Andy Minor Chiropractic PC
A Minor Adjustment

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

Last Name	First	Middle	Age	Birth Date	Sex (Circle One)
				/ /	M / F

How Many Children?	Home Phone #	Alternate Phone # Spouse Parent Other Cell	Marital Status (Circle One)	Name of Spouse
	( )	( )	S / M / D / W	

Street Address	City	State	Zip	Contact Preference (Circle One)
				Email Alternate # Home # Work # Text/Phone Carrier_____

Occupation	Employer	Office Phone	Referred By
		( )	

IF MINOR: Parents' Names Address (if different)

INSURANCE INFORMATION

Name of Primary Insurance:	Primary Subscriber's Name:	Subscriber's S.S.N.:	Subscriber's Birth Date:
			/ /

Subscriber's Employer: Patient's relationship to subscriber: (Circle one)

SELF / SPOUSE / CHILD / OTHER

Name of Secondary Insurance: Primary Subscriber's Name : Subscriber's S.S.N.: Subscriber's Birth Date:

/ /

Subscriber's Employer: Patient's relationship to subscriber: (Circle one)

SELF / SPOUSE / CHILD / OTHER

Person Responsible for bill (if not patient): Address (If Different): Phone (If Different):

( )

What is your chief complaint?_____

How would you rate your overall health?

O Excellent O Very Good O Fair O Poor

What type of exercise do you do?

O Strenuous O Moderate O Light O None

Indicate if you have any immediate family members with any of the following:

O Rheumatoid Arthritis O Diabetes O Lupus
O Heart Problems O Cancer O ALS

Date of last menstrual cycle (if absent, reason) ?_____

Pregnant or could be pregnant? O Yes O No

HIPAA *You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time.*

Please print your name and the names of any others with access to your medical records:

_____

X_____ **DATE**_____

PATIENT/GUARDIAN SIGNATURE

AGREEMENT **PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED**

I agree and consent to services rendered by physician and staff including applicable radiological examination, treatment, and therapies that correspond with treatment with all conditions stated. Payment for service due in full at time of service, we will accept payment directly from the insurance company but is patient insurance contract and if claims are not paid full balance it will be patient's responsibility. Nonpayment of any charge is considered breach of contract and will be assessed without any promotions once in collection status. Attorney's fees and collection fees as well as court costs will be the patient's responsibility if this breach occurs.

X_____ **DATE** **EMAIL** **SS#**

PATIENT/GUARDIAN SIGNATURE

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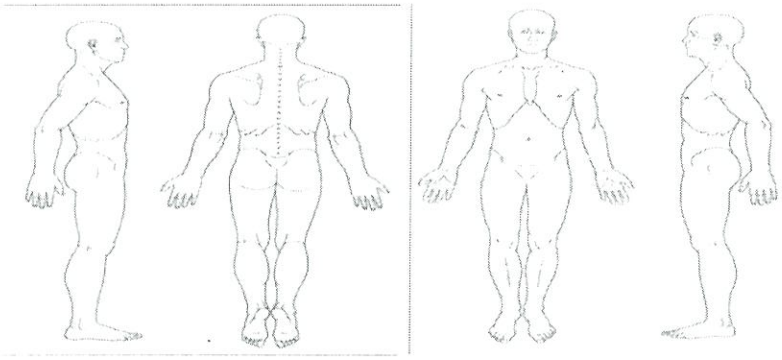
Patient Name:_____ DOB:_____ Date:_____

1. **Is today's problem caused by:** O Auto Accident O Workman's Compensation O None
2. **Indicate on the drawings below where you have pain/symptoms**



3. **How often do you experience your symptoms?** O Constantly (76-100% of the time) O Occasionally (26-50% of the time)
   O Frequently (51-75% of the time) O Intermittently (1-25% of the time)
4. **How would you describe the type of pain? (Check all that apply)**
   O Sharp O Dull O Diffuse O Sharp with motion
   O Achy O Burning O Shooting O Shooting with motion
   O Stiff O Numb O Tingly O Stabbing with motion
   O Other:_____ O Electric with motion
5. **How are your symptoms changing with time?** O Getting worse O Staying the same O Getting Better
6. **Using a scale from 0-10 (10 being the worst), how would you rate your problem in the...** (Circle One)
   Last 24 hours ? 0 1 2 3 4 5 6 7 8 9 10
   Past week ? 0 1 2 3 4 5 6 7 8 9 10
7. **How much has the problem interfered with your work?** O Not at all O A little bit O Moderately O Quite a bit O Extremely
8. **How much has the problem interfered with your social activities?**
   O Not at all O A little bit O Moderately O Quite a bit O Extremely
9. **Who else have you seen for your problem?**
   O Chiropractor O Neurologist O Primary Care Physician O ER Physician
   O Orthopedist O Massage Therapist O Physical Therapist O No One
   O Other_____
10. **How long have you had this problem and how did it begin?**_____
    _____
11. **Do you consider this problem to be severe?** O Yes O No O Yes, At times
12. **What concerns you the most about your problems? What does it prevent you from doing?**_____
    _____
13. **List All Prescription medications you are currently taking:**_____
    _____
14. **List all of the over-the-counter medications you are currently taking:**_____
    _____
15. **List all surgical procedures you have had:**_____
    _____
16. **List your Primary and any other doctors you see and their specialties:**_____
    _____
17. **List any previous radiology studies and the conditions for them:**_____
    _____

