Chapel, McMurtrie & Bartlett

Chiropractic Orthopedics and Sports Medicine

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Patient Information

Name _____ Date _____

Address_____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

E-Mail Address _____ Social Security # _____

RACE: AMERICAN INDIAN ALASKA NATIVE ASIAN AFRICAN-AMERICAN OTHER PACIFIC ISLANDER WHITE NATIVE HAWAIIAN	**ETHNICITY:** NON-HISPANIC OR NON-LATINO HISPANIC LATINO HEIGHT_____ WEIGHT_____	**DO YOU SMOKE?** NO YES **IF YES, HOW MUCH** _____ **ARE YOU A FORMER SMOKER?** NO YES

Employer _____ Occupation _____

Describe Daily Duties _____

Hobbies / Recreational Sports _____

Date Of Birth _____ Age _____ Marital Status [Married] [Widowed] [Single] [Divorced]

Spouses Name _____ Employed By _____

Children (Names/Ages) _____

Primary Insurance Company _____ ID# _____

Secondary Insurance Company _____ ID # _____

Patient History

What is your major complaint? _____

Date Of Injury _____ How did the injury occur? _____ List other doctor(s)/therapists seen for this condition? _____

What activities make the problem worse? _____

What activities make the problem better? _____

Is this condition getting better or worse? _____

Is the pain constant or does it come and go? _____

Is this condition related to an automobile or on-the-job injury? _____

Current Medications *(over the counter & prescription)*

_____

Family Physician _____ Females: *Are you pregnant, or a chance you might be pregnant?* *yes* *no*

How were you referred to our office? _____

CHAPEL McMURTRIE AND BARTLETT

CHIROPRACTIC ORTHOPEDICS AND SPORTS MEDICINE

936 CHESTERFIELD PARKWAY EAST
CHESTERFIELD, MISSOURI 63017 (636) 537-0564

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CHIROPRACTIC ORTHOPEDICS AND SPORTS MEDICINE

MEDICAL HISTORY:

Please indicate (1) if previously had, OR (2) if presently have for conditions listed below:

Musculo-Skeletal:
__low back pain
__pain between shoulders
__neck problems
__arm problems
__leg problems
__painful joints
__stiff joints
__sore muscles
__weak muscles
__broken bones

Nervous System
__numbness
__loss of feeling
__paralysis
__dizziness
__fainting
__headaches
__muscle jerking
__convulsions
__forgetfulness
__confusion
__depression

Cardiovascular-Respiratory
__chest pain
__difficult breathing
__persistent cough
__coughing blood
__rapid heartbeat
__blood pressure problems

Burning
__heart problems
__lung problems

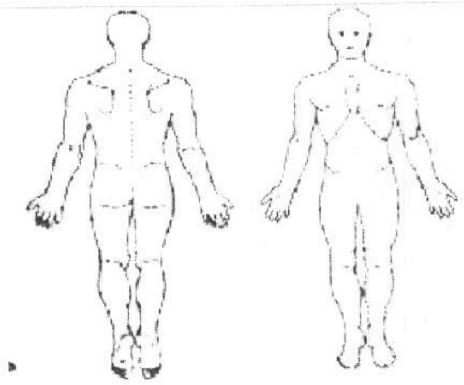
Gastro-Intestinal:
__poor appetite
__excessive hunger
__difficulty swallowing
__nausea
__vomiting food
__vomiting blood
__abdominal pain
__diarrhea
__constipation
__black stool
__bloody stool
__hemorrhoids
__liver trouble
__gall bladder problems
__weight trouble

Urinary:
__bladder trouble
__excessive urine
__painful urination
__discolored urine

Female
__vaginal bleeding
__vaginal discharge
__breast pain
__breast augmentation
__lumps in breast

Other:
_____
_____

Using the symbols given below, mark the areas on your body where you feel the described sensations, include all affected areas:



