STUPKA

CHIROPRACTIC & WELLNESS CENTER

CONFIDENTIAL PATIENT INFORMATION

114 WEST EUCLID
MCPHERSON, KS
(620)504-6677
STUPKACHIRO@GMAIL.COM

Date: _____ /_____ / _____

Patient's Full Name_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____ E-Mail: _____

☐Male ☐Female Date of Birth: ____ / ____ / _____ ☐ Married ☐Single ☐ Widowed ☐Separated ☐ Divorced

Spouse's Name: _____ Name of insured: _____ Insured DOB: _____

How did you find us?

☐ Existing Patient ☐ Doctor Referral ☐ Advertisement ☐ Other_____

Social Security # _____ /_____ / _____

Status: ☐Employed ☐Full-Time Student ☐Part-Time Student ☐Retired ☐Unemployed ☐Occupation:_____

Employer: _____ Employer Address: _____ Business Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____-_____-_____

Family Physician: _____ City: _____ State: _____ Phone: _____-_____-_____

Previous Chiropractic Care: ☐ Yes ☐ No

Is Today's Visit Due to a Work Related Injury: No Yes Date of Injury: _____

Is Today's Visit Due to an Auto Accident: No Yes Date of Injury: _____

----- **If yes to either question above, please check with receptionist, additional information is needed** -----

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Stupka Chiropractic and Wellness Center) **are paid in full**.

Patient Signature:_____ **Date:** _____ /_____ /_____

Informed Consent

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, and exercises, may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated and acupuncture may be used with your consent with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of Aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Test have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results: I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE
Reasonable alternative to these procedures have been explained to me including rest home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a case for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____
(if a minor)

Signature of Witness: _____ Date: _____

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Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Present Complaint(s): _____

When did your symptoms begin? (Specific date if possible): _____

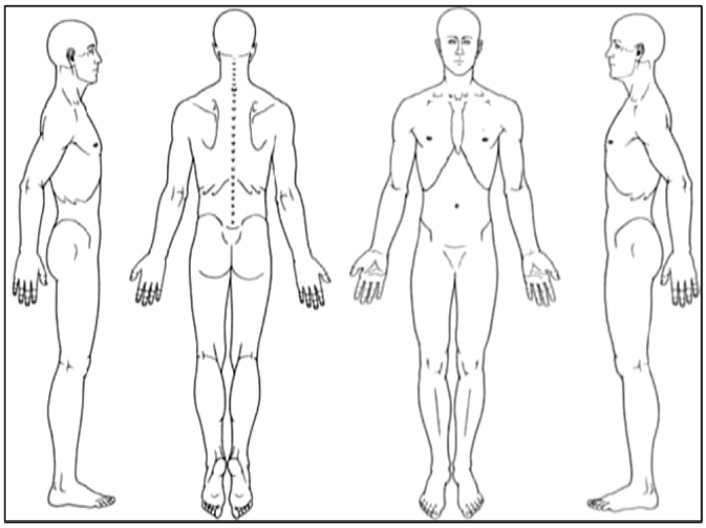
How did your symptoms begin? (i.e. Lifting, etc.): _____

In the past have you had anything similar to this? ☐Yes ☐No Please explain _____

_____

PAIN CHART

Please Mark the Areas of Pain Below then Describe Your Pain



Describe Your Pain

#1 Complaint _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 5 6 7 8 9 10

No Pain Unbearable

Check all that apply to your #1 Complaint

☐Sharp	☐Ache	☐Tingling
☐Stabbing	☐Soreness	☐Numbness
☐Burning	☐Weakness	☐Dull
☐Shooting	☐Throbbing	☐Constricting

☐Other_____

How often are your complaints present?

☐Constant 100% of the time ☐Frequently 75%
☐Intermittent 50% ☐Occasional 25%

Describe Your Pain

#2 Complaint _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 5 6 7 8 9 10

No Pain Unbearable

Check all that apply to your #2 Complaint

☐Sharp	☐Ache	☐Tingling
☐Stabbing	☐Soreness	☐Numbness
☐Burning	☐Weakness	☐Dull
☐Shooting	☐Throbbing	☐Constricting

☐Other_____

How often are your complaints present?

☐Constant 100% of the time ☐Frequently 75%
☐Intermittent 50% ☐Occasional 25%

Describe Your Pain

#3 Complaint _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 5 6 7 8 9 10

No Pain Unbearable

Check all that apply to your #3 Complaint

☐Sharp	☐Ache	☐Tingling
☐Stabbing	☐Soreness	☐Numbness
☐Burning	☐Weakness	☐Dull
☐Shooting	☐Throbbing	☐Constricting

☐Other_____

How often are your complaints present?

