Advanced Wellness Chiropractic LLC

11520 St. Charles Rock Rd Suite #104 Bridgeton, MO 63044

Patient Intake

Date: _____ E-mail: _____ Referred By: _____

Name: _____ Birthdate: _____ Age: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

SS #_____ Sex: □Male □Female

Occupation: _____ Employer/School: _____

□ Married □ Widowed □ Single □ Divorced □ Minor

Insurance Company Name: _____ Health Savings Account: Yes ☐ No ☐

Secondary Insurance Company Name: _____

Spouse's Name: _____ Spouse's Employer: _____

Have you ever received Chiropractic care? □Yes □No If so, When & Where? _____

Have you ever received Physical Therapy services? □Yes □No If so, When & Where? _____

In Case of Emergency Contact:

Name: _____

Relationship: _____

Home phone: (_____) _____

Work phone: (_____) _____

Accident Information

Is condition due to an accident? □ Yes □ No Date: _____

Type of accident: □ Auto □ Work □ Home □ Other: _____

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp. □ Other_____

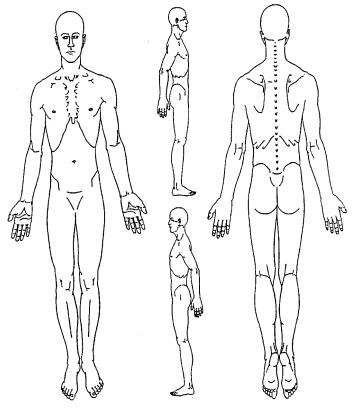
Attorney Name (if applicable): _____

Attorney Phone Number: _____

Patient Complaints

Please List all of the complaints/problems you would like the doctor to look at today. Mark an X on the picture for each problem. Please prioritize them from most important to least important. You will be given complaint forms for each problem listed to more thoroughly describe each problem.

1. _____
2. _____
3. _____
4. _____
5. _____



Patient Name: ***Date:***

Health History

To help us rule out any conditions which might be aggravated by massage, please fill in all the appropriate information.

Are you currently being treated for any medical condition? Medical, chiropractic, physical therapy or other treatment? □ No □ Yes

If yes, who is treating you, what is/are the condition(s), how long have you been treated and how are you being treated?

Physician	Condition	How Long	Type of Treatment

Do you have a primary care physician? □ No □ Yes Name: _____

Date of Last: Physical Exam: _____ Spinal Exam: _____
Spinal X-ray: _____ Chest X-ray: _____ MRI, CT, Bone Scan: _____
Blood Test: _____ Urine Test: _____

Are you Pregnant? □ No □ Yes Due Date: _____

Please mark on "Yes" or "No" to indicate if you have had any of the following:

1. AIDS/HIV	□ Yes	□ No	6. Epilepsy	□ Yes	□ No	11. Migraines	□ Yes	□ No	16. Prosthesis	□ Yes	□ No
2. Arthritis	□ Yes	□ No	7. Fractures	□ Yes	□ No	12. MS	□ Yes	□ No	17.Rheumatoid Arthritis	□ Yes	□ No
3. Bleeding disorders	□ Yes	□ No	8. Gout	□ Yes	□ No	13. Osteoporosis	□ Yes	□ No	18.Stroke	□ Yes	□ No
4. Cancer	□ Yes	□ No	9. Herniated Disk	□ Yes	□ No	14. Pacemaker	□ Yes	□ No	19. Tumors/Growths	□ Yes	□ No
5. Diabetes	□ Yes	□ No	10.Metal Implants	□ Yes	□ No	15. Pinched Nerve	□ Yes	□ No	20. Other_____	□ Yes	□ No

If "Yes", please write the number of the condition and explain when it was diagnosed and how it was treated

#	*When you had it*	*How it was treated*	*Additional explanation*

Habits

Tobacco	□ Regularly	□ Rarely	□ Never	Explain_____
Alcohol	□ Regularly	□ Rarely	□ Never	Explain_____
Caffeine	□ Regularly	□ Rarely	□ Never	Explain_____
Exercise	□ Regularly	□ Rarely	□ Never	Explain_____
High Stress	□ Regularly	□ Rarely	□ Never	Explain_____

Would you be interested in additional information on any of the following?
□ Nutrition □ Exercise/Stretching □ Work Station □ Other _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head injuries		
Broken Bones		
Dislocations		
Surgeries		
Car accidents		

Work Activity

What do you do for work: _____
□ Sitting □ Standing □ Computer □ Repetitious tasks
□ Lifting □ Weird postures □ Light labor □ Heavy labor

Is your desk set up ergonomically? □ No □ Yes
Do you take breaks? □ No □ Yes
Is your job stressful? □ No □ Yes Why?_____

Medications/Supplements

_____For:_____
_____For:_____
_____For:_____
_____For:_____

Allergies: _____
_____

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Informed Consent for Chiropractic Treatment

I have explained my complaints to the doctor and staff at Advanced Wellness Chiropractic. I have had a competent examination of my complaints by an evaluating doctor at the clinic. Further I have received from my doctor a treatment plan designed to alleviate my complaints and help restore me to a healthy, pain-free state. I have had my questions and concerns adequately addressed. I have been made aware of the benefits and possible risks of the treatment plan.