Numbness **Pins & Needles**

---------- 000000000000000 XXXXX

Aching **Stabbing**

******* ///////////////

Please List all Hospitalizations and / or Surgeries:_____

_____

_____

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Signature _____ Date _____

(If patient is a minor, signature of parent or guardian)

Payment Policies

1. **Patient Portions / Payments:**
   a. Are collected after **EACH** visit.
   b. We accept: Cash, Personal Check, Visa and Mastercard
2. **Health Insurance**:
   a. We **DO** accept most insurance plans, and most insurance plans **DO** cover Chiropractic care. It is **YOUR** responsibility to give to the correct information about your insurance company, and is **YOUR** responsibility to follow the rules outlined by your insurance company. E.g. referrals
   b. We will call your insurance company to verify your chiropractic coverage. We will collect any co-payment and/or deductible amounts quoted by your insurance at the time services are rendered. If there are any discrepancies when the claims are processed, you may be responsible for any additional monies. We advise you to contact your insurance company to verify your benefits. If you are told different benefits, please advise our office.
   c. We will submit all claims for services rendered in our office to your insurance company
   d. We feel all procedures performed in our office are medically necessary. However, some insurance companies in an attempt to save cost, will consider some services as "non-covered", or "not medically necessary." Any services, which are denied, will be your responsibility.
3. **Auto Accidents:**
   a. The patient **MUST** select which entity (personal health insurance, personal auto med pay, party at fault auto insurance) will be responsible for reimbursement of services rendered by the conclusion of the first visit. (Please direct questions regarding the selection to the Doctors during your consultation)
   b. A signed lien is a **REQUIREMENT** for treatment in this office.
   c. If you are dealing with an auto insurance company or involved in a lawsuit that affects the payment of the services rendered, please be advised that payment is due no later then **90 days** of discharge from our office, whether or not your case has settled. It is **YOUR** responsibility to stay on top of your case with the party at fault auto insurance, and/or your attorney.
4. **Medicare**:
   a. We **DO NOT** accept Medicare assignment. Medicare members must pay in full at the time services are rendered. We will submit claims to Medicare, and any reimbursement they make will be sent directly to you.
   b. It is **YOUR** responsibility to make our staff aware if you have a secondary insurance and if you are set up for "cross-over."
5. **Overdue Accounts**
   a. Any patient portion unpaid after 90 days from the date of service will be subject to an 18% charge.

I have read the above terms and hereby assume full responsibility.

_____ _____

Patient / Responsible Party Date

Informed Consent to Chiropractic Treatment

Chiropractic treatment, including spinal adjust, has been the subject of government reports and multi-disciplinary studies conducted over many years and had been demonstrated to be effective treatment for many neck and back conditions involving

pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from Chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

Doctors of Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.

b) There are reported cases of cerebral vascular accident associated with many common neck movements. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently and estimated at one per one million. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustments is extremely remote.

c) There are rare reported cases of aggravation of existing disc conditions following cervical and lumbar spinal adjustment although no scientific study has even demonstrated such injuries are causes, or may be caused by spinal adjustments or Chiropractic treatment.

I acknowledge that if I have any questions regarding the nature and purpose of my Chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the content of the consent I will ask my Chiropractor in advance.

I consent to the Chiropractic treatments offered or recommended to me by my Chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future Chiropractic care.

Dated this _____ day of _____, 20_____
(day) (month)

_____ _____
Patient Signature (or Legal Guardian) Signature of Witness

_____ _____
Patient Name Printed Witness Name Printed

Personal Medical Information Consent Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

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CHIROPRACTIC ORTHOPEDICS AND SPORTS MEDICINE

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

HIPAA gives the patient a right to add restrictions to the release of PHI. We as an office do not have to agree to these restrictions, but if we do they are legally binding.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Patient Signature: _____ Date:_____

Right to Revise Privacy Practices: As permitted by law, Chapel McMurtrie and Bartlett Chiropractic Orthopedics reserves the right to amend or modify our privacy policies and practices. A change in our office polices and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice at your next office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature: _____ Date: _____

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