
		Nose Bleeds
		Difficulty swallowing
		Sore Throat
		Migraines
		Ringing in the Ears
		Vision Problems
		Other Nose Problems
		Excessive Thirst
		Voice Changes
		Chronic Sinusitis
		Vertigo/Dizziness
		Visual Disturbances
		TMJ (jaw pain)
		Loss of taste
		Other:

Internal Conditions

Me	Family	Condition
		Liver Problems
		Kidney Stones
		Bladder Infection
		Incontinence
		Cancer
		Urinary Tract Infections
		Hepatitis
		Kidney Disorders
		Frequent Urination
		Painful Urination
		Non-Cancer Tumor
		Renal Disease
		Hemorrhoids
		Gallbladder Problems
		High Cholesterol
		High Triglycerides
		Other:

Chest, Lung, & Heart Conditions

Me	Family	Condition
		Chest Pain
		Heart Attack
		Palpitations
		Bronchitis
		Pneumonia
		Other Lung Problem
		Aortic Aneurysm
		Heart Disease
		Blood Pressure Issues
		COPD
		Asthma
		Angina
		Rapid Heartbeat
		Chronic Cough
		Emphysema
		Shortness of Breath
		Other:

Digestive Conditions

Me	Family	Condition
		Nausea
		Belching/Gas
		Abdominal Pain
		Ulcer
		Heartburn
		Diarrhea
		Colitis
		Leaky Gut Syndrome
		Bloating
		Constipation
		Irritable Colon/Bowel
		Other:

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Musculoskeletal Conditions

Me	Family	Condition
		Scoliosis
		Wrist Pain
		Neck Pain
		Hip Pain
		Poor Posture
		Arm/Elbow Pain
		Mid Back Pain
		Knee/Leg Pain
		Poor Posture
		Arm/Elbow Pain
		Mid Back Pain
		Knee/Leg Pain
		Hand Pain
		Shoulder Pain
		Low Back Pain
		Foot/Ankle Pain
		Other:

Female-Only Conditions

Me	Family	Condition
		Congested Breasts
		Cramps or Backache
		Endometriosis
		Menopausal Symptoms
		Lumps in Breasts
		Irregular Cycle
		PMS
		Excessive Menstrual Flow
		Painful Periods
		Breast Soreness
		Hot Flashes
		Absent Periods
		Other:

Male-Only Conditions

Me	Family	Condition
		Prostate Problems
		High PSA
		Other:

Disease, Neurological, Mental, and Other Conditions

Me	Family	Condition
		Tuberculosis
		Diabetes
		Blood Disorder
		Thyroid Disease
		Hashimoto's
		Lyme
		Rheumatoid Arthritis
		Gout
		Osteoarthritis
		Swollen/Stiff Joints
		Stroke
		Convulsions
		Epilepsy
		Fainting
		Muscular Incoordination
		Muscle Cramps
		Bruise Easily
		Seasonal Allergies
		Skin Problems
		Night Sweats
		Anorexia
		Bulimia
		Weight Gain
		Weight Loss
		Low Energy / General Fatigue
		Poor Appetite
		Anxiety
		Depression
		Mental Disease
		Insomnia
		Other:

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Medications/Supplements:

Are you currently taking any <u>prescription</u> medications?

☐ No, not currently prescribed any medications.

☐ Yes, Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Use the space below to continue listing if needed.

Are you currently taking any <u>non-prescription</u> medications, vitamins, or supplements?

☐ No, not currently taking anything else.

☐ Yes, Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Name _____ _____ mg _____ times/day

Use the space below to continue listing if needed.

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Incident Report

Was your primary complaint today caused by an incident like a slip-and-fall, trauma, or other injury?

If so, please answer the questions below. If not, you may skip this page.

If your primary complaint today was caused by a **car accident for which you are currently seeking insurance compensation, or for which the case is still open, please stop here and alert the front desk immediately so the proper procedures can be initiated.