I do hereby consent to receive chiropractic and therapy services at Advanced Wellness Chiropractic.

Signature_____ **Date**_____

Letter of No Accident or Injury

☐ I hereby state with my signature, that I was **NOT** involved in any auto accident, slip and fall, or work-related injury that any other party may be responsible or liable for.

☐ I hereby state with my signature, that I **WAS** involved in an auto accident, slip and fall, or work-related injury that another party may be responsible or liable for.

Signature_____ **Date**_____

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With Regard to Your Insurance and Provider's Lien

To our patients:

As we all know, medical care has changed significantly in the past few years. We are asking for our patients to help in dealing with the new realities of insurance coverage. Please keep in mind the following very important instructions so we can better take care of your medical needs.

1. Please notify us of any changes in your medical insurance and provide us with your new insurance card for copying.

2. Please keep us informed of any address or phone number changes.

3. Your co-payments are due at the time of service. We accept cash, or major credit cards.

4. **IMPORTANT!!** Please initial all of the attached documentation. This allows us to legally bill for the services provided to you, to receive payment directly from your insurance company, and to act as your agent to your insurance company in upholding your health care rights and benefits. If your insurance company denies payment on a service we provide, your signature allows us to file an appeal on your behalf. Please expect to receive periodic notification from your insurance carrier regarding payments that were made to this office. These are called Explanation of Benefit forms (or E.O.B.s). You can also expect to receive notices from your insurance carrier that certain "codes, dates, or billings are denied or not payable and that (you) the insured owe this amount." If you have any questions concerning your E.O.B. please bring them to our attention. However, in many cases, your only obligation to our office is your per-visit contribution to your deductible, co-insurance and/or co-payment, which was quoted to you by our insurance staff on your first visit.

____initial

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In some cases, our office may agree to operate on a lien basis which typically works differently than the above situations. You will need to provide us with additional information, which may result in less out-of-pocket expense for you. These types of situations occur during instances where your presentation in our office is the fault of another party and it is agreed they will assume the liability of your financial obligations to our office. Personal injury, motor vehicle accidents, and worker's compensation cases are the most common examples. **_____initial**

In-network benefits may work differently than the previous referenced situations. In-network benefits are contractually agreed upon by the individual provider and the insurance company. If your insurance coverage is considered "in-network," we will explain these benefits to you. **_____initial**

IMPORTANT!! Please note that at times some insurance carriers will make payment for our services directly to you, the patient. We ask that when you receive these payments, that you forward these to us immediately, along with the documentation that the insurance carrier provides with the check. **Please understand that failure to forward these payments to Advanced Wellness Chiropractic will result in patient being held responsible for amount issued for services rendered.**

_____initial

5. We want to help you avoid the stresses and worries of dealing with these new changes in the insurance industry. **Your focus as a patient is to maintain your scheduled treatment plan and to work towards a healthy, pain-free future.** By scheduling appointments in advance, you will be guaranteed your ideal treatment schedule and the ability to adjust your appointments to your convenience.

6. Should you have any questions or concerns, please feel free to ask for clarification.

Signature_____

Date_____

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Notice of Our Privacy Practices

This notice describes how medical information about may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our commitment here at Advanced Wellness Chiropractic is to serve our patients with compassion and professionalism, being sure at all times to protect their privacy. During the course of your treatment it may be necessary to share information with other medical providers or attorneys. The following are examples of instances where your information may be shared:

- Any required laboratory analysis, insurance billing services, second opinions, general correspondence with family and/or friends of the patient, phone conversations between staff and patient, sign-in sheets, patient recognition, etc.

We here at Advanced Wellness Chiropractic are committed to obeying all federal, state and local laws and regulations regarding privacy protection practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released with the written consent of the patient involved. This written authorization may be revoked at any time by the individual as allowed by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our office.

By signing below, you acknowledge that you have read and understand the above Notice of Privacy Practices

Signature_____ **Date**_____