Heritage Chiropractic Clinic

103 S Jefferson Raymore MO 64083 ♦ (816) 322-1990 ♦ FAX (816) 322-0005

PATIENT INFORMATION – PLEASE PRINT – LEAVE NO BLANKS

Today's Date: _____ Social Security # (**required**): _____

Full Name: _____ Date of Birth_____

Address: _____ City/ State: _____

Zip: _____ Cell Phone: _____ Work/Home/other: _____

Email: _____

Emergency Contact Name: _____ Phone Number: _____

Emergency Contact Address: _____ Relationship: _____

Marital Status: □ Married □ Single □Divorced Widowed Other: _____

Employment Status: □ Full-Time □ Part-Time □ Retired □ Not Employed

Student Status: □ Full-Time □ Part-Time **Gender:** □ Male □ Female

How did you hear about us? Family/Friend – Building Signage – Newspaper – Insurance Company – Office Website – Google – Other: _____

If someone referred you, may we ask who? _____

It is our practice to send a Free Coupon to our current patients who refer others to us. If applicable, may we mention your name on the Coupon? Yes / No

Nature of Today's Problem,/where are you experiencing pain? _____

_____

Are the symptoms related to a: Fall – Auto Accident

Brief Description of this Event, (Accident/ Injury, if any): _____

_____

Has This Ever Occurred Before? Describe: _____

Has the symptoms worsened recently: _____

Have you tried to improve symptoms at home? If so, what has helped? _____

_____

Does any activity worsen symptoms? _____

Are the symptoms disturbing your sleep or any other activities you do on a daily basis? _____

_____

Rate the pain on a scale of 1-10 currently with 10 being the worst pain you ever: _____

What is your normal diet like, what type of food are you eating regularly? _____

Do you exercise? If so, how much and how often? _____

What are you normal job duties? (i.e. sitting, standing, lifting) _____

How much sleep do you get per night? _____

For Women: When was your most recent women's wellness exam? _____

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

In the course of your care as a patient at our office, we may use or disclose personal and health-related information about you in the following ways:

Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, PPO, or your employer (if they are or may be responsible for the payment of your services.) Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine or voice mail if you are called at work. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

It is the practice of this office to provide therapies in an "open therapy" environment. This involves several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing exams or presenting reports of findings. These procedures are completed in a private, confidential setting. Because of various interpretations under federal law with respect to what is known as "incidental disclosures" of health information, we are requesting your authorization.

Under federal law, we are permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.
- Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like the information in a different form, please advise us in writing as to your preferences.

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I CONSENT to the use or disclosure of my Protected Health Information (PHI) by Heritage Wellness Solution LLC, including its staff/ employees (hereinafter referred as "Heritage") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Heritage. I understand that diagnosis or treatment of me by Heritage may be conditioned upon my consent as evidenced by my signature on this document.

I UNDERSTAND I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Heritage is not required to agree to the restrictions that I may request; however, if Heritage agrees to a restriction that I request, the restriction is binding on Heritage. I understand that I must request my restriction preferences in writing.

I HAVE THE RIGHT to revoke this consent, in writing, at any time, except to the extent that Heritage has taken action in reliance on this consent.

MY "PROTECTED HEALTH INFORMATION" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I UNDERSTAND I have a right to review Heritage's Notice of Privacy Practices (NPP) prior to signing this document. Heritage's NPP has been made available to me. The NPP describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills, or in the performance of health care operations at Heritage. The NPP for Heritage is located at 103 S. Jefferson, Raymore, MO. This NPP also describes my rights and Heritage's duties with respect to my PHI.

Heritage reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by calling the office and requesting a revised copy be sent in the mail or by electronic format, or by asking for one at the time of my next appointment.

If you want more information about our privacy practices or have questions or concerns, please contact us. If you have a complaint about how we protect your right to privacy, you may file a complaint using the contact information listed below, or you may submit a written complaint to the U.S. Department of Heath and Human Services at **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

Contact Officer: Dr. Michael B. Brucks Phone: (816) 322-1990
Address: 103 S. Jefferson, Raymore, MO 64083-9703

By signing below, I acknowledge I have read this form and give full disclosure of my information.

_____ _____
Patient Signature (parent/guardian if patient is a minor) **Date**

_____
Printed Patient Name

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Consent to Treat

We are committed to every patient achieving his or her maximum health & wellness potential. Good health and wellness is not merely the absence of disease; it means that you should be able to perform your daily functions and jobs, and live your life pain-free. Wellness also means that you should get sick less often, use fewer medications, feel good about yourself, and have more defenses against diseases. Chiropractic Healthcare uses natural healing methods to help achieve these results. Examples include adjusting the spine and other joints of the body to ensure that they have the correct motion and position. Adjustments remove the nerve irritation from the area and allow proper healing to take place. They also allow the nervous system to function properly. A properly functioning nervous system is essential to maintaining a strong immune system. Other examples of chiropractic healthcare include recommending nutrition and lifestyle changes. These help bring the body into homeostasis (maintenance against internal & external environments). We do not claim to cure any disease, nor do we practice allopathic or osteopathic medicine. We simply bring the body into proper balance and allow the body to begin to heal itself. There is a rare occasion of adverse side effects during chiropractic treatments. This includes dizziness, nausea, or lightheadedness. However, the probability of incurring these side effects are much less than with standard medical care because we are not using drugs or surgery. On very rare occasions, strokes have also been recorded after neck manipulation (Approximately 1 in 2 million chances).

I have read and understood the above information. I hereby give my consent for Heritage Wellness Solutions to treat me with the understanding that they are not specifically treating diseases but they are helping to bring my entire body into balance so that it can function properly. I realize that I have to work with the doctor and follow his recommendations in order to achieve the best results.

_____ _____

Patient Signature **Date**
(Parent/Guardian if Patient is a Minor)

_____ _____

Patient Printed Name **Dr. Signature**

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CONSENT TO X-RAY AND PREGNANCY WARNING

As a state requirement, all Doctors of Chiropractic must attend a minimum of 12 hours of Radiology as part of their continuing education per year. When X-Rays are warranted, you can be assured that we have taken every possible precaution to minimize the risk of radiation exposure.

I authorize that an X-ray or X-rays may be performed on me with my consent. **Patient Initial** ☐

***For our female patients only*:** By initialing below, I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to put my unborn baby at risk. I understand that the 10 days following the onset of a menstrual period are generally considered to be safe for X-ray exams. With those factors in mind, I am advising my doctor that:

I am pregnant:	Yes ☐ No ☐ Don't Know ☐
I could be pregnant:	Yes ☐ No ☐ Don't Know ☐
I am late with my menstrual period:	Yes ☐ No ☐ Don't Know ☐
I am on birth control (pill, patch, IUD, etc.):	Yes ☐ No ☐ Don't Know ☐
I have had a tubal ligation (tubes tied) or hysterectomy:	Yes ☐ No ☐ Don't Know ☐
I have irregular menstrual periods:	Yes ☐ No ☐ Don't Know ☐

My last menstrual period began on: _____. **Patient Initial** ☐

DOCTOR'S LIEN & ASSIGNMENT OF MEDICAL BENEFITS FOR X-RAY CONSULT

I understand that Dr. Brucks may submit my x-rays to **Midwest Radiology Consultants** for further radiological evaluation. I also understand that the fee for such services will be submitted to my insurance company, worker's compensation carrier, or my attorney. If I do not have insurance coverage, I understand that I will receive the bill and am responsible for payment. **I authorize my insurance company to pay directly to Midwest Radiology Consultants for service rendered.**

In the event my insurance company, attorney, or workman's compensation carrier does not reimburse for the fee in full, or if I do not have insurance coverage, I agree that I am directly responsible for the charges or any unpaid portion. Returned checks for insufficient funds will be assessed a **$20.00** service charge. Accounts delinquent by 90 days from the time of my first billing statement may be placed with a legal collection agency. ***I am fully responsible for all collection costs unless prior payment arrangements have been made with Midwest Radiology Consultants.***

I understand that Dr. Doran L. Nicholson is not a participating provider in my insurance plan, and that his services may not be covered by my insurance. *I also understand that this service is not covered by Medicare.* In the event that my insurance company sends payment directly to me, I agree to promptly remit such payments to Midwest Radiology Consultants.

By initialing the above paragraphs and signing below, I acknowledge that I have read and agree with all above-stated information.

_____ _____

Patient signature (parent/guardian if patient is a minor) Date

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AUTHORIZATION AND ASSIGNMENT OF BENEFITS INCLUDING PI PATIENTS

In Consideration of your agreement to treat me, I, THE UNDERSIGNED, agree to the following:

ACKNOWLEDGEMENT AND UNDERSTANDING:
I acknowledge that I am receiving, or am about to receive, health care services from Heritage Wellness Solutions LLC (Heritage), and I have been advised that Michael Brucks, DC and Heritage requests that payment be made for services when the services are rendered. Also, I understand that any contracts I have with any third-party payer is a contract strictly between the payer and me, and **I am totally responsible for my bill.**

For Auto Accidents --the auto insurance becomes the primary coverage. The medical insurance, if any becomes secondary. In addition, if there is any PIP/MED-Pay on the policies that coverage also becomes primary and is used accordingly.

AUTHORIZATION TO RELEASE INFORMATION:
I authorize Heritage to release all information necessary concerning me or my physical condition to any insurance company, attorney, or adjuster in order to process all claims for reimbursement of charges incurred as the result of professional services rendered, and I release Heritage from any consequences thereof. I also authorize any insurance company, health care provider, or my attorney to discuss the details and particulars of my case with Heritage without further permission from me.