FRONT & BACK

Name:_____ DOB:_____

18. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Frequent Urination
O	O	Mid Back Pain	O	O	Stroke	O	O	Smoking/Tobacco Use
O	O	Low Back Pain	O	O	Angina	O	O	Drug/Alcohol Dependance
O	O	Shoulder Pain	O	O	Kidney Stones	O	O	Allergies
O	O	Elbow/Upper Arm Pain	O	O	Kidney Disorders	O	O	Depression
O	O	Wrist Pain	O	O	Bladder Infection	O	O	Systemic Lupus
O	O	Hand Pain	O	O	Painful Urination	O	O	Epilepsy
O	O	Hip Pain	O	O	Loss of bladder control	O	O	Dermatitis/Eczema/Rash
O	O	Upper Leg Pain	O	O	Prostate Problems	O	O	HIV/AIDS
O	O	Knee Pain	O	O	Abnormal Weight Gain/Loss	O	O	Anxiety/Nervousness
O	O	Ankle/Foot Pain	O	O	Loss of Appetite	O	O	Hepatitis
O	O	Jaw Pain	O	O	Abdominal Pain	O	O	Dizziness
O	O	Joint Pain/Stiffness	O	O	Ulcer	**For Females Only		
O	O	Arthritis	O	O	Cancer	O	O	Birth Control Pills
O	O	Rheumatoid Arthritis	O	O	General Fatigue	O	O	Hormonal Replacement
O	O	Tumor	O	O	Liver/Gall Bladder Disorder	O	O	Pregnancy
O	O	Muscular Incardination	O	O	Asthma			
O	O	Visual Disturbances	O	O	Chronis Sinusitis	OTHER_____		

Do you smoke? Y N If yes, how often? _____

19. What aggravates your problem?

Check all that apply for activities in which you have **Pain** or **Difficulty** with: O **Always or** O **Sometimes**

	A	S		A	S		A	S
Bending/Twisting/Turning	O	O	Heavy Lifting and Movement	O	O	Housework/Yard work: Specify_____	O	O
Climbing Stairs	O	O	Exercise/Sports	O	O	Sexual intercourse	O	O
Running	O	O	Dressing the lower/upper body	O	O	Shopping	O	O
Sitting	O	O	Grooming/Bathing	O	O	Stress	O	O
Sleeping	O	O	Going to the bathroom	O	O	Taking care of baby/child	O	O
Standing	O	O	Driving/Riding in car	O	O	Weather Change	O	O
Walking	O	O	Getting in and out of car	O	O	Typing/Computer work/Reading	O	O
Breathing/Coughing	O	O	Cooking	O	O	Recreational/Work/Other activities:	O	O
Carrying Groceries/Laundry	O	O	Needlework, knitting, hand sewing	O	O	Specify_____	O	O

20. What alleviates your problem? Check all that apply

O Adjustments O NSAIDS O Prescription Pain Meds O Resting O Stretching
O Massage O Ice O Heat O Nothing O Acupuncture
O Analgesic Creams O Other _____

21. What activities do you do at work?

Sit:	O Most of the day	O Half of the day	O A little of the day	O Not at all
Stand:	O Most of the day	O Half of the day	O A little of the day	O Not at all
Computer Work:	O Most of the day	O Half of the day	O A little of the day	O Not at all
On the Phone:	O Most of the day	O Half of the day	O A little of the day	O Not at all

22. What activities do you do outside of work?_____

_____

23. Anything else pertinent to your visit today?_____

_____

Andy Minor Chiropractic PC
A Minor Adjustment

801W Main
Blue Springs, MO 64015
Phone: (816)228-5522 Fax: (816)220-0205

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to and sign prior to any treatment. Any breach of contract due to non-payment of any portion of your services will be billed to you in full with all promotions removed and court costs and collection fees as well as attorney's fees will be assessed as your responsibility at that time.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, checks, and Visa/MasterCard

We do offer an extended payment plan with prior credit approval

REGARDING INSURANCE

We will accept payment directly from the insurance company. Not all insurance pays at 100% of the charges, and the patient will be responsible for charges up front for what the insurance deems their patient responsibility. During specials we charge a fee up front for your patient responsibility and we bill the insurance our usual and customary rates at the specialist office rate according to guidelines. There will be several codes sent regarding your care.

UCR (Usual and Customary Rates)

Our practice is committed to providing the best treatment possible for our patients and we charge what is **usual and customary** for our area which is governed by state and federal guidelines. You are responsible for paying your patient responsibility determined at time of service.

AUTOMOBILE ACCIDENTS AND WORKMAN'S COMPENSATION

We accept 3rd party automobile accidents with signed liens and assignment of direct pay we will submit to all parties including attorney, med pay, PIP, 3rd party insurance as applicable.

XRAY RELEASE AND MEDICAL RECORDS RELEASE GUIDELINES

The full medical chart, including hard copy of x-rays, is the property of Andy Minor Chiropractic PC. All patients are entitled to a copy of their records or x-rays with a 3 day notice. Main Street digital x-ray copy charge is $25.00 with signed release. We will assume liability of mailing x-rays directly to a health care provider with a signed medical release and agreement to return the original within 30 days can be established. We prefer to send a radiologic findings report to the provider with 3 days notice. We will not release hard copy x-rays to any patient directly.

I have read, understand, and agree to the above Financial Policy.

Patient Name (Please Print)_____ DOB_____

Patient or Responsible Party_____ Date_____
Signature

Co-Responsible Party_____ Date_____

Andy Minor Chiropractic PC
A Minor Adjustment

Andy Minor, D.C.
Cary Minor, D.C.

801 W Main Street, Blue Springs, MO 64015
Phone: 816-228-5522 Fax: 816-220-0205

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Name: _____ Date Signed: _____

Signature of Patient/Guardian: _____

Approved by: _____ Attending Doctor: _____