Patient Information

Name: _____ Date: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

S. S. #: _____-_____-_____ Birth Date: _____/_____/_____ Age: _____ Sex: _____

Occupation: _____ Employer: _____

Address: _____ Phone: _____

Marital Status: M S D W # of Children: _____ Drivers License #: _____

Spouses Name: _____ Person Responsible for Payment: _____

Referred by: _____ Have you ever seen a chiropractor before?_____

If yes, when: _____ Is this injury/illness work related?_____

Have you reported it to your employer?_____ Date of injury: _____

Is this injury/illness due to an auto accident? _____ (if yes, please give the following information)

Auto Insurance Company: _____ Policy #: _____

Claim #: _____ Agents Name: _____

Phone: _____

Attorney's Name: _____ Phone #: _____

Do you have any type of Health Insurance?: _____ Policy/Group #: _____

Insured's Name: _____ Relation: _____ S.S. #: _____

Are you covered by any other group or individual health insurance policy through yourself or spouse?: _____

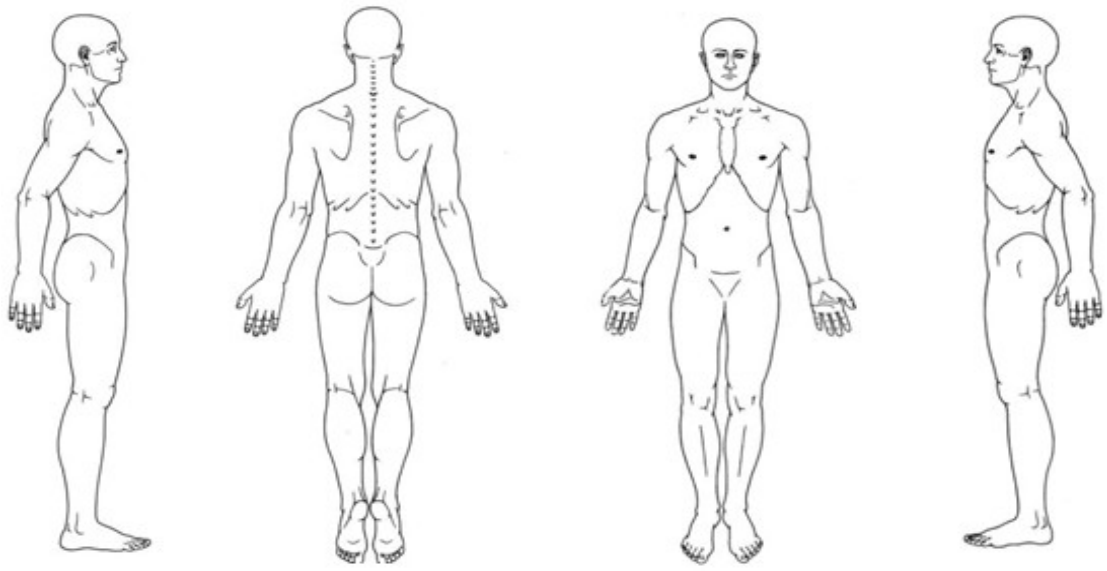
Insurance Company: _____ Policy/Group#: _____

Insured Date of Birth: _____Insured S.S. #:_____ Relation: _____

Drugs you take now: ☐ Aspirin ☐ Pain Killers ☐ Tranquilizers ☐ Insulin
☐ Birth Control Pills ☐ Other: _____

Please List ALL of Your Complaints/Symptoms			
Complaint #1	**Type of Pain:**	**Worse with which of these activities:**	**Result of:**
_____	☐ Aching ☐ Tight	☐ Lying on back ☐ Sitting	Accident
_____	☐ Burning ☐ Stiff	☐ Lying on side ☐ Standing	Work
Began?: _____	☐ Deep ☐ Tender	☐ Lying on stomach ☐ Walking	Other:
Have you had this in the past?	☐ Numb ☐ Tingling	☐ Turning over ☐ Sneezing	_____
☐ Yes ☐ No	☐ Sharp ☐ Stabbing	☐ Lifting ☐ Coughing	_____
Is it getting worse?	☐ Throbbing ☐ Shooting	☐ Stooping ☐ Twisting	_____
☐ Yes ☐ No	☐ Sore	☐ Bending ☐ Reaching	
Complaint #2	**Type of Pain:**	**Worse with which of these activities:**	**Result of:**
_____	☐ Aching ☐ Tight	☐ Lying on back ☐ Sitting	Accident
_____	☐ Burning ☐ Stiff	☐ Lying on side ☐ Standing	Work
Began?: _____	☐ Deep ☐ Tender	☐ Lying on stomach ☐ Walking	Other:
Have you had this in the past?	☐ Numb ☐ Tingling	☐ Turning over ☐ Sneezing	_____
☐ Yes ☐ No	☐ Sharp ☐ Stabbing	☐ Lifting ☐ Coughing	_____
Is it getting worse?	☐ Throbbing ☐ Shooting	☐ Stooping ☐ Twisting	_____
☐ Yes ☐ No	☐ Sore	☐ Bending ☐ Reaching	
Complaint #3	**Type of Pain:**	**Worse with which of these activities:**	**Result of:**
_____	☐ Aching ☐ Tight	☐ Lying on back ☐ Sitting	Accident
_____	☐ Burning ☐ Stiff	☐ Lying on side ☐ Standing	Work
Began?: _____	☐ Deep ☐ Tender	☐ Lying on stomach ☐ Walking	Other:
Have you had this in the past?	☐ Numb ☐ Tingling	☐ Turning over ☐ Sneezing	_____
☐ Yes ☐ No	☐ Sharp ☐ Stabbing	☐ Lifting ☐ Coughing	_____
Is it getting worse?	☐ Throbbing ☐ Shooting	☐ Stooping ☐ Twisting	_____
☐ Yes ☐ No	☐ Sore	☐ Bending ☐ Reaching	
Complaint #4	**Type of Pain:**	**Worse with which of these activities:**	**Result of:**
_____	☐ Aching ☐ Tight	☐ Lying on back ☐ Sitting	Accident
_____	☐ Burning ☐ Stiff	☐ Lying on side ☐ Standing	Work
Began?: _____	☐ Deep ☐ Tender	☐ Lying on stomach ☐ Walking	Other:
Have you had this in the past?	☐ Numb ☐ Tingling	☐ Turning over ☐ Sneezing	_____
☐ Yes ☐ No	☐ Sharp ☐ Stabbing	☐ Lifting ☐ Coughing	_____
Is it getting worse?	☐ Throbbing ☐ Shooting	☐ Stooping ☐ Twisting	_____
☐ Yes ☐ No	☐ Sore	☐ Bending ☐ Reaching	
Complaint #5	**Type of Pain:**	**Worse with which of these activities:**	**Result of:**
_____	☐ Aching ☐ Tight	☐ Lying on back ☐ Sitting	Accident
_____	☐ Burning ☐ Stiff	☐ Lying on side ☐ Standing	Work
Began?: _____	☐ Deep ☐ Tender	☐ Lying on stomach ☐ Walking	Other:
Have you had this in the past?	☐ Numb ☐ Tingling	☐ Turning over ☐ Sneezing	_____
☐ Yes ☐ No	☐ Sharp ☐ Stabbing	☐ Lifting ☐ Coughing	_____
Is it getting worse?	☐ Throbbing ☐ Shooting	☐ Stooping ☐ Twisting	_____
☐ Yes ☐ No	☐ Sore	☐ Bending ☐ Reaching	

Please mark your areas of pain on the figures below:



Habits	
☐ Smoking	Packs/Day: _____
☐ Alcohol	Drinks/Day: _____
☐ Coffee	Cups/Day: _____
☐ Water	Glasses/Day: _____
☐ Soft Drinks	Drinks/Day: _____
☐ Vitamins	List: _____
☐ Wear Seat Belts	
☐ Experience Stress	

Exercise
☐ None
☐ 1-2 days/week
☐ 3-4 days/week
☐ 5+ days/week
Type:
_____
_____
_____

Family History

Please check all that apply

	Stroke	Bad Posture	Heart Trouble	High Blood Pressure	Cancer	Headaches	Arthritis/ Joint Pain	Other
Father								
Mother								
Brother								
Sister								
Child								
Child								

Check the following conditions as they apply to you

Previously	Presently	General
☐	☐	Migraines
☐	☐	Allergy
(what)		_____
☐	☐	Bronchitis
☐	☐	Chills (constant)
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Headache
☐	☐	Loss of Sleep
☐	☐	Loss of Weight
☐	☐	Nervousness
☐	☐	Night Sweats
☐	☐	Numbness or Pain
☐	☐	in arm/legs/hands
☐	☐	Wheezing
☐	☐	Alcoholism
☐	☐	Anemia
☐	☐	Chicken Pox
☐	☐	Rheumatic Fever
☐	☐	Pleurisy
☐	☐	Arthritis
☐	☐	Cancer
☐	☐	Tuberculosis
☐	☐	Venereal Disease
☐	☐	HIV Positive
☐	☐	Diabetes
☐	☐	Measles
☐	☐	_____ other
☐	☐	_____ other
		For Females Only
☐	☐	Irregular Cycle
☐	☐	Cramps
☐	☐	Hot Flashed
☐	☐	Painful Periods
☐	☐	**Pregnant at this time?**
_____ Last Menstrual Cycle		

Previously	Presently	Gastro-intestinal
☐	☐	Belching/gas
☐	☐	Acid Reflux
☐	☐	Heart Burn
☐	☐	Colon Trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Gall Bladder Issue
☐	☐	Hemorrhoids
☐	☐	Jaundice
☐	☐	Liver Trouble
☐	☐	Nausea
☐	☐	Stomach Pain
☐	☐	Vomiting
☐	☐	Vomiting Blood
☐	☐	Bloody Stool
☐	☐	Irritable Bowel
☐	☐	Ulcers
☐	☐	_____ other
		Cardio-Vascular
☐	☐	High Blood Pressure
☐	☐	Strokes
☐	☐	Low Blood Pressure
☐	☐	Chest Pain
☐	☐	Heart Condition
☐	☐	Poor Circulation
☐	☐	Rapid Heart
☐	☐	Slow Heart
☐	☐	Swollen Ankles
☐	☐	Varicose Veins
☐	☐	Pacemaker
☐	☐	_____ other
		Neurological
☐	☐	Anxiety
☐	☐	Mood Swings
☐	☐	Phobias
☐	☐	Mental Disorders
☐	☐	Multiple Sclerosis
☐	☐	Epilepsy
☐	☐	Memory Loss
☐	☐	Depression

Previously	Presently	Eye/Ear/ Nose/ Throat
☐	☐	Sinusitis
☐	☐	Asthma
☐	☐	Deafness
☐	☐	Earache
☐	☐	Ear Noises
☐	☐	Thyroid Problems
☐	☐	Frequent Colds
☐	☐	Hay Fever
☐	☐	Nasal Obstruction
☐	☐	Nose Bleeds
☐	☐	Pain in Eyes
☐	☐	Poor Vision
☐	☐	Blurred Vision
☐	☐	Sore Throats
☐	☐	Tonsillitis
☐	☐	_____ other
		Muscles & Joints
☐	☐	Backache
☐	☐	Stiff Neck
☐	☐	Foot Trouble
☐	☐	Hernia
☐	☐	Painful Tail Bone
☐	☐	Spinal Curvature
☐	☐	Swollen Joints
☐	☐	Tremors
☐	☐	Twitching
☐	☐	Spinal Disc Disease
☐	☐	Dislocated Joints
☐	☐	_____ other
		Genito-Urinary
☐	☐	Blood in Urine
☐	☐	Frequent Urination
☐	☐	Kidney Stones
☐	☐	Painful Urination
☐	☐	Prostate Condition
☐	☐	_____ other
		Respiratory
☐	☐	Chronic Cough
☐	☐	Difficulty Breathing
☐	☐	Spitting Blood

Functional Assessment Questionnaire

Using the key below please circle one answer in each box that indicates your ability to do the following activities

Key: 0=no difficulty 5=unable

Activity	Score					
	No difficulty					Unable
Sleep normally	0	1	2	3	4	5
Up and down stairs	0	1	2	3	4	5
Food prep, cooking, eating	0	1	2	3	4	5
Walking	0	1	2	3	4	5
Grooming (bath, comb hair, shave, etc..)	0	1	2	3	4	5
Getting up and down from a chair or bed	0	1	2	3	4	5
Dressing - manage normal dressing activities	0	1	2	3	4	5
Dressing - tie shoes, buttoning a shirt	0	1	2	3	4	5
Lifting, carrying up to 10 pounds	0	1	2	3	4	5
Sitting for normal periods of time	0	1	2	3	4	5
Standing for normal periods of time	0	1	2	3	4	5
Reaching above head or across body	0	1	2	3	4	5
Leisure, recreational sports activities	0	1	2	3	4	5
Squatting down to pick up items	0	1	2	3	4	5
Running, jogging	0	1	2	3	4	5
Driving	0	1	2	3	4	5
Everyday job requirements	0	1	2	3	4	5

Pain Scale: Please circle the number that describes the pain/symptoms you have experienced over the last two weeks with 0 being no pain/symptoms and 10 being the worst imaginable pain/symptoms

0	1	2	3	4	5	6	7	8	9	10

What activities are your symptoms preventing you from doing that you like to do?

_____

_____

_____

_____

Verification of non-pregnancy

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.

_____
Patient Name

_____ Date _____
Patient Signature

_____ Date _____
Witness Signature

St. Francis Integrative Medicine and Wellness

Summary of notice of privacy practices

Our legal duty: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with notice of our legal duties and privacy practices with respect to your medical information. This notice of privacy practices (notice) is posted in our facilities, available on our website and upon request.

Parties following the notice: The notice will be followed by St. Francis Integrative Medicine and Wellness and its affiliates, together with their health care professionals and staff.

How we may use and disclose medical information about you: We may use or disclose identifiable health information about you for many reasons, including:

Treatment
Payment
Health care operations
Activities of our affiliates
Appointment reminders
Fundraising activities
Research
As required by law
To avert a serious threat to health or safety
Organ donation
Activities of managed care networks
To military command authorities
Workers' compensation
Public health purposes
Auditing
Health oversight purposes
Lawsuits and disputes
Law enforcement purposes
To coroners, medical examiners, funeral directors
National security and protective services.

In general, other uses and disclosures of your medical information will require your written authorization. We may use or disclose certain limited information about you, unless you object or request a limitation of the disclosure, for:

* Hospital directories
* Individuals involved in your care or payment

Your Privacy Rights:

You have the following rights with respect to your health information:

* The right to inspect and copy certain medical information that we maintain about you
* The right to request an amendment of your health information
* The right to an accounting of certain disclosures of your health information
* The right to request restrictions on certain uses of your health information
* The right to request confidential communications and alternative means to communication with you

Changes to the notice: We reserve the right to change the notice. We will post any revised notice.

Complaints: If you believe your rights have been violated, you may file a written complaint with the Privacy Officer Patient Representative or with the Security of the U.S. Department of Health and

Human Services.

Acknowledgment

Patient Name: _____

Patient Acknowledgment: I acknowledge that a copy of the notice was made available to me, as well as this summary for St. Francis Integrative Medicine and Wellness and its affiliates. I also acknowledge that I have been provided with the opportunity to ask questions regarding the notice and its contents.

Signature of Patient : _____ **Date: _____**

For use by St. Francis Integrative Medicine and Wellness Personnel Only: [Complete if patient acknowledgement is not obtained]
The patient was provided with the notice of privacy practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the notice and summary. An acknowledgment was not obtained because:
_____

Signature of St. Francis I.M.W. Representative: _____

Date: _____ Effective date of Summary: _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The Doctor will use his/her hands or mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasounds, or dry hydrotherapy may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

* Over-the-counter analgesics; risks associated with these medications include: irritation to stomach, liver, kidneys, and other side effects in a significant number of cases.
* Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics; risks of these drugs include a multitude of undesirable side effects and patient dependence.
* Hospitalization, in conjunction with medical care, adds risk of exposure to virulent communicable disease.
* Surgery, in conjunction with medical care, creates risk of adverse reaction to anesthesia and/or an extended convalescent period.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

TO BE COMPLETED BY PATIENT

Patient's Name_____ Signature of Patient_____

Date Signed_____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name_____ Signature of Patient_____
Date Signed_____ Signature of Representative_____
Relationship of Patients Representative_____

Missed Appointment Policy

Our goal is to provide the highest quality, individualized care in a timely manner.
No-shows, late shows, and cancellations inconvenience those individuals who need access to care.
We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely care.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a 24 hour notice.

No Show Policy: A "No Show", is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no show".

The first time there is a "no show" or late cancellation there will be no charge to the patient. A 2nd occurrence will result in a fee of the visit. The 3rd occurrence will be the fee of the visit and the patient may be discharged from the practice.

We greatly appreciate your understanding and compliance with this policy, so we may offer the absolute best patient experience possible.
Dr. Ryan Overton & Staff

Patient Signature:_____ Date:_____

St. Francis Integrative Medicine and Wellness Financial Policy

Patient Name: _____
ID#: _____
Date: _____

Thank you for choosing St. Francis Integrative Medicine and Wellness. Our goal is to provide you with the highest quality chiropractic care to fit your individual healthcare needs. Based on your health history, examination findings, and diagnosis, we are recommending that you receive chiropractic care and if clinically necessary, certain other types of physical medicine and rehabilitation services. Most patients begin treatment for active care conditions. Examples of these conditions include sprains, strains, pain syndromes, loss of joint mobility, inability to perform normal daily activities and functional mechanical disabilities. These types of conditions are typically covered by insurance. St. Francis Integrative Medicine and Wellness also provides wellness and maintenance are that is not typically covered by insurance.

While it is our general policy at St. Francis Integrative Medicine and Wellness to bill your insurance company as a courtesy to you, we would like to clarify our billing policy for your information.

For patients that receive chiropractic and therapy services for medically necessary conditions as mentioned above, we need to follow a complex set of clinical guidelines and administrative procedures. For example:

* Obtain your insurance information and verify your coverage.
* Initial treatment usually requires more intense therapy (e.g., traction, muscle stretching, and strengthening, upper and lower extremity adjusting) which requires you to spend more time with the doctor.
* Complete insurance authorization forms.
*Submit each claim to your insurance company and often re-submit claims.
* Track and post payments that we receive from your insurance company.
* And often times wait weeks or sometimes months to receive reimbursement.
* This office has established a single fee schedule that applies to all patients for each service provided.
*You may be entitled to a network or contractual discount under the following circumstances:
    * We have become a participating provider in your health plan.
    * You are covered by a State or Federal program with a mandated fee schedule.
    * You are a member of ChiroHealthUSA, or another Discount Medical Plan Organization we may join.

We called your insurance company and spoke to _____ at _____
He/She stated that you do / do not have coverage for chiropractic care. Your deductible is $_____ of which $_____ has still not been met. After the deductible, your co-insurance is estimated to be $_____ per visit.

Based on your health history, examination findings, and diagnosis/diagnoses, we are recommending approximately _____ visits over the next _____ weeks. These visits may include periodic re-evaluations and certain additional chiropractic therapies.

Estimated cost of exams/ x-rays:	$_____
Estimated cost of deductible:	$_____
Estimated co-pay/ co-insurance per visit:	$_____
Estimated cost for non-covered services per visit:	$_____
Estimated charge per visit:	$_____
Total estimated insurance payment:	$_____
Total estimated discounts:	$_____
Total estimated patient responsibility:	$_____

Depending upon your type of insurance, we will be reimbursed a percentage of this amount. Our fee for wellness/maintenance care, (which usually begins after the first 12-36 visits) and not covered by insurance ranges from $_____ to $_____. This type of care usually requires less time, less intense therapy, and may provide a discount from our standard fee schedule because there are no administrative costs (e.g., printing insurance claims, folding and stuffing enveloped, postage fees) that are involved with collecting the fee. Also, we do not have to call insurance company representatives, engage in written correspondence with the insurance company and wait weeks, months, or even longer to receive payment.

We offer several payment options. You can choose to pay by cash, check, debit, major credit card, or you may qualify for an interest-free plan thru _____. You represent that you are an authorized signor on the credit card we have on file and authorize us to charge your card consistent with the above payment option chosen. You authorize us to make automatic withdrawals from your checking account or credit/debit card in the amount of $_____ per month until your balance is zero.

Patient Acknowledgement:

I understand that the above information is not a guarantee of insurance benefits. Benefits will be determined by a number of factors by my insurance company, including but not limited to; eligibility at the time the services are rendered or medical necessity. The above is only an estimate of benefits as relayed by my insurance company. I assume responsibility for all charges incurred on my account. I understand and agree that no doctor can or should guarantee results for any course of treatment and that no spinal correction can be guaranteed. I understand that I am responsible for all payments after any deductible, co-payment, and co-insurance is handled. I understand that my insurance is an agreement between me and my insurance company and all service rendered to me are my responsibility.

I understand that I have the option to decline and/or discontinue care at this office for any reason. In the event that care is discontinued, I will not be penalized in any fashion. Any unpaid balance associated with care which has actually been rendered shall continue to be payable. If there is credit remaining on my account, it will be refunded.

I have read, understand, and agree to the above financial policy. I acknowledge that I am signing this

notice voluntarily and that it is not being signed after services have been provided. I have had ample opportunity to ask questions about my financial obligations and other treatment options. I understand that by signing this form I am fully responsible for all non-covered services and any out of pocket costs associated with the covered services that I receive.

Method of payment you plan to use for today's charges:

☐ Check ☐ Cash ☐ Card

_____

Patient Printed Name

_____

Patient Signature

_____

Date