ASSIGNMENT OF CAUSE OF ACTION:
In the event that any insurance company is obligated by contractual agreement to make payments for my treatment, I hereby assign and transfer to Heritage the cause of action that exists in my favor and I authorize you to process the claim. Heritage is obligated to keep me informed of all transactions and of any amounts of overpayment by any contractually obligated insurance company.

AUTHORIZATION OF PAY DIRECTLY TO THE DOCTOR:
In consideration of the chiropractic services rendered, and to be rendered, by Dr. Michael B. Brucks and Heritage, I authorize and direct the payment to Heritage Wellness Solutions LLC any amount I now or hereafter owe Heritage out of the proceeds of any settlement of my case and/or by any insurance companies obligated to reimburse me for the charges of services or otherwise obligated to reimburse me or make payments to me based in whole or in part upon the charges made for services rendered.

I, THE UNDERSIGNED, HEREBY AGREE THAT IN THE EVENT OF DEFAULT IN THE PAYMENT OF ANY AMOUNT DUE, THAT THE UNDERSIGNED WILL PAY ADDITIONAL CHARGES EQUAL TO THE COST OF COLLECTIONS WITH A COLLECTION AGENCY AND A REASONABLE ATTORNEY'S FEE AND COURT COSTS IF SUIT IS BROUGHT AGAINST ME IN A COURT OF LAW.

_____ _____

Patient Signature (parent/guardian if patient is a minor Date

_____

Printed patient name

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PATIENT HISTORY CHECKLIST

PATIENT'S NAME: _____ DOB: _____ DATE: _____

Have you ever been in an Auto Accident? Yes____ No ____
If so, when? (List date or dates) _____

DO YOU HAVE:

1. Pain that wakes you from a sound sleep? Yes____ No ____
2. Headaches for hours or days? Yes____ No ____
3. Pain in your neck, jaw or face? Yes____ No ____
4. Blurred vision, double vision, or any visual disturbances? Yes____ No ____
5. A drooping eyelid or any change in your pupils? Yes____ No ____
6. Blackouts or fainting spells, or have you lost consciousness lately? Yes____ No ____
7. Any nausea or vomiting? Yes____ No ____
8. Vertigo (dizziness)? Yes____ No ____
9. Slurred speech? Yes____ No ____
10. Ringing in your ears (tinnitus)? Yes____ No ____
11. Chest pain? Yes____ No ____
12. Any change in bowel or bladder habits or loss of control? Yes____ No ____
13. Any unusual bleeding or discharge? Yes____ No ____
14. Any coughing up blood or blood in your stools or urine? Yes____ No ____
15. A sore that will not heal? Yes____ No ____
16. Unexplained weight loss? Yes____ No ____
17. Any thickening in your breasts or elsewhere? Yes____ No ____
18. A change in any wart or mole? Yes____ No ____
19. Indigestion or difficulty swallowing? Yes____ No ____
20. A nagging cough or hoarseness? Yes____ No ____
21. Night sweats? Yes____ No ____
22. A history of stroke in your family? Yes____ No ____
23. Cancer now, or ever before? Yes____ No ____

Do you take Birth Control (pills, patch, etc)? Yes____ No ____
When was your LMP? _____ Are you pregnant? Yes____ No ____
How many children do you have? _____

Are you seeing any other doctor now for any reason? Yes____ No ____
Why? _____

What prescription medication are you taking if any?

( ) High Blood Pressure Medications: _____
( ) Blood Thinners: _____
( ) Other: _____

What over-the-counter drugs are you taking if any? (Aspirin, etc.): _____

Dr. Signature: _____

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PATIENT HISTORY CHECKLIST (Page 2)

Patient Name: _____

Who is your Primary Care Physician? _____
PCP Address: _____ Phone: _____
Other current Doctors (name/ address/ phone):_____
_____
May we contact? _____ Date of most recent physical: _____

MEDICAL HISTORY

(Please list all conditions and previous hospitalizations, surgeries, auto accidents, fractures, strain/sprains, etc.): _____
_____
_____
_____
List Allergies: _____

Have you ever visited a Doctor of Chiropractic before? _____
When and how often? _____

SOCIAL HISTORY

Smoker: Yes____ No ____, If yes, how many packs per day? _____
Alcohol: Yes____ No ____, If yes, how much how frequently? _____

FAMILY HISTORY

Did your mother or father or grandparents have any of the following? Put **M** for mother, **F** for father, **GM** for grandmother, **GF** for grandfather.

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizures/Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes Type I/Type II
( ) Kidney Disease
( ) Pacemaker
( ) Ulcer/Stomach Problems
( ) Stroke
( ) Arthritis/Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Issues
( ) Cancer
( ) Osteoporosis

Comments:_____
_____
_____
_____

Dr. Signature: _____