When did the incident/injury occur? _____

Immediately after the accident/injury, did you feel dazed? Yes No
Did you lose consciousness? Yes No
Was your head injured? Yes No

Immediately after the accident, did you experience: Headaches Neck Pain Low back pain

Did you see another doctor before coming here? Yes No If yes, name of doctor: _____

Did you go to a hospital after the accident/injury? Yes No If yes, which hospital? _____

How did you get to the hospital? Ambulance Drove Self Police Somebody else

Were any of the following test performed at the hospital? X-rays MRI CT Labs

Did the injury occur on the job? Yes No
Was it reported? Yes No

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Current Complaints

Do you feel your condition is:	Improving	Staying the same	Getting worse
Have you lost time from work?	Yes	No	
Can you perform physical work activities?	Yes	No	
If no, because of:	Pain	Weakness	Stress

Activates of Daily Living Please circle all activates with which you are currently experiencing problems.

Seeing	Tasting	Smelling	Eating	Hearing	Insomnia
Dressing	Reading	Typing	Writing	Grasping	Using the toilet
Standing	Leaning	Walking	Stooping	Squatting	Loss of sexual drive
Bending	Twisting	Carrying	Lifting	Pushing	Restful sleeping
Sitting	Driving	Sports	Exercising	Reclining	Loss of concentration
Irritable	Riding in car	Air travel	Climbing	Pulling	Changes in personality
Grooming	Pinching	Kneeling	Reaching	Nervous	Loss of tactile feeling

Can you sleep without problems?	Yes	No
Do you awaken because of pain?	Yes	No
Did you have sleep problems before?	Yes	No

Please list your complaints/concerns in order of importance to you. You will have opportunity to elaborate on each one on the next page.

1.) _____ Your biggest concern with is problem is:
_____

2.) _____ Your biggest concern with is problem is:
_____

3.) _____ Your biggest concern with is problem is:
_____

4.) _____ Your biggest concern with is problem is:
_____

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Complaint # 1 Please grade your pain 0-10: _____

This complaint came on:	Gradually	Immediately		
Is it getting:	Better	Same	Worse	
The intensity of this complaint is:	Minimal Slight	Moderate	Severe	
The frequency of this complaint is:	Occasional	Frequent	Constant	
The pain is located on the:	Left Side	Right Side	Both Sides	
The Pain is:	Dull	Sharp	Aching	Shooting
	Spasm	Throbbing	Shooting	Tingling

	Aggravates	Relieves		Aggravates	Relieves
Morning:	☐	☐	Straining:	☐	☐
Afternoon:	☐	☐	Standing:	☐	☐
Bending forward:	☐	☐	Lifting:	☐	☐
Bending back:	☐	☐	Sitting:	☐	☐
Bending left:	☐	☐	Heat:	☐	☐
Bending right:	☐	☐	Cold:	☐	☐
Twisting left:	☐	☐	Rest:	☐	☐
Twisting right:	☐	☐	Lying down:	☐	☐
Coughing:	☐	☐	Medications:	☐	☐
Sneezing:	☐	☐			

Complaint # 2 Please grade your pain 0-10: _____

This complaint came on:	Gradually	Immediately		
Is it getting:	Better	Same	Worse	
The intensity of this complaint is:	Minimal Slight	Moderate	Severe	
The frequency of this complaint is:	Occasional	Frequent	Constant	
The pain is located on the:	Left Side	Right Side	Both Sides	
The Pain is:	Dull	Sharp	Aching	Shooting
	Spasm	Throbbing	Shooting	Tingling

	Aggravates	Relieves		Aggravates	Relieves
Morning:	☐	☐	Straining:	☐	☐
Afternoon:	☐	☐	Standing:	☐	☐
Bending forward:	☐	☐	Lifting:	☐	☐
Bending back:	☐	☐	Sitting:	☐	☐
Bending left:	☐	☐	Heat:	☐	☐
Bending right:	☐	☐	Cold:	☐	☐
Twisting left:	☐	☐	Rest:	☐	☐
Twisting right:	☐	☐	Lying down:	☐	☐
Coughing:	☐	☐	Medications:	☐	☐
Sneezing:	☐	☐			

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Complaint # 3 Please grade your pain 0-10: _____

This complaint came on:	Gradually	Immediately		
Is it getting:	Better	Same	Worse	
The intensity of this complaint is:	Minimal Slight	Moderate	Severe	
The frequency of this complaint is:	Occasional	Frequent	Constant	
The pain is located on the:	Left Side	Right Side	Both Sides	
The Pain is:	Dull	Sharp	Aching	Shooting
	Spasm	Throbbing	Shooting	Tingling

	Aggravates	Relieves		Aggravates	Relieves
Morning:	☐	☐	Straining:	☐	☐
Afternoon:	☐	☐	Standing:	☐	☐
Bending forward:	☐	☐	Lifting:	☐	☐
Bending back:	☐	☐	Sitting:	☐	☐
Bending left:	☐	☐	Heat:	☐	☐
Bending right:	☐	☐	Cold:	☐	☐
Twisting left:	☐	☐	Rest:	☐	☐
Twisting right:	☐	☐	Lying down:	☐	☐
Coughing:	☐	☐	Medications:	☐	☐
Sneezing:	☐	☐			

Complaint # 4 Please grade your pain 0-10: _____

This complaint came on:	Gradually	Immediately		
Is it getting:	Better	Same	Worse	
The intensity of this complaint is:	Minimal Slight	Moderate	Severe	
The frequency of this complaint is:	Occasional	Frequent	Constant	
The pain is located on the:	Left Side	Right Side	Both Sides	
The Pain is:	Dull	Sharp	Aching	Shooting
	Spasm	Throbbing	Shooting	Tingling

	Aggravates	Relieves		Aggravates	Relieves
Morning:	☐	☐	Straining:	☐	☐
Afternoon:	☐	☐	Standing:	☐	☐
Bending forward:	☐	☐	Lifting:	☐	☐
Bending back:	☐	☐	Sitting:	☐	☐
Bending left:	☐	☐	Heat:	☐	☐
Bending right:	☐	☐	Cold:	☐	☐
Twisting left:	☐	☐	Rest:	☐	☐
Twisting right:	☐	☐	Lying down:	☐	☐
Coughing:	☐	☐	Medications:	☐	☐
Sneezing:	☐	☐			

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Intake Consent
(Legal guardians use line below)

I, the patient, have read the intake form and have answered the questions honestly and to the best of my ability.

Patient Signature: _____ Date: _____

Consent for Treatment of Minor or Dependent

I consent that I am the parent or legal guardian of the patient listed below.

I have read the intake form and have answered the questions honestly and to the best of my ability.

I hereby authorize Dr. Jere Mills and whomever he may designate as his assistants to administer treatment as he deems necessary to the patient. I acknowledge that all reasonable efforts will be made to inform me of the treatments or modalities Dr. Mills recommends for the patient, and to get my consent to move forward before initiating treatment.

Patient Name: _____

Guardian Name: _____

Relationship of Guardian: _____

Guardian Signature: _____

Date of Signature: _____

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OTHERS INVOLVED IN MY HEALTHCARE

Patient Name: _____

As the patient, you may give consent that your Protected Health Information (PHI) as defined by the U.S. HIPAA laws may be disclosed to family members or friends who may be involved in your care. You may revoke or amend this consent at any time in writing, or by completing this form again.

I consent that Dr. Jere Mills and members of his staff MAY discuss my healthcare with the following people. (Please include name, relationship, and whether you want only specific aspects of care discussed. If you do not specify aspects of care, we presume we may discuss any aspect of your care.)

_____

_____

As the patient, you may also request that any part of your Protected Health Information (PHI) as defined by the U.S. HIPAA laws may NOT be disclosed to family members or friends who may be involved in your care or used for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing (this signed form is sufficient) and must state the specific restrictions and to whom you want the restriction applied.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, they may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions you wish to request with your physician.

