New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Mailing address

Address | City | State | Zip

Telephone (Work) | (home) | Referred By

Age | Birth Date | Social Security # | Number of Children

Occupation | Employer

Marital Status | Spouse's Name | Spouse's Occupation

Spouse's Employer | Spouse's Health Status

Emergency Contact | Phone

Current Complaints

Nature of Injury: ☐ Automobile* ☐ Work ☐ Other

Please describe:

Date of Injury | Date symptoms appeared

Have you ever had same condition? ◯ No ◯ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care? ◯ No ◯ Yes

If yes, please describe

Insurance Information

Name of party responsible for payment | Phone

Do you have health insurance? ◯ No ◯ Yes Name of company

*** If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone: | Claim #

Signatures

Name of the insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

Medical History

Have you been treated for any conditions in the last year? ◯ No ◯ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ◯ No ◯ Yes

Have you had X-rays taken? ◯ No ◯ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)I

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	◯	◯	
Been hospitalized?	◯	◯	
Been in an auto accident?	◯	◯	
Had Sprains/Strains?	◯	◯	
Been struck unconscious?	◯	◯	
Had surgery?	◯	◯	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	◯ No	◯ Yes
Do your symptoms interfere with daily life?	◯ No	◯ Yes
Does pain wake you up at night?	◯ No	◯ Yes
Are your symptoms worse during certain times of the day?	◯ No	◯ Yes
Do changes in weather affect your symptoms?	◯ No	◯ Yes
Do you wear orthotics?	◯ No	◯ Yes
Do you take vitamin supplements?	◯ No	◯ Yes

What activities aggravate your symptoms?

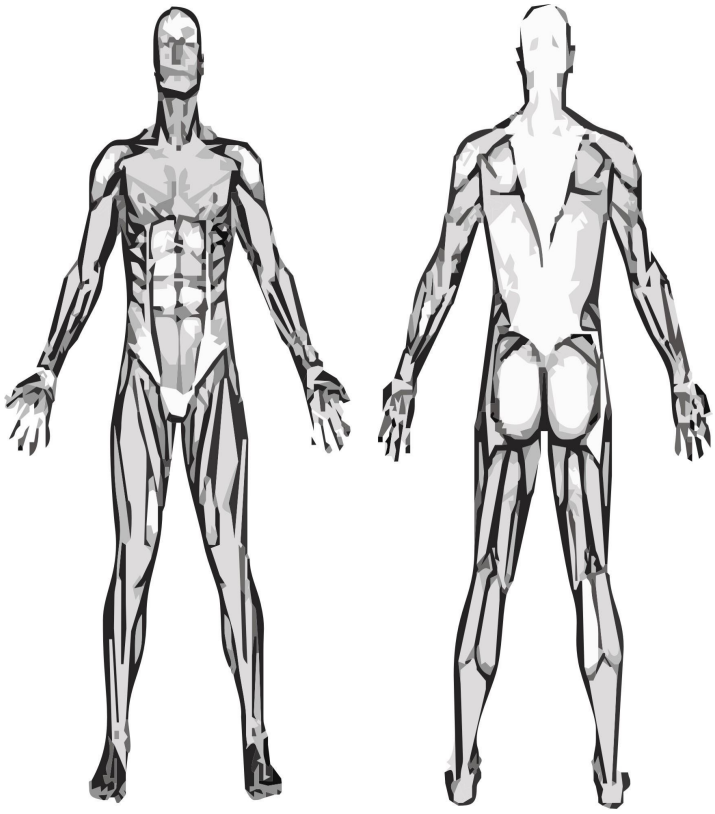
Habits	None	Light	Moderate	Heavy
Alcohol	◯	◯	◯	◯
Coffee	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Drugs	◯	◯	◯	◯
Exercise	◯	◯	◯	◯
Sleep	◯	◯	◯	◯
Appetite	◯	◯	◯	◯
Soft Drinks	◯	◯	◯	◯
Water	◯	◯	◯	◯
Salty Foods	◯	◯	◯	◯
Sugary Foods	◯	◯	◯	◯
Artificial Sweeteners	◯	◯	◯	◯

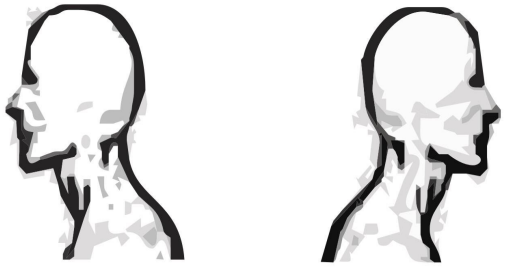
Have you ever suffered from:

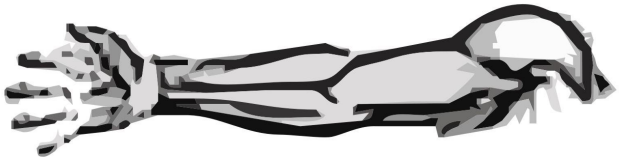
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing







HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health No I am not but it was working just fine or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: W may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law. Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in , a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtainapapercopyofthisnoticefrom us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on/or before April 14, 2003.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____ Signature _____

Date _____

Mary Hasley, D.C.,P.C.
241 SW Noel Street
Lee's Summit, MO 64063
PH(816)-525-1311

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 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 the best course of treatment based upon the 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 strains/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 consent. I have had an opportunity to ask questions about my examination and treatment. By signing on the reverse side, 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.

Please Initial_____

Mary Hasley, D.C.,P.C.
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Lee's Summit, MO 64063
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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

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ACCIDENT WAIVER FORM

_____, I hereby state with (Patient Printed Name) my signature that I was not involved in any auto accident, slip or fall, or work injury. My treatment was in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment.
Please process and pay all claims immediately.

_____ date _____ (Patient Signature)

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ASSIGNMENT - AUTHORIZATION & LIEN

I hereby irrevocably authorize and direct _____ (my insurance company), my attorney, and any and all third-party payers to pay directly to my doctor (Dr. _Mary Hasley_) all such sums of money due them for any and all services rendered to me or a minor by whom I am responsible for by reason of accident, illness and by any and all reason of any other bills that are due or may become due, and to withhold such

sums from any disability benefits, including but not limited to foundation grants, governmental or agency benefits or third-party benefits, no fault benefits, health and accident benefits, workers' compensation benefits, and/or any other insurance or third-party benefits obligated to reimburse the undersigned or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed to this office and assignee.

The parties further agree that, in the event my insurance company and/or attorney obligated to make payment to me upon the charges made by this office and assignee for its service(s) refused to make such payment, this agreement is to act as an assignment of the undersigned rights and benefits to the extent of the office(s) services provided. Therefore, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name. And further, I authorize this office assignee to settle or otherwise resolve said claim or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby further agree to give a full lien to said office against any and all insurance benefits named herein, any and all proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by said office and assignee.

The undersigned patient and/or assignee further agree that the assignee's right for payment from the undersigned patient shall be tolled by any statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and the undersigned patient are resolved. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctor's and/or these offices' rights to recover and agree to be held fully responsible for all debts I incur by this office.

It is further agreed that the undersigned patient shall remain personally responsible for the total amount due this office and assignee for its services. The undersigned further understand and agree that this Assignment, Authorization and Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment from me immediately and at any time upon rendering service at their option. Such option requires that I pay for all sums due and owing in full within 10 days of demand. I further understand that a monthly service charge is computed by a periodic rate of 1.5% per month, which is an annual percentage rate of 18% which is applied to the previous balance after deducting current payments, and that the service charge may change without notice. It is understood that returned checks made to this office for insufficient funds, stop payments or other reasons of non-payment will be assessed a $25.00 service charge, for which I agree to be held responsible for. I understand that all

money due this office will be paid in a timely manner with no amount of money due past 90 days from the date service was incurred, and that I am responsible for payment of all outstanding balances at the time, regardless of any attorney liens, representation of any attorney pending settlement(s) or other matters unless approved in writing by this office in advance to the 90-day limit. Parties further agree and understand that if need arises, accounts delinquent by 90 days may be placed to a legal collection agency, for which I am fully responsible for, and in full all court costs, filing fees, attorney costs and all associated collection costs.

Further understand and agree that, as necessary, this office and its staff may submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf, which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that the above-mentioned office is given full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee. Patient authorizes the doctor to deposit checks received on patient's account when made out to the patient. Understand that this office, its doctors and staff are accepting my cause based on examination, findings and belief the outlined treatment should produce change and/or improvement. However, as with any doctor's treatment, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur, but that I am still fully obligated to all charges for all services rendered to me.

Signature _____Date _____

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Chiropractic Health Center Office Policy

● **Signing in:** Please report to the front desk then check in using the kiosk or ipad. You will be called back to a treatment room based on the nature of your visit and the time of your appointment.

● **New Injury/ Auto accident:** In the event you sustain a new injury or have been involved in an auto accident please inform the front desk immediately. There may be additional paperwork to be filled out.

● **Appointments:** We set up specific treatment schedules for our patients. A certain number of treatments in a set amount of time are required for us to get the results we

both desire. If you need to make changes to the plan in order to accommodate your schedule please make every effort to make up the appointment on the same day. If you are unable to do so please make your doctor aware of the issue so that we may make up the appointment at another time. If you do not give 24 hour notice a $35.00 charge will be assessed to your credit card. At the conclusion of your visit please check out with the front desk and schedule your follow up appointment.

● **Payment of bills:** Please refer to the office financial policy regarding payments. If you have insurance, and the insurance company sent remittance for our services to you directly please bring the check and explanation of benefits to our office.

● **Progress Evaluations and Re-examinations:** Progress evaluations and re-examinations will be performed periodically to determine your rate of progress and future course of treatment. There is a fee for all progress evaluations. A special time will be set up for the evaluations.

● **Upsets:** We are here to serve you. Please speak with the staff or doctor about anything that could be upsetting you. Your comments help us to help you as well as others.

I, _____(printed name) have read and understand the above statements.

_____Patient Signature _____ Date

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OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses and allows you to place your family under care.

If you do not have Insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100.00 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

If you have Insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100.00 or care may be terminated.
You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage.
Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.
If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment
When your schedule of visits goes into wellness or maintenance care and is once per month or longer, your insurance usually will not pay (check your policy). Charges for services rendered will be due as they are rendered.
If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's printed name: _____ Date: _____

Signature: _____

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CONSENT TO TREATMENT OF MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby (name of minor)
authorize _____ as agent(s) for the undersigned (name of agent)

to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.
It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.
This authorization shall remain effective until _____, 20____,
(month/day) unless sooner revoked in writing delivered to the agent(s) noted above.

Relationship to minor: Mother Father

Other explain_____

Signature: _____

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