

Winchester-Hilgefort Spine & Joint Center

40 Walter Court Moscow Mills, MO 63362 Phone (636) 356-5557

Confidential Patient Information

Fax (636) 356-5558 Website: www.whsjc.com

Date: ____/____/____

Patient's Full Name _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Date of Birth: ____/____/____ Male Female Spouse's Name: _____

Married Single Widowed Separated Divorced Number of Children/Ages _____

Social Security # _____ - _____ - _____ Referred by (Friend, Relative, Physician or Newspaper) : _____

Status: Employed Full Time Student Part Time Student Retired Unemployed Occupation: _____

Employer: _____ Employer Address: _____ Business Phone _____

Primary Insurance Company _____ ID# _____ Group# _____

Insured's Name _____ Date of Birth: ____/____/____ Employer: _____ Relation to Insured: _____

Secondary Insurance Company _____ ID# _____ Group# _____

Insured's Name _____ Date of Birth: ____/____/____ Employer: _____ Relation to Insured: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Physician: _____ City: _____ State: _____ Phone _____

Previous Chiropractic Care: Yes No If Yes, for what Problem: _____

Doctor's Name _____ City: _____ State: _____

What type of care are you interested in: Pain relief only Healing of current condition Optimizing your health All three

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

Your education level: Highschool Some college College Graduate Post Graduate Other: _____

Is Today's Visit Due To A Work Related Injury: Yes No **Is Today's Visit Due To An Auto Accident:** Yes No
(If yes to either questions above, please check with receptionist, additional information is needed)

Date Of Injury: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you.**
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Winchester-Hilgefort Spine & Joint Center) are **paid in full.**

Patient Signature _____ Date ____/____/____

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Confidential Patient History

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Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

In general, would you say your health is (check one): Excellent Very good Good Fair Poor

PAST HEALTH HISTORY:

1. Have you ever experienced your present problem before for which you are consulting us: Yes No If yes, When: _____
Was treatment provided: Yes No If yes, By whom: _____ Outcome: _____
2. Have you **ever** had a **stroke** or issues with **blood clotting**? Yes No If yes, when: _____
3. Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? Yes No If yes, explain: _____
4. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries**? Yes No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following areas? (Please mark Y for yes or N for no in each of the following:)

- | | | |
|----------------------------------|-------------------------|--|
| 1. ___ Eyes | 7. ___ Muscles | 13. ___ Allergies |
| 2. ___ Ears, Nose, Mouth, Throat | 8. ___ Nerves | 14. ___ Psychological/Emotional |
| 3. ___ Heart | 9. ___ Joints/Bones | Females only: |
| 4. ___ Lungs/ Breathing | 10. ___ Skin | 15. ___ Gynecological/Menstrual/Breast |
| 5. ___ Intestines/Bowels | 11. ___ Internal Organs | Males Only: |
| 6. ___ Urinary | 12. ___ Blood | 17. ___ Prostate/Testicular/Penile |

Please explain any above **Yes** answers: _____

SOCIAL HISTORY:

Recreational Activities (Hobbies): _____

- | | | | |
|--------------------------|--------------------------|-------------------------------------|--|
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise? _____ | times per week |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? _____ | packs per day |
| | | | If you have quit smoking, when did you quit? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use other forms of tobacco? | What/How much per day? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you consume alcohol? | How many drinks per week? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you eat a balanced low fat diet? | If no, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get adequate sleep? | If no, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is work stressful to you? | If yes, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is family life stressful to you? | If yes, explain: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use recreational drugs? | If yes, explain: _____ |

Chief complaint _____

Secondary or related complaint(s) if any: _____

Date of Onset/ When did your symptoms begin?: _____ Have you had this problem before? Yes No

Was the Onset Gradual Sudden Since its' onset, has it gotten: Worse Better

Describe what caused the pain: _____

Have you detected any possible relationship of your current complaint with any of the following:

Muscle Weakness Bowel/Bladder problems Digestion Cardiac/Respiratory Other: _____

Have you tried any self-treatment or taken any medication (over the counter or prescription): Yes No

If yes, explain: _____ Results: _____

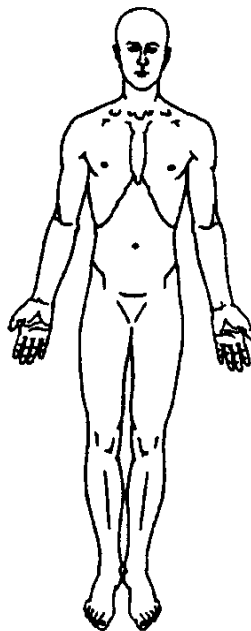
What medications are you currently taking? _____

Are you currently pregnant? Yes No Are you currently taking anti-coagulant or blood thinning medication? Yes No

PAIN CHART

Please Mark Areas of Pain using these Codes!

- +++ Burning
- ### Dull/Ache
- *** Numbness/Tingling
- === Throbbing
- 000 Stabbing/Sharp



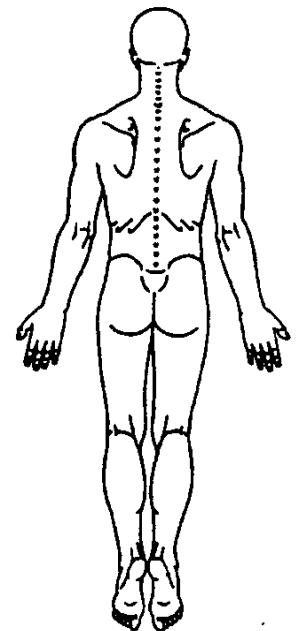
(Front)



(Left)



(Right)

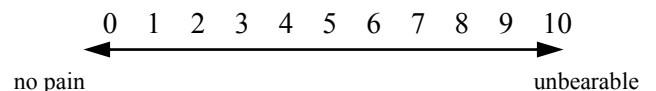


(Back)

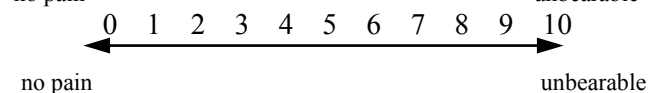
SEVERITY OF PAIN

List region of pain and circle the number which represents the intensity of your pain.

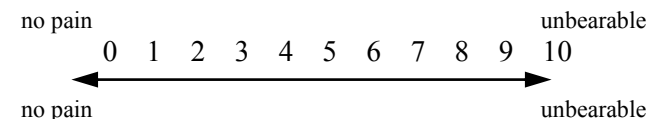
1. Complaint: _____



2. Complaint: _____



3. Complaint: _____



INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient	Date _____
_____ Signature of Parent or Guardian (if a minor)	Date _____
_____ Signature of Witness	Date _____

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Financial/Privacy Policy and Disclaimer

Insurance Verification

- **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

Deductible Payments

- **It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be **collected at the time of service.**
- If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. **Payment is due within 30 days** of receipt of the bill.
- **In the event a bill is disputed, you must notify use within 30 days.** If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue **interest at the rate of 18% per annum.** In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.
- All balances remaining **unpaid after 30 days may be reported to a credit bureau** and affect your credit rating.

Returned Checks

- It is our policy to collect **\$25.00 for checks that are returned to us.** This is to cover any fees that apply from the transaction

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **\$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator, Ann Franke.

HIPPA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you.
- By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.

patient signature

date