VITALITY CHIROPRACTIC & FAMILY WELLNESS

Your Facts

1

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apartment #:** _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____

Email: _____

How did you find us? Patient *(who)*: _____ Doctor *(who)*: _____ Staff *(who)*: _____

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other: _____

Your preferred method of communication for patient appointment reminders (*circle one*): Email Text Message No Reminder

If you'd like text message reminders please circle your provider: AT&T Verizon Sprint T-Mobile Other: _____

Do you know your height and weight? (height): _____ (weight): _____

Date of Birth: ____/____/____ **Gender** (*circle one*): Male Female **Marital Status** (*circle one*): M D W S

Employer: _____ **Work #:** _____ **Ext:** _____

Spouse: _____ **Occupation:** _____ **Employer:** _____

How many children? _____ **Ages of children:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Primary Care Physician (PCP): _____ **Phone #** (PCP): _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

Smoking Status (*circle one*): Never Former Occasional Every Day **Smoking Start Date**: ____/____/____

Race (*circle one*): White (Caucasian) Black or African American Asian American Indian or Alaska Native

Native Hawaiian or Pacific Islander I Decline to Answer Other: _____

Ethnicity *(circle one):* Hispanic or Latino Not Hispanic or Latino I Decline to Answer

Are you currently taking any medications?

Medication Name	Dosage and Frequency

Are you currently taking any supplements?

Supplement Name	Dosage and Frequency

VITALITY CHIROPRACTIC & FAMILY WELLNESS

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my medical information by Vitality Chiropractic and Family Wellness, LLC and/or the affiliate practioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of VCFW. I understand that diagnosis or treatment of me by VCFW 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 medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. VCFW is not required to agree to the restrictions that I may request. However, if VCFW agrees to a restriction that I request, the restriction is binding on VCFW. I have the right to revoke this consent, in writing, at any time, except to the extent VCFW has taken action in reliance on this consent.

My "medical 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 medical 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 VCFW's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of Your Wellness Connection.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of VCFW. This Notice of Privacy Practices also describes my rights and the duties of VCFW with respect to my medical information. VCFW 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 asking for one at the time of my next appointment.

_____ **Today's Date:** ____/____/____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

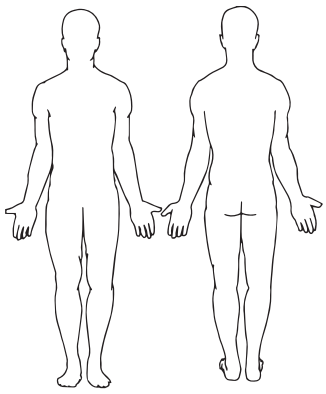
VITALITY CHIROPRACTIC & FAMILY WELLNESS

Your Consultation

3

Name: _____ **Date of Birth:** _____ **Date:** _____

Pain Location



Front **Back**

A = Achy
B = Burning
ST = Stabbing
SP = Spasm
N = Numbness
P = Pins and Needles
T = Throbbing

Doctor Notes:

Height: _____

Weight: _____

Blood Pressure: _____/_____

Present Condition

*List conditions **in order of concern.*** *Date of Onset* *Due to:*

1. _____ _____ ☐ Auto ☐ Work ☐ Other

(minor) **Pain Scale** *(extreme)*

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Has condition changed since onset? ☐ Yes ☐ No ☐ Better ☐ Worse *Explain:*

_____

What makes pain better? _____

What makes pain worse? _____

Have you ever had the same or similar symptoms? ☐ Yes ☐ No *If Yes, when and describe:*

_____

2. _____ _____ ☐ Auto ☐ Work ☐ Other

(minor) **Pain Scale** *(extreme)*

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Has condition changed since onset? ☐ Yes ☐ No ☐ Better ☐ Worse *Explain:*

_____

What makes pain better? _____

What makes pain worse? _____

Have you ever had the same or similar symptoms? ☐ Yes ☐ No *If Yes, when and describe:*

