Welcome

Patient Information

Date _____.

SS/Patient ID# _____.

Patient Name _____.
Last Name

_____.
First Name Middle Initial

Address _____.

City _____.

State _____ Zip _____.

Email _____.

Sex ○ M ○ F Age _____.

Birthday _____.

○ Married ○ Widowed ○ Single ○ Minor

○ Separated ○ Divorced ○ Partnered for ____ years

Spouse's Name _____.

Birthday _____.

SS# _____.

Employment Information

Occupation _____.

Patient Employer _____.

Employer/School Add _____.

_____.

Emp/Schl Phone (_____) _____.

Spouse Emply _____.

Phone Numbers

Home Phone (_____) _____.

Cell Phone (_____) _____.

Best time to reach you _____.

IN CASE OF EMERGENCY, CONTACT

Name _____.

Relationship _____.

Home phone (_____) _____.

Work Phone (_____) _____.

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

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 _____

SHAPE ReClaimed Informed Consent & Acceptance of Responsibility

Patient Informed Consent

I, _____, understand that SHAPE ReClaimed is a lifestyle modification, health restoration program designed to help me improve my overall health. This program is not intended to replace the guidance of my primary health care experts. While this program is not used to diagnose, treat, cure or prevent any disease, I understand any medications I am currently taking may need dose adjustment. I agree to notify my prescribing physician that I am working with Plaza Chiropractic and Acupuncture PC, and will be closely monitored while incorporating this program for embracing a healthier lifestyle. I understand an anti-inflammatory nutritional regimen will be recommended based on my unique health history, urine analysis and symptoms.

Doctor/Office/Clinic Statement of Intent

We, Plaza Chiropractic and Acupuncture, PC understand that our intent and responsibility is to determine if SHAPE ReClaimed is a program that would be beneficial for assisting your body in its innate healing process. Our first appointment with you will be multi-faceted. We agree to do the following:

- Take full health history
- Assess the patient
- Discuss health goals
- Perform baseline urine analysis
- Make specific patient recommendations (nutritional, supplements, diagnostics)
- Determine patient follow-up protocol
- Educate the patient regarding living a healthy lifestyle

Patient Acceptance of Responsibility

I have been informed and understand that nutritional and lifestyle recommendations may involve certain risks. These may include, but are not limited to detoxification symptoms, such as: initially feeling worse due to the release of stored toxins, digestive symptoms, fatigue, headaches, muscle and joint pain, allergic reactions or any unpredictable reaction with my prescribed medications that has not been found in research literature, etc.
In addition, I agree to do the following:

- Submit full health history
- Discuss health goals
- Have consistent urine analysis and follow-up visits as recommended by SHAPE practitioner
- Read "The Complete Patient Guidebook"
- Review the information provided under the "Patient Education" tab on the SHAPE ReClaimed website (www.shapereclaimed.com)
- Be aware that I can become a member of the "OFFICIAL SHAPE ReClaimed Support Group" on Facebook and will not substitute recommendations from Facebook for my specific health needs.
- Understand that my SHAPE Practitioner can refuse sale of additional product if I have not followed the recommended protocol set up for my healing

I have read, or have had read to me, the above information. I have had the opportunity to ask questions about its content and by signing below, I agree to these conditions for the duration of my SHAPE ReClaimed journey. I am responsible for all fees incurred and agree to pay, in full, for any service provided the day service is rendered.

_____ Terri K Monahan DC

Printed name of patient | Printed name of practitioner

_____ _____

Signature of patient | Date Signed

Plaza Chiropractic & Acupuncture, PC

Terri K Monahan, DC
675 Pointe Basse Dr/PO Box 271, Ste Genevieve, MO 63670
(573) 883-7177
www.terrimonahan.com

Patient Acknowledgement Form for Non-Covered Services

Patient Name:_____

Your health insurance plan requires you to be responsible for co-payments, co-insurance and deductibles for covered services and products as well as those services/products that exceed certain benefit limits. You are also financially responsible for all non-covered services and products, as well as any product we provide whose allowed fee is less than the purchased price to our office associated with the product.

Your health insurance plan either does not cover the product type or service noted below, or allows less than the purchase price associated with the product/service we provide. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay the office's charge.

PRODUCT OR SERVICE	REASON FOR NON-COVERAGE	PATIENT RESPONSIBILITY
Shape Reclaimed Program: • Shape Drops • Shape Consultation • Shape Follow-up • Products related to shape program	Insurance will not pay	$65.00 $80.00 - $120.00 $28.00 - $48.00 $_____

Patient Acknowledgement:

I _____ , acknowledge that I have been told in advance by this office that my health insurance plan either does not cover the product listed above or pays less than the purchase price associated with the product we provided, and I agree to pay for this product at the time it is of service. I have been told that there may be other products available at lower purchase prices that still meet my insurance plan's medical necessity requirements.

Patient Signature:_____ Date:_____

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.

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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

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

Plaza Chiropractic & Acupuncture, PC
675 Pointe Basse Dr | P.O. Box 271
Ste. Genevieve, MO 63670

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 _____ / _____