Name____________________________________ DOB ____/____/____ Marital Status M/S/W/D/Other
Address __________________________________ SSN _______________ Phone____-____-______
__________________________________ Email ____________________________________
Emergency Contact Name____________________ Student Status: Full Time/Part Time/ Other
Emergency Contact Number _____-_____-______ School ___________________________________

REQUIRED QUESTIONS FOR MEANINGFUL USE (government required)
Do you have any limitations to how we may contact you about your personal health information? Yes/no
If yes, please list.____
Race__________________ Primary Language ________________ Gender Identity__________________________________
Sexual Orientation ________________________Ethnicity: Hispanic or Latino/ Not Hispanic or Latino/ Declined/Unknown

List medications, over the counter drugs and supplements: ____
____List
diagnosed psychological disorders:____
Do you smoke? Yes/No If yes, how much_____________ If No, are you a previous smoker Yes/No, How long ago _______
# of drinks per week _________ # days/week you exercise __________
List allergies ____
List surgeries and their dates ____
____
List implants, plates or screws____

Have you been diagnosed with : If a family member has been diagnosed, list which member
-Cancer ____
-Anemia ____
-HIV/AIDS ____
-Hemophilia ____
-Hepatitis ____
-High Blood Pressure ____
-Low Blood Pressure ____
-Lung Disorders ____
-Hemorrhoids ____
-Raynaud's Phenomenon ____
-Sickle Cell Anemia ____
-Chronic Sinus Infections ____
-Stroke ____
-Wegner's Granulomatosis ____

Reason for visit:____ When did it begin:________________________________
Are you pregnant? Yes/No Last Physical Date:____________Last Xray: ________________Last MRI________________
% of time you have the symptoms: ____% Have you tried other treatments? __________________________________
Is it worse in the: Morning/Afternoon/Night/Weather Change/Does Not Change
Have you tried: Ice, Heat, Medication, Nothing, Other____
What activities are limited by you symptoms?

Bending	Driving	Pulling	Sleeping	Urination
Bowel Movements	Getting Up	Pushing	Sneezing	Walking
Coughing	Lifting	Reading	Standing	Working
Daily Routine	Lying Down	Sitting	Turning my head	Other:_____________________________

*******************Continue if this visit is for an Auto Injury or Workman's comp*******************

Have you tried other treatments for this condition? ____

Where ____

Is this the result of an accident? Auto/Work/Other Were you: Driver/Passenger/Bystander

Did you file: Police Report/Report with Employer/Other____

Were you wearing a belt:	Yes/No	Did the airbag deploy:	Yes/No
Did you hit another vehicle:	Yes/No	Did a vehicle hit you:	Yes/No
Did you see it coming:	Yes/No		

How much work have you missed? _________________How did you feel after the accident? ___________________

What were you driving? __________________________What were the other vehicles involved? _______________________

Where was the location of the incident? ____

If there is an Attorney, list their name and phone number: ____

Authorizations and Releases

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time.

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate.

I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: hhs.gov - Understanding Health Information Privacy

- The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
- The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
- The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
- This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
- Patients have the right to file a formal complaint with our privacy official about any suspected violations.
- This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

You may direct any questions regarding this financial obligation to the clinic manager or physician.

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Insurance / Medicare payment-Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct.

I authorize this office and/or doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits, and I authorize payment of these benefits to this clinic and/or doctor of record on my behalf for any services and materials furnished.

Consent to Chiropractic Treatment

I hereby authorize treatment using chiropractic care by the licensed providers at Overland Park Chiropractic, PA

Name: ____________________________________ Guardian Name: ____________________________________

Signature: ________________________________ Guardian Signature: ________________________________

Date: ______/______/______ Date: ______/______/______