I consent that Dr. Jere Mills and members of his staff MAY NOT discuss my healthcare (or the aspects listed) with the following people, unless it is needed to provide emergency treatment. (Please include name/s, relationship, and your detailed restriction/s. If no restrictions are provided, we presume we may not discuss any aspect of care.)

_____

_____

_____

I have accurately provided all details listed above to the best of my ability at the date of completion, and consent to all above terms of this agreement.

Patient Signature: _____ Today's Date:_____

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.
- Comply with any disclosure required by law, such as in the case of abuse, natural disaster, etc.
- Communicate with family or friends if necessary as deemed appropriate by this office.

I understand that my protected health information will NOT be used for such activities as marketing or sales without my express written permission.

I understand that by providing this office with my phone number, email, and address, I am authorizing communication through those channels, and acknowledge that there can be no guarantee of security for digital communications which may include PHI. It is the practice's responsibility to make all reasonable efforts to secure lines of digital communication, and/or minimize PHI sent on those channels. However, I accept the risks associated with digital communication regarding my PHI by providing my information.

I understand that I have the right to revoke in writing any authorization at any time, or request restrictions on certain use/disclosures. I understand I have a right to inspect and copy my PHI.

I understand that I may request this office's full privacy practices at any time.

I have read and understood the summary of this office's Notice of Privacy Practices above.

Patient Name: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) _____

Staff Signature: _____ Date: _____

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OFFICE PAYMENT POLICY SUMMARY

We ask that all patients keep a payment card on file. If this isn't possible, please reach out to us so other arrangements can be made.

Patients with a **membership wellness contract** will have their card auto-drafted each month per the terms of their contract. A-la-carte wellness services beyond the contract and not part of an active care plan will be charged to the card on file at the end of each week with a discount applied per the terms of their contract. NOTE: Most commercial health plans and Medicare do not cover wellness services. You will be made aware of any services not covered by insurance before they are completed.

Services that are part of an **active care treatment plan** can be paid for with any of the following:

Insurance: We are in network with BCBS and Aetna (and Medicare). Benefits quoted are not a guarantee of payment. We will notify you once the Explanation of Benefits (EOB) has identified the patient's portion of payment due, then run the card on file. If your insurance is out-of-network, we will be happy to supply a superbill patients can submit to carriers for potential reimbursement.

Medicare: Medicare will pay 80% of medically necessary adjustments. There is no coverage for exams or modalities. We will submit to your supplemental insurance once Medicare has paid their share. You will be responsible for your deductible. We do not accept Medicare as a Secondary Payer.

HSA/FSA/HRA: To pay with these methods, you may keep the card on file with us, then request receipts for services that you can submit to your plan carrier for reimbursement. Each plan has different rules about what qualifies for reimbursement, and it is the patient's responsibility to comply with those rules.

Self-pay: If a patient chooses to self-pay or if services aren't covered by their insurance, the payment card on file will be charged at the end of each week for any services rendered that week. Self-pay patients will receive a 10% discount for full and prompt payment.

Patients seeing us for **automobile accident cases** need to notify us immediately if a claim is opened and if an attorney is representing you, and notify their auto insurance carrier immediately of visit/s to our office. The patient is ultimately responsible for their bill, but we will wait for settlement for up to six months after conclusion of care. Balance not paid within 6 months after conclusion of your care will be charged to your credit card on file. You will be sent a payment voucher.

Please be courteous and arrive for your appointments on time. If you are unable to make your scheduled appointment, please cancel your appointment using the cancellation link in your appointment confirmation email, or contact our office number as soon as possible. If we do not receive notice from you prior to your scheduled appointment time, a no-show appointment fee may be charged to your account. Our no-show appointment fee is $25.

I have read, understood, and agreed to the terms listed above.

Patient/Guardian Signature: _____ Today's Date: _____