



Heritage Chiropractic & Wellness Center, LLC

“Old Country Charm with High-Tech Healing”

CONFIDENTIAL PATIENT INFORMATION – PLEASE PRINT – LEAVE NO BLANKS

Today’s Date: _____ Social Security # (required): _____

Full Name: _____ Date of Birth: _____

Address: _____ City/ State/ Zip: _____

Home Phone: _____ Cell: _____ Work: _____ Email: _____

Emergency Contact Name: _____ Phone: _____ Cell: _____

Emergency Contact Address: _____ Relationship: _____

Marital Status: Married Single Divorced Widowed **Gender:** Male Female

Employment Status: Full-Time Part-Time Retired Unemployed **Student Status:** FT PT

How did you hear about us? Family Member/Friend, Newspaper, Phone Book, Building Sign,

Insurance Company, Your Web Site (lowback.net) Other Internet, Doctor Referral Other _____

If someone referred you to us, who? _____ It is our practice to send a Free Coupon to our **current patients** who refer others to us. **Brief description of today’s problem** (Accident/injury, if any):

Survey Question: Do you have **Med Pay** on your Auto Insurance Policy? Yes, No, Don’t Know. (Please see brochure for more information about the benefits of Med Pay if you should have an Auto Accident.)

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*A Note from the Heritage Staff about Insurance Benefits:*

Here at Heritage we try very, very hard to make sure we get all the information accurately from your insurance company. We can assure you that we make every effort to collect the correct amount of co-pays, co-insurance and deductibles that are due.

However, you must understand that in the words of the insurance company, “*verification of benefits is not a guarantee of payment.*” What this means is that we don’t really know for certain that the insurance company gave us the right information (and if they do give us wrong information, they routinely deny that they did). This means that you may end up owing more money, or you may end up with a credit. The only way we can be sure is to check the EOB’s (explanation of benefits) once they have been sent to us. Sometimes this can take months to figure out.

Although the insurance companies are supposed to pay for your care, you must realize that they are in business to make money. They make more money by cleverly designing health plans that are full of fine print, exceptions, and exclusions. Often times we don’t find out all the details until after the claims go through. We will make every effort to get them to cover your care as they are required. However, you are ultimately responsible for your bill.

We realize that this may be confusing; however, we are not the ones that make it complicated—that is your insurance company. If you ever have any questions about your bill, please feel free to contact us. We may also contact you for help in getting the insurance company to pay the claim as they are supposed to. Please cooperate, this helps us to get paid—so we don’t have to bill you. We appreciate your understanding in this area.

\_\_\_\_\_ Patient Acknowledgment



# Heritage Chiropractic & Wellness Center, LLC

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## PATIENT HISTORY CHECKLIST

PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

Have you ever been in an Auto Accident? Yes \_\_\_ No \_\_\_  
If so, when? (List date or dates) \_\_\_\_\_

### DO YOU HAVE:

1. Pain that wakes you from a sound sleep? Yes \_\_\_ No \_\_\_
2. Headaches for hours or days? Yes \_\_\_ No \_\_\_
3. Pain in your neck, jaw or face? Yes \_\_\_ No \_\_\_
4. Blurred vision, double vision, or any visual disturbances? Yes \_\_\_ No \_\_\_
5. A drooping eyelid or any change in your pupils? Yes \_\_\_ No \_\_\_
6. Blackouts or fainting spells, or have you lost consciousness lately? Yes \_\_\_ No \_\_\_
7. Any nausea or vomiting? Yes \_\_\_ No \_\_\_
8. Vertigo (dizziness)? Yes \_\_\_ No \_\_\_
9. Slurred speech? Yes \_\_\_ No \_\_\_
10. Ringing in your ears (tinnitus)? Yes \_\_\_ No \_\_\_
11. Chest pain? Yes \_\_\_ No \_\_\_
12. Any change in bowel or bladder habits or loss of control? Yes \_\_\_ No \_\_\_
13. Any unusual bleeding or discharge? Yes \_\_\_ No \_\_\_
14. Any coughing up blood or blood in your stools or urine? Yes \_\_\_ No \_\_\_
15. A sore that will not heal? Yes \_\_\_ No \_\_\_
16. Unexplained weight loss? Yes \_\_\_ No \_\_\_
17. Any thickening in your breasts or elsewhere? Yes \_\_\_ No \_\_\_
18. A change in any wart or mole? Yes \_\_\_ No \_\_\_
19. Indigestion or difficulty swallowing? Yes \_\_\_ No \_\_\_
20. A nagging cough or hoarseness? Yes \_\_\_ No \_\_\_
21. Night sweats? Yes \_\_\_ No \_\_\_
22. A history of stroke in your family? Yes \_\_\_ No \_\_\_
23. Cancer now, or ever before? Yes \_\_\_ No \_\_\_

Do you take Birth Control (pills, patch, etc)? Yes \_\_\_ No \_\_\_  
When was your last menses (period)? \_\_\_\_\_ Are you pregnant? Yes \_\_\_ No \_\_\_

Are you seeing any other doctor now for any reason? Yes \_\_\_ No \_\_\_  
Why? \_\_\_\_\_

What prescription medication are you taking if any?  
( ) High Blood Pressure Medications: \_\_\_\_\_  
( ) Blood Thinners: \_\_\_\_\_  
( ) Other: \_\_\_\_\_

What over-the-counter drugs are you taking if any? (Aspirin, etc.): \_\_\_\_\_

Dr's Initials



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## PATIENT HISTORY CHECKLIST (Page 2)

Patient Name: \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

PCP Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Other current Doctors (name/ address/ phone): \_\_\_\_\_

May we contact? \_\_\_\_\_ Date of most recent physical: \_\_\_\_\_

### MEDICAL HISTORY

(Please list all conditions and previous hospitalizations, surgeries, auto accidents, fractures, strain/sprains, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Allergies: \_\_\_\_\_

Have you ever visited a Doctor of Chiropractic before? \_\_\_\_\_

When and how often? \_\_\_\_\_

### SOCIAL HISTORY

Smoker: Yes \_\_\_\_\_ No \_\_\_\_\_, If yes, how many packs per day? \_\_\_\_\_

Alcohol: Yes \_\_\_\_\_ No \_\_\_\_\_, If yes, how much how frequently? \_\_\_\_\_

### FAMILY HISTORY

Did your mother or father or grandparents have any of the following? Put **M** for mother, **F** for father, **GM** for grandmother, **GF** for grandfather.

- |                           |                               |
|---------------------------|-------------------------------|
| ( ) High Blood Pressure   | ( ) Ulcer or Stomach Problems |
| ( ) Heart Attack          | ( ) Stroke                    |
| ( ) Emphysema             | ( ) Arthritis/ Rheumatism     |
| ( ) Seizures/ Convulsions | ( ) Mental Illness            |
| ( ) HIV Positive          | ( ) Thyroid Disease           |
| ( ) Asthma                | ( ) Circulation Problems      |
| ( ) Diabetes              | ( ) Cancer                    |
| ( ) Kidney Disease        | ( ) Osteoporosis              |
| ( ) Pacemaker             |                               |

Comments: \_\_\_\_\_

Dr's Initials



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

In the course of your care as a patient at our office, we may use or disclose personal and health-related information about you in the following ways:

Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, PPO, or your employer (if they are or may be responsible for the payment of your services.) Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message may be left on your answering machine or voice mail if you are called at work. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

It is the practice of this office to provide therapies in an “open therapy” environment. This involves several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing exams or presenting reports of findings. These procedures are completed in a private, confidential setting. Because of various interpretations under federal law with respect to what is known as “incidental disclosures” of health information, we are requesting your authorization.

Under federal law, we are permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.
- Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like the information in a different form, please advise us in writing as to your preferences.



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## **CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

**I CONSENT** to the use or disclosure of my protected health information by Heritage Chiropractic & Wellness Center (Heritage) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Heritage. I understand that diagnosis or treatment of me by Dr. David K. Leonard may be conditioned upon my consent as evidenced by my signature on this document.

