

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? _____ **Names and 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

Do you have any medication allergies?

Medication	Reaction

Are you currently taking any supplements?

Please list your major health goals:

Supplement Name	Dosage and Frequency

FOR OFFICE USE ONLY

Height: _____ **Weight:** _____ **Blood Pressure:** _____ / _____

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 practitioners 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.

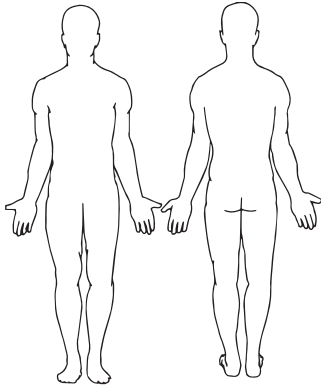
The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of VCFW. This Notice of Privacy Practices also describes my rights and the duties of VCFW with respect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

Patient or Personal Representative Signature: **Today's Date:** _____ / _____ / _____

Printed Name of Patient or Personal Representative:

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:

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

<p>1</p> <ul style="list-style-type: none"> <input type="checkbox"/> Neck Pain/stiffness <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Lower Back Pain <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Joint Swelling/Pain ----- <input type="checkbox"/> Knee pain <input type="checkbox"/> Leg Cramps <p>2</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tingling/Numbness in Legs <input type="checkbox"/> Weakness in Legs <input type="checkbox"/> Tingling/Numbness in Toes ----- <p>3</p> <ul style="list-style-type: none"> <input type="checkbox"/> Recent Bowