AMUNDSON CHIROPRACTIC HEALTH SERVICES, LLC
104 NW STATE ROUTE 7 SUITE G
BLUE SPRINGS MO 64014
WWW.AMUNDSONCHIRO.COM

DR. JENNIFER AMUNDSON-MULLINS
PH: 816-220-0660
FX: 816-220-11661

WELCOME TO AMUNDSON CHIRORACTIC HEALTH SERVICES!

Thank you for choosing us to be a part of your health care team! We are looking forward to meeting with you and your family!

Please take a moment to fill these patient forms out completely. The more detailed you are, the more we will be able to understand your condition. You will have computer work to do when you arrive and having these forms filled out ahead of time will help save you some time in the office.

Please bring with you:

- **Driver's License**
- **Insurance Card**
- **Completed Forms**
- **Form of Payment**
- **Recent X-rays, or MRI's with report**
- **Any labs you have had in the last 3 months (if this is a nutrition appointment)**

Please arrive 15 minutes before your scheduled appointment time.

See you soon!

Dr. Jennifer Amundson-Mullins

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NEW PATIENT INTAKE FORMS

Please Print All Answers

Name:_____Age_____ Sex_____ Date_____

Address:_____ City_____ State_____ Zip_____

Phone:_____ Cell_____ Cell Provider_____

Email_____ Best # to call & when_____

Birthdate_____ Family Doctor_____

___Married ____Single ____ Divorced ____Widowed Spouse's Name_____

Employer_____ Spouse's Employer_____

Employer Address_____Spouse's Birthdate_____

Emergency Contact_____ Phone Number_____

Name of Relative Not Living with You _____ Phone:_____

Whom may we thank for referring you to our office?_____

HEALTH INSURANCE INFORMATION (We will need copies of Driver's License & Card)

Name of Insurance Company _____ Group Number_____

Name of Insured (Policy Holder) _____ Policy Number _____

Medication i.e. Lipitor	# of Refills	Quantity of pills	Strength i.e. 10 mg	Dose Form i.e. capsule	Md's Instructions i.e. 1 per day

Are you allergic to any medicines? List Below **I do not have any medical allergies** _____

Name of Drug: i.e. penicillin	Symptom: i.e. headache

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DEMOGRAPHICS: Ethnicity & Race & Preferred Contact (Please Circle)

Hispanic or Latino Not Hispanic or Latino Preferred Language: English Other

White American Indian/Alaskan Native Asian Black/African American Pacific Islander 2 + more

Phone Call: yes no Text: Message: yes no Written/email: yes no Social Media Invite: yes no

HISTORY OF PAST AND PRESENT CONDITIONS

Please indicate if immediate family members have any of the following:

Rheumatoid Arthritis Diabetes Lupus Heart Problems Cancer ALS High Blood Pressure

Please indicate if you use or suffer from any of the following:

Smoking Tabacco Drug/Alcohol Abuse Caffeine Depression Allergies

Past	Present	Past	Present	Past	Present
___	___ Headaches	___	___Neck Pain	___	___ Upper Back Pain
___	___ Lower back Pain	___	___ Shoulder Pain	___	___ Wrist/Hand Pain
___	___Hip Pain	___	___Knee Pain	___	___Ankle/Foot pain
___	___Jaw Pain	___	___ Arthritis	___	___ General Fatigue
___	___Dizziness	___	___Muscle Issues	___	___Joint Pain/Stiffness
___	___Heart Attack	___	___Angina	___	___High Blood Pressure
___	___Chest Pains	___	___Stroke	___	___Kidney Stones/Disorders
___	___Loss of Appetite	___	___Tumor	___	___Bladder/Prostate Disorders
___	___Asthma	___	___Sinus issues	___	___Abdominal Pain
___	___Ulcers	___	___Hepatitis	___	___Liver/Gallbladder Disorders
___	___Eczema/Rash	___	___HIV/AIDS	___	___Systemic Lupus
___	___Diabetes	___	___Excessive Thirst	___	___Frequent Urination
___	___Epilepsy	___	___Rheumatoid Arthritis		
Females Only					
___	___Birth Control	___	___Pregnancy	___	___Miscarriages/Abortions
___	___Hormone Issues				