**I UNDERSTAND** I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Heritage is not required to agree to the restrictions that I may request; however, if Heritage agrees to a restriction that I request, the restriction is binding on Heritage and Dr. Leonard.

**I HAVE THE RIGHT** to revoke this consent, in writing, at any time, except to the extent that Dr. Leonard or Heritage has taken action in reliance on this consent.

**MY “PROTECTED HEALTH INFORMATION”** means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

**I UNDERSTAND** I have a right to review Heritage’s Notice of Privacy Practices prior to signing this document. Heritage’s Notice of Privacy Practices has been made available to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Heritage. The Notice of Privacy Practices for Heritage is located at 103 S. Jefferson, Raymore, MO. This Notice of Privacy Practices also describes my rights and Heritage’s duties with respect to my protected health information.

Heritage reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

If you want more information about our privacy practices or have questions or concerns, please contact us. If you have a complaint about how we protect your right to privacy, you may complain to us using the contact information listed below, or you may submit a written complaint to the U.S. Department of Health and Human Services.

Contact Officer: Yvette Y. Leonard  
Address: 103 S. Jefferson, Raymore, MO 64083-9703

Phone: (816) 322-1990

By signing below, I acknowledge I have read this form and give full disclosure of my information.

\_\_\_\_\_  
Patient Signature (or Personal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Printed)



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## Consent to Treat

We are committed to every patient achieving his or her maximum health & wellness potential. Good health and wellness is not merely the absence of disease; it means that you should be able to perform your daily functions and jobs, and live your life pain-free. Wellness also means that you should get sick less often, use fewer medications, feel good about yourself, and have more defenses against diseases. Chiropractic Healthcare uses natural healing methods to help achieve these results. Examples include adjusting the spine and other joints of the body to ensure that they have the correct motion and position. Adjustments remove the nerve irritation from the area and allow proper healing to take place. They also allow the nervous system to function properly. A properly functioning nervous system is essential to maintaining a strong immune system. Other examples of chiropractic healthcare include recommending nutrition and lifestyle changes. These help bring the body into homeostasis (maintenance against internal & external environments). We do not claim to cure any disease, nor do we practice allopathic or osteopathic medicine. We simply bring the body into proper balance and allow the body to begin to heal itself. There is a rare occasion of adverse side effects during chiropractic treatments. This includes dizziness, nausea, or lightheadedness. However, the probability of incurring these side effects are much less than with standard medical care because we are not using drugs or surgery. On very rare occasions, strokes have also been recorded after neck manipulation (Approximately 1 in 2 million chance).

I have read and understood the above information. I hereby give my consent for Heritage Chiropractic & Wellness Center to treat me with the understanding that they are not specifically treating diseases but they are helping to bring my entire body into balance so that it can function properly. I realize that I have to work with the doctor and follow his recommendations in order to achieve the best results.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_  
Patient Signature (Parent/Guardian if Patient is a Minor)

\_\_\_\_\_  
Patient Printed Name (please!)

Dr's Initials

9/10



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## **AUTHORIZATION AND ASSIGNMENT OF BENEFITS INCLUDING PI PATIENTS**

In Consideration of your agreement to treat me, I, THE UNDERSIGNED, agree to the following:

### **ACKNOWLEDGEMENT AND UNDERSTANDING:**

I acknowledge that I am receiving, or am about to receive, health care services from Heritage Chiropractic & Wellness Center LLC (Heritage), and I have been advised that Dr. David K. Leonard and Heritage requests that payment be made for services when the services are rendered. Also, I understand that any contracts I have with any third-party payer is a contract strictly between the payer and me, and **I am totally responsible for my bill.**

### **AUTHORIZATION TO RELEASE INFORMATION:**

I authorize Heritage to release all information necessary concerning me or my physical condition to any insurance company, attorney, or adjuster in order to process all claims for reimbursement of charges incurred as the result of professional services rendered, and I release Heritage from any consequences thereof. I also authorize any insurance company, health care provider, or my attorney to discuss the details and particulars of my case with Heritage without further permission from me.