_____

Have you had any major past or recent illnesses, injuries, falls, auto accidents or surgeries?
Women, please include information about childbirth (include dates):

_____

_____

Current Symptoms

1
- ☐ Neck Pain/stiffness
- ☐ Mid Back Pain
- ☐ Lower Back Pain
- ☐ Muscle Spasms
- ☐ Joint Swelling/Pain

2
- ☐ Knee pain
- ☐ Leg Cramps
- ☐ Tingling/Numbness in Legs
- ☐ Weakness in Legs
- ☐ Tingling/Numbness in Toes

3
- ☐ Recent Bowel/Bladder changes
- ☐ Difficulty Urinating

3
- ☐ Bladder/Urinary Tract infections
- ☐ Menstrual Difficulties/Irregularities
- ☐ Constipation
- ☐ Indigestion
- ☐ Belching/Reflux
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Hemorrhoids

4
- ☐ Shoulder pain
- ☐ Arm Pain
- ☐ Tingling/Numbness in Arm
- ☐ Tingling/Numbness in Fingers
- ☐ Cold Hands

4
- ☐ Circulatory Problems
- ☐ Shortness of Breath
- ☐ Chest pain/Tightness

5
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Fainting
- ☐ Ringing in Ears
- ☐ Headaches: Frequency____
- ☐ Migraines: Frequency_____
- ☐ Sight Sensitivity
- ☐ Loss of Smell/Taste
- ☐ Fever

6
- ☐ Nervousness
- ☐ Irritability
- ☐ Fatigue
- ☐ Stress
- ☐ Tension
- ☐ Sleep Problems
- ☐ Hot/Cold Sweats

7
- ☐ Allergies
- ☐ Asthma
- ☐ Hay Fever
- ☐ Hives
- ☐ Other _____
- ☐ Other _____

(913) 962-7408 (office) | (913) 962-7416 (fax) | 7410 Switzer, Shawnee, KS 66203 | vitalitychiropractickc@gmail.com | www.vitalitychiropracitckc.com

VITALITY CHIROPRACTIC & FAMILY WELLNESS

Your History

Name: _____ **Date of Birth:** _____ **Date:** _____

Medical History

	Self	Siblings	Mom	Dad	GPs
ADD/ADHD	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Arthritis - *Type*_____	☐	☐	☐	☐	☐
Birth Trauma	☐	☐	☐	☐	☐
Blood Pressure Low/High	☐	☐	☐	☐	☐
Broken Bones/Factures	☐	☐	☐	☐	☐
Cancer -*Type*_____	☐	☐	☐	☐	☐
Cholesterol - High	☐	☐	☐	☐	☐
Chronic Fatigue	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Convulsions	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐
Eye Condition	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Gall Bladder Problems/Removal	☐	☐	☐	☐	☐
Gastric/Reflux/Ulcer	☐	☐	☐	☐	☐
Glasses/contacts	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐
Immune System - Weak	☐	☐	☐	☐	☐

	Self	Siblings	Mom	Dad	GPs
Irritable Bowel Syndrome	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐
Muscular Dystrophy	☐	☐	☐	☐	☐
Neuritis/Neuralgia	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐
Scarlet Fever	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Shingles	☐	☐	☐	☐	☐
Skin Disorder	☐	☐	☐	☐	☐
Sleep Disorder	☐	☐	☐	☐	☐
Stroke/Hypertension	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Varicose Veins	☐	☐	☐	☐	☐
Venereal Disease	☐	☐	☐	☐	☐
Weight Gain/Loss	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐

Who Have You Seen:

Who have you seen for your symptoms, and when? ***Date***

Chiropractor: _____

_____

Medical Doctor: _____

_____

Physical Therapist: _____

_____

Other: _____

_____

Have You Had:

Blood analysis ☐ Yes

Blood pressure check ☐ Yes

Bone density ☐ Yes

Eye exam ☐ Yes

MRI ☐ Yes

Spinal x-ray ☐ Yes

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VITALITY CHIROPRACTIC & FAMILY WELLNESS

Chiropractic Informed Consent

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Name: _____ **Date of Birth:** ____/____/____

Phone: _____ **Email:** _____

Address: _____

Chiropractic evaluation and treatment involves certain inherent risks. There are several benefits associated with performing an evaluation. They include: working diagnosis of present condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.