Other:_____

Patient Signature_____ Date:_____

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Consent to Treatment

CHIROPRACTIC CARE:

I, _____, hereby authorize and consent to the performance upon me of the treatment of Chiropractic by Dr. Jennifer Amundson, or any of the physicians who may become associated with them in the practice of Amundson Chiropractic Health Services, LLC. Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that is responsible to let you know:

1. Risk of stroke is reported to be 1 in 5-8 million or so…and the cause has yet to be determined.
2. While extremely rare, there have been reports of ligament sprains, and even rib fractures reported.
3. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both, clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

CONSENT TO TREAT WITH ACUPUNCTURE:

I also hereby authorize and consent to the performance upon me of the treatment of acupuncture by Dr. Jennifer Amundson, or any of the physicians who may become associated with them in the practice of Amundson Chiropractic Health Services, LLC and to the employment of such assistants as they may deem necessary to carry out such treatment. Acupuncture has been explained to me as a chiropractic specialty treatment performed by the insertion of special needles (with or without the application of small pulses of electric current to the needles) through the skin into underlying tissues at certain indicated points on the surface of the body, for the purpose of seeking the alleviation, of an undetermined time, of pain or of bodily disorders. Other methods of acupuncture treatments may include: teishin, activator, ion balls or any other means by which acupuncture points may be stimulated/sedated to cause a physiological effect on me as deemed necessary by the doctor.

POSSIBLE HAZARDS OF ACUPUNCTURE NEEDLE USE: may include, but not be limited to: Skin irritation & Redness, Bruising, Bleeding, Infection of the skin or other bodily tissues and/or organs, Pneumothorax (Collapsed Lung) and Needle breaking off under (which would need to be removed by a medical practitioner). All needles in our clinic(s) are brand new, sterile packaged needles. Needles are NEVER re-used. All needles are discarded into a medically approved sharps container (Such as used in Hospitals and other types of Doctor's offices for their needles). I am aware that it is IMPERATIVE that while I am retaining needles that I am to remain completely still. Any moving or getting up and around could cause severe injury to me from needles being bumped, hit, embedded, etc…Therefore; I agree to remain still and without motion.

I am aware that the use of acupuncture is not a common practice in this country. The nature and purpose of my treatment and the hazards and potential complications have been explained to me and no warranty or guarantee has been made to me as to any result of a cure.

I have been advised that acupuncture is not covered by Medicare policies and, thus, Dr. Amundson is not a participating physician. I understand that I am responsible for the payments of all the professional services rendered by her at the time of service.

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I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of the Health & Nutrition Center. This consent applies to all present and future care for me and my family.

NUTRITION:

I specifically authorize Dr. Jennifer Amundson to do health analysis and to develop a natural, complimentary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease.

I understand that this is not a method for "diagnosing", "preventing", or "treating" any disease(s) or condition(s) including, but not limited to: conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional health, nutritional or dietary programs recommended, but rather I understand that it is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success.

I have read and understand the forging. This permission form applies to subsequent visits and consultations.

Patient name:_____ Date:_____

CONSENT FOR MINOR:

I (we) have legal custody/guardianship of said minor _____ and do hereby authorize the doctors at Amundson Chiropractic Health Services, LLC to treat the above said minor for examination, x-rays, and treatment deemed advisable by a licensed chiropractor. This authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agents to give specific consent to any and all such diagnosis and treatment which the chiropractor deemed medically necessary. This authorization allows doctor to treat without parent/guardian present. This authorization will be in effect until 12/31/____ unless revoked by written communication.

Patient name:_____

_____ _____

Patient/Guardian Signature **Today's Date**

AMUNDSON CHIROPRACTIC / DR. JENNIFER AMUNDSON
104 NW 7 HWY SUITE G, BLUE SPRINGS, MO 64014

(816) 220-0660
FAX: (816) 220-1161

HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, 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 the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge. In the event collection processes are required, you will be responsible for all court fees, attorney fees, and administrative fees which may include the doctor's time out of the office.
8. Patient cash accounts are not allowed to have a balance over $100 and must be paid in full within 1 week. We accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Patient Name _____ Date _____ Dr. Jennifer Amundson _____

Signature (if minor, parent must sign) _____