PLAZA CHIROPRACTIC & ACUPUNCTURE. PC

PATIENT INFORMATION

Date _____

Legal Name: (Last) _____ (First) _____ (MI) _____

Primary Phone: _____ ☐Home ☐Cell ☐Work Secondary: _____ ☐Home ☐Cell ☐Work

Address: _____ City: _____

State: _____ Zip: _____ Sex ☐M ☐F Age: _____ Birth Date: _____

Social Security # _____ Employer/School: _____

Employer/School Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE ASSIGNMENT & RELEASE

Who is financially responsible for this account? ☐ Self-pay or Other (List Name) _____

Member # _____ If 'Other' what is relationship to patient? _____

Subscriber Name _____ DOB_____ Relationship to Patient _____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to *Dr. Terri K. Monahan, DC* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

➡ Responsible Party Signature _____

Relationship _____ Date _____

HIPAA CONSENT TO LEAVE A MESSAGE

I wish to be called at *(check all that apply)* regarding my care, follow-up and appointment reminders

☐ Home _____ ☐ Mobile _____ ☐ Work _____ ☐ Other _____

I do ☐, I do not ☐ give permission to leave relevant medical information on my answering machine or voice mail.

I do ☐, I do not ☐ wish to receive text message reminders regarding my appointment.

I do ☐, I do not ☐ want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

_____

I certify that the above information is complete and true. I understand that inaccurate, false, or missing information may result in my financial obligation for all services.

➡ Signature _____

HEALTH HISTORY Name: Date: PLEASE ANSWER ALL QUESTIONS

CONSTITUTIONAL — DATE

Good general health lately ... No Yes
Recent weight change ... No Yes
Fever ... No Yes
Fatigue ... No Yes
Headaches ... No Yes
Anorexia/Bulimia ... No Yes

EYES

Eye disease or injury ... No Yes
Wear glasses/contact lenses ... No Yes
Blurred or double vision ... No Yes
Glaucoma ... No Yes
Macular degeneration ... No Yes

HEAD/ENT

Hearing loss ... No Yes
Ringing in the ears ... No Yes
Earaches or drainage ... No Yes
Sinus problems ... No Yes
Allergies ... No Yes
Mouth sores ... No Yes
Bleeding gums/nose bleeds ... No Yes
Bad breath or bad taste ... No Yes
Sore throat or voice change ... No Yes
Swollen glands in neck ... No Yes

CARDIOVASCULAR

Heart trouble/chest pains/stints ... No Yes
Hypertension/high blood pressure ... No Yes
Sudden heart beat changes/pacemaker ... No Yes
Swelling of feet, ankles or hands ... No Yes
History of stroke or TIA's ... No Yes

RESPIRATORY

Frequent coughing ... No Yes
Spitting up blood ... No Yes
Shortness of breath ... No Yes
Asthma or wheezing ... No Yes

GASTROINTESTINAL

Loss of appetite ... No Yes
Change in bowel movements ... No Yes
Nausea or vomiting ... No Yes
Frequent diarrhea/Constipation ... No Yes
Acid Reflux ... No Yes
Stomach pain ... No Yes

GENITOURINARY — DATE

Frequent urination ... No Yes
Burning or painful urination ... No Yes
Incontinence or dribbling ... No Yes
Kidney Stones ... No Yes
Sexual dysfunction ... No Yes

MUSCULOSKELETAL

Joint pain ... No Yes
Joint stiffness or swelling ... No Yes
Weakness of muscles or joints ... No Yes
Muscle pain or cramps ... No Yes
Arthritis, osteo or rheumatoid ... No Yes
Back pain/neck pain ... No Yes
Pins, plates, implants, screws ... No Yes
Scoliosis ... No Yes
Difficulty in walking ... No Yes

SKIN/BLOOD DISORDERS

Rash or itching ... No Yes
Change in skin color/hair/nails ... No Yes
Varicose veins ... No Yes
Easy bruising/Bleeding disorders ... No Yes
Anemia ... No Yes

NEUROLOGICAL

Frequent or recurring headaches ... No Yes
Light headedness or dizzy ... No Yes
Convulsions or seizures ... No Yes
Numbness or tingling sensations ... No Yes
Tremors ... No Yes
Migraines ... No Yes
Stroke/Paralysis ... No Yes

ENDOCRINE

Glandular or hormone problems ... No Yes
Thyroid disease ... No Yes
Excessive thirst /Diabetic ... No Yes
Osteopenia/Osteoporosis ... No Yes