Today's treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, active or passive stretching, instrument-assistant soft tissue manipulation (IASTM), massage techniques (including but not limited to effleurage, petrissage, compression, and tapotement) and the application of kinesiology tape. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, disc injury, reddening of the skin and/or development of petechiae (small broken capillaries in the skin's surface), bruising, itching and/or blistering of the skin, muscle, ligament, or joint injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability to ensure the maximum improvements. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to Dr. Jimenez by calling 913-962-7408.

Adjustment – Spinal manipulation that involves precise impulses in a specific direction to restore normal motion and position of individual vertebrae.

Interferential Current Therapy – Small electrical impulses are used to stimulate muscles and relieve tension by reducing nerve irritation. This current promotes the secretion of natural painkillers (endorphins).

Intersegmental Traction Therapy – This therapy utilizes rollers that slowly travel the length of the spine. By stretching individual joints, it promotes increased mobility and blood flow that leads to faster healing.

Active or Passive Stretching – Areas of the body taken through active or passive range of motions to encourage stretching and lengthening of the muscles and increased circulation.

Instrument-Assisted Soft Tissue Release (IASTM) – A treatment to break up adhesions or scar tissue detected by the stainless steel instrument in the area of complaint to increase range of motion, decrease pain, improve circulation, encourage healing, and prevent the formation of the development of scar tissue.

Massage Techniques – Including but not limited to effleurage, petrissage, compression, and tapotement techniques to encourage muscle relaxation, stretching and lengthening of the muscles and increase circulation.

Kinesiology Tapin – The application of elastic adhesive tape to the area of complaint to help eliminate pain, aid in proper muscle and joint function, provide support and neuromuscular re-education.

Risk factors have been reduced to the best of our ability. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatments.

By signing this form you consent to disclose any and all relevant medical health conditions (i.e. cardiovascular, neurological, skin, muscle or joint conditions) that could be a contraindication to treatment to Dr. Jimenez.

DO NOT RECEIVE TREATMENT IF YOU HAVE ANY OF THE FOLLOWING: AN INFECTIOUS OR CONTAGIOUS SKIN DISEASE, OR INFLAMMATORY CONDITION AFFECTED BY INCREASED BLOOD CIRCULATION.

Signature: _____ **Today's Date:** ____/____/____

Printed Name: _____

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VITALITY CHIROPRACTIC & FAMILY WELLNESS

Our Financial Policy

6.1

It is the policy of this office that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment.

PATIENTS WITHOUT INSURANCE OR SELF PAY: If you are not insured OR not insured by a plan we participate with, **payment is expected in FULL at each visit.** If you are seeing our doctors on an "out of network" basis you may request a "Superbill" so that you may submit it to your insurance company for out-of-network reimbursement.

PATIENTS WITH INSURANCE: Vitality Chiropractic and Family Wellness, LLC (VCFW) participates with Blue Cross Blue Shield and Unitedhealthcare. Knowing your chiropractic insurance benefits is your responsibility. **All co-payments and deductibles must be paid at the time of service.**

PATIENT BILLING & BALANCES DUE: Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. In the event that you do not pay your co-payment or deductible payment at the time of service OR your insurance carrier assigns any additional patient responsibility amounts after the claim is processed, **we will charge the credit card on file for such patient responsibility, co-payment or deductible amount to the following extent:**