### **ASSIGNMENT OF CAUSE OF ACTION:**

In the event that any insurance company is obligated by contractual agreement to make payments for my treatment, I hereby assign and transfer to Heritage the cause of action that exists in my favor and I authorize you to process the claim. Heritage is obligated to keep me informed of all transactions and of any amounts of overpayment by any contractually obligated insurance company.

### **AUTHORIZATION OF PAY DIRECTLY TO THE DOCTOR:**

In consideration of the chiropractic services rendered, and to be rendered, by Dr. David K. Leonard and Heritage, I authorize and direct the payment to Heritage Chiropractic & Wellness Center LLC any amount I now or hereafter owe Heritage out of the proceeds of any settlement of my case and/or by any insurance companies obligated to reimburse me for the charges of services or otherwise obligated to reimburse me or make payments to me based in whole or in part upon the charges made for services rendered.

I, THE UNDERSIGNED, HEREBY AGREE THAT IN THE EVENT OF DEFAULT IN THE PAYMENT OF ANY AMOUNT DUE, THAT THE UNDERSIGNED WILL PAY ADDITIONAL CHARGES EQUAL TO THE COST OF COLLECTIONS WITH A COLLECTION AGENCY AND A REASONABLE ATTORNEY’S FEE AND COURT COSTS IF SUIT IS BROUGHT AGAINST ME IN A COURT OF LAW.

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Patient Signature/ Parent Signature (if minor)

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Date

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Printed Name (both, if two signatures)



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## CONSENT TO X-RAY AND PREGNANCY WARNING

Dr. David Leonard has worked at a Nuclear Power Plant for 13 years and is very knowledgeable about X-rays and radiation. As a state requirement, all Doctors of Chiropractic must attend a minimum of 12 hours of Radiology as part of their continuing education per year. When X-Rays are warranted, you can be assured that we have taken every possible precaution to minimize the risk of radiation exposure.

I authorize that an X-ray or X-rays may be performed on me with my consent.

Patient Initial

**For our female patients only:** By initialing below, I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to put my unborn baby at risk. I understand that the 10 days following the onset of a menstrual period are generally considered to be safe for X-ray exams. With those factors in mind, I am advising my doctor that:

I am pregnant: Yes  No  Don't Know

I could be pregnant: Yes  No  Don't Know

I am late with my menstrual period: Yes  No  Don't Know

I am on birth control (pill, patch, IUD, etc.): Yes  No  Don't Know

I have had a tubal ligation (tubes tied) or hysterectomy: Yes  No  Don't Know

I have irregular menstrual periods: Yes  No  Don't Know

My last menstrual period began on: \_\_\_\_\_.

Patient Initial

## DOCTOR'S LIEN & ASSIGNMENT OF MEDICAL BENEFITS FOR X-RAY CONSULT

I understand that Dr. Leonard may submit my x-rays to **Midwest Radiology Consultants** for further radiological evaluation. I also understand that the fee for such services will be submitted to my insurance company, worker's compensation carrier, or my attorney. If I do not have insurance coverage, I understand that I will receive the bill and am responsible for payment. **I authorize my insurance company to pay directly to Midwest Radiology Consultants for service rendered.**

In the event my insurance company, attorney, or workman's compensation carrier does not reimburse for the fee in full, or if I do not have insurance coverage, I agree that I am directly responsible for the charges or any unpaid portion. Returned checks for insufficient funds will be assessed a \$20.00 service charge. Accounts delinquent by 90 days from the time of my first billing statement may be placed with a legal collection agency. ***I am fully responsible for all collection costs unless prior payment arrangements have been made with Midwest Radiology Consultants.***

I understand that Dr. Doran L. Nicholson is not a participating provider in my insurance plan, and that his services may not be covered by my insurance. *I also understand that this service is not covered by Medicare.* In the event that my insurance company sends payment directly to me, I agree to promptly remit such payments to Midwest Radiology Consultants.

By initialing the above paragraphs and signing below, I acknowledge that I have read and agree with all above-stated information.

\_\_\_\_\_  
Patient, Parent, or Legal Guardian

\_\_\_\_\_  
Date