OTHER

Memory loss or confusion ... No Yes
Anxiety/Depression/Nervousness ... No Yes
Sleep problems ... No Yes
Breast pain ... No Yes
C-section, hysterectomy/other surgery ... No Yes
Are you pregnant? ☐ No ☐ Yes If yes, due date _____

INJURIES/SURGERIES	**DESCRIPTION**	**DATE**
Falls		
Head Injuries		
Broken Bones / Dislocations		
Surgeries		

What treatment have you already received for your condition? ☐ Surgery ☐ Physical Therapy ☐ Pain Management ☐ Medications

Date of Last: Spinal X-Ray _____ Extremity _____ MRI / CT / Bone Scan _____

PLAZA CHIROPRACTIC & ACUPUNTURE, PC
675 Pointe Basse Dr.
Ste. Genevieve, MO 63670
573-883-7177

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

X-rays, Labs and Reports

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

PLAZA CHIROPRACTIC & ACUPUNCTURE PC
Terri K. Monahan DC

Expiration Date of Authorization
This authorization is effective for one year from the date of the patient's signature unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

Patient or Legally Authorized Individual Signature _____ Date _____

Print Patient's Full Name _____ Time _____

Witness Signature _____ Date _____

Plaza Chiropractic and Acupuncture, P.C. Financial Policy

- All payments for insurance co-pays, supplements and supplies are due at time of service unless prior arrangements have been approved.

- Unaccompanied minors need to have made arrangements for payment with the person or persons responsible for their account prior to being seen by the doctor or services, supplements and supplies cannot be provided. Parents who are divorced or separated: the parent who brings in the child in for the exam will be responsible for out-of-pocket expenses (co-pays & deductibles) due at that time, regardless of which parent carries the insurance on the child.

- It is the patient's responsibility to present updated insurance information and current address and phone number to our receptionist at the time of visit. If you fail to update us you are 100% responsible for all charges.

- Should your insurance deny payment of your claim for "Patient Responsibility" reason code, patient will be responsible to address the matter with the insurance company if you disagree, payment will be expected. Your primary insurance is the insurance policy that we follow in case of discrepancy between primary and secondary insurance.

- Additional fees may apply for services not covered by insurance company: nutritional, consulting, acupuncture, supplements, and durable goods. These fees are due at the time of service.

- Upon receipt of invoice from our office, it is the patient's responsibility to pay within 30 days. If no payment is received, an interest of 1.5% will be added to the balance along with a surcharge of $5.00 assessed each month that an additional statement is sent unless payment arrangements are made with our billing department. If no payment is made on your account after 90 days, the account will be forwarded to our collection agency and credit bureau. If further litigation is necessary, the patient will be responsible for all collection costs and court costs.

- Any documents that a patient needs copied will be charged $.57 a page and forms that the patient needs filled out will be $15.00 per form.

- It is NOT our job to fight with the insurance company. This is the patient's responsibility. If paperwork is requested you must comply.

- Any scheduled appointments that are missed without a 15 minute notice before the scheduled time will be charged a $20 missed appointment fee.

Please sign below to indicate that you have *read, understand* and *agree* to the above financial policies.

_____ _____

Patient Signature Date

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding my consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: _____.

_____ _____

Patient's Name (print) Patient's Signature

_____ _____

Date Relationship or authority if not signed by patient

_____

Witness

PLAZA CHIROPRACTIC AND ACUPUNCTURE PC
675 Pointe Basse Dr, PO Box 271
Ste Genevieve MO 63670
573-883-7177

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Plaza Chiropractic and Acupuncture PC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Describe and Notify private areas available upon request

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name: _____ **Last Name:** _____

Email Address: _____ @ _____

DOB: _____ /_____ /_____ **Gender:** ☐ Male ☐ Female

Preferred Language: ☐ English ☐ Other (list) _____

Smoking Status: ☐ Every day smoker ☐ Occasional smoker ☐ Former smoker ☐ Never smoked

I. FAMILY MEDICAL HISTORY *(Please record at least one diagnosis in your family history and the affected)*

Diagnosis (write in below)	Father	Mother	Sibling ☐ Brother ☐ Sister	Offspring ☐ Son ☐ Daughter
Example: Heart Disease		*X*		

II. Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White (Caucasian) ☐ Native Hawaiian or Pacific Islander ☐ I decline to answer

III. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I decline to answer

IV. Are you currently taking any medications? *(Include regularly used over the counter medications)*

Medication Name	Dosage and Frequency

V. Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

➡ ☐ **I choose to decline receipt of my clinical summary after every visit.** *(These summaries are often blank as a result of the nature and frequency of chiropractic care)*

➡ **Patient Signature:** _____ **Date:** _____

For office use only
Height _____ Weight _____ Blood Pressure _____ / _____