1. **If the balance due is less than $100 your card will be charged automatically.**
2. **If the balance due is greater than $100, we will contact you 72 hours prior to your card being charged.** Should you decide to use an alternate method of payment OR set up a payment plan, please **alert our office within 72 hours of our contact,** and our contact shall include a voice message from us to you if we are unable to reach you.
3. Payment plans ARE available upon request.
4. **A $10 late fee per month may** be charged to your account if your balance is unpaid 90 days after your last visit until balance is paid in full.
5. If we do not receive payment in full for the balance due, or you have not set up an automatic payment plan **after 6 months of an unpaid balance your account may be forwarded to collections,** and you hereby agree that if VCFW, LLC places your account with an agency or attorney for collection, you will pay VCFW, LLC all of its costs and expenses in collecting monies owed by you to the extent allowed by applicable law.
6. If your credit/debit card on file expires or otherwise becomes uncollectible, we will expect you to promptly provide a new credit or debit card.
7. **A $25 returned check fee will** apply towards your account for checks returned for insufficient funds.

I hereby authorize Vitality Chiropractic and Family Wellness, LLC to charge my credit, debit, or HSA card on file for the full amount owed by me for all services and/or treatment rendered by VCFW, LLC in accordance with the terms above.

Please check one box:

☐ Run my card I have swiped & saved in secure system. Signature still needed on next page.

or

☐ Run my card information provided in the box below.

CREDIT CARD INFO

Credit Card # _____ **Card Type:** VISA MASTERCARD DISCOVER AMEX

Expiration Date: _____ **3-digit Security Code:** _____

Name on Card: _____

...our financial policly is continued on the next page...

VITALITY CHIROPRACTIC & FAMILY WELLNESS

Our Financial Policy *(continued...)*

6.2

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the Notice of Privacy Practices and agree to its terms.

ASSIGNMENT OF BENEFITS: I, the undersigned certify that I (or my dependent) have coverage with my insurance as presented and assign directly to VCFW, LLC all insurance benefits, payable to me for services rendered, I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services, I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

AUTHORIZATIONS: I hereby acknowledge that I have read the above policy regarding my financial responsibility to VCFW, LLC for medical services and treatment provided and I agree to pay Vitality Chiropractic and Family Wellness, LLC any balance unpaid by my insurance carrier for myself or the below named person

By executing this Financial Policy and Patient Authorization, you hereby guarantee payment of all charges from VCFW, LLC for medical services and treatment provided.

This authorization shall remain effective unless and until it is revoked by you in writing and delivered to the office of VCFW, LLC 7410 Switzer Rd., Shawnee, KS 66203

_____ **Today's Date:** ____/____/____

Signature of Patient/Parent/Guardian

_____

Printed name of Patient/Parent/Guardian

Family members who are minors (under the age of 18) you approve this financial policy to be applied to and approve the provided card to be ran for services provided to them.

_____ **Age:** _____

Family Member Name

_____ **Age:** _____

Family Member Name

VITALITY CHIROPRACTIC & FAMILY WELLNESS

Insurance Data Collection

7

Last Name: _____ **First Name:** _____

Date of Birth: ____ / ____ / _____

Insurace Verification: FOR OFFICE USE ONLY

Date: ____ / ____ / ____ **Ins. Contact Name:** _____ **Eff. Date of Coverage:** ____ / ____ / ____

Deductibles: In Net: _____ **How much met?** _____ **How much remains?** _____

Co-Pay(s): _____ **Coinsurance %:** _____ **Max Benefits / Year:** _____

Photocopy/scan the front and back of the insurance card in the area below.

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Notice of Patient Privacy Practices

We are committed to preserving the privacy of your medical information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may require your written consent before we use or disclose to others your medical information for purposes of diagnosing or providing treatment to you, obtaining payment for your health care bills or to conduct health care operations of Your Wellness Connection (YWC).

***Treatment** includes activities performed by a practitioner, chiropractic assistant, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

***Health Care Operations** includes the necessary administrative and business functions of our office.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you nconfidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. This Notice is posted in our lobby. We may revise our Notice from time to time. The effective date at the lower left-hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our Privacy Officer at (913) 962-7408.