☐Constant 100% of the time ☐Frequently 75%
☐Intermittent 50% ☐Occasional 25%

Is your Pain:
☐Increasing
☐Decreasing
☐Not Changing
☐Varies

Was the onset:
☐Gradual
☐Sudden

Pain is aggravated by:

☐Walking	☐Lifting
☐Sitting	☐Bending
☐Riding in a car	☐Stretching
☐Standing	☐Twisting

☐Other_____

Pain is improved by:

☐Medication	☐Therapy
☐Rest	☐Chiropractic Adjustment
☐Exercise	☐Stretching

☐Other_____

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Family Doctor / Primary Care Physician (PCP)?_____

We normally keep your family doctor and/or referring physician informed regarding your care at this office.

☐Yes ☐No Is it okay to inform your PCP? If Yes please specify name and address _____

☐Yes ☐No Is pain affecting your ability to work or be active? If Yes explain: _____

☐Yes ☐No Any change in bowel or bladder (bathroom) function? If Yes explain: _____

☐Yes ☐No Any fever or chills? If Yes explain: _____

☐Yes ☐No Any dizziness associated with symptoms? If Yes explain: _____

☐Yes ☐No Have you experienced any unexplained weight loss, fatigue, or blood loss? If Yes explain: _____

☐Yes ☐No Are your complaints affecting your sleep? If Yes explain: _____

☐Yes ☐No Have you had any tests for this complaint? (i.e. x-rays, MRI, CT) If Yes explain: _____

☐Yes ☐No Any recent falls/ accidents/ surgeries/broken bones? If Yes explain: _____

☐Yes ☐No Have you seen any other physicians in the past 6 months? If Yes explain: _____

☐Yes ☐No Have you had any prior treatment, including any physical therapy If Yes, who? _____

What treatment? _____

☐Yes ☐No Have you been in the hospital or had surgery for any reason? If Yes explain: _____

☐Yes ☐No Have you ever been in an accident? If Yes explain: _____

What **Non-Prescription** medication are you taking?

☐ Tylenol ☐ Aspirin
☐ Ibuprofen ☐ None
☐ Other _____

How often? ☐ Daily ☐ Weekly
☐ Other:_____

What **Prescription** medication are you taking?

☐ Anti-inflammatory ☐ Birth Control Pill ☐ Diet Pills
☐ Pain Killers ☐ Cholesterol Meds ☐ Nerve Ills
☐ Muscle Relaxers ☐ Insulin ☐ HRT
☐ Blood Pressure Meds ☐ Tranquilizers ☐ Sleeping Aid
☐ Other _____ ☐ None

Specific names if possible: _____
_____

☐Yes ☐No Do you smoke? If Yes how much?: _____

If you have quit smoking, when did you quit? _____

☐Yes ☐No Do you consume alcohol?

☐Yes ☐No Do you exercise? If Yes what is your routine? _____

What type of care are you interested in: ☐Pain relief only ☐Healing of current condition ☐Optimizing your health ☐All three

Family History and Health Status: List any diseases, disorders, or major illnesses. If deceased, please provide cause.

Mother: _____ Father: _____
Brother(s): _____ Sister(s): _____
Other: _____ Other: _____

Other health concerns? _____

Financial / Privacy Policy and Disclaimer

Insurance Verification

- Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.

Deductible Payments

- It is our policy to collect at time of service. Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service.
- If an "Explanation of Benefit's or EOD shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. Payment is due within 30 days of receipt of the bill.
- In the event a bill is disputed, you must notify use within 30 days. If you do not notify us within that time, the bill will be presumed valid and due. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.
- All balances remaining unpaid after 30 days may be turned over to a collection agency.

Returned Checks

- It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a $20.00 charge added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding your account at any time. Please direct account questions to our billing administrator(s) Brandon or Morgan Stupka.

HIPAA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you. By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

Designation of Authorized Representative

- I do hereby designate SCWC to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from SCWC. These rights include the right to at on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

IRREVOCABLE Power of Attorney

- I do hereby authorize Stupka Chiropractic & Wellness Center to act on my behalf to pursue claims and exercise all rights in order to collect insurance payments with respect to any medical or other health care expense(s) incurred as a result of the service I receive from SCWC.

Patient Signature _____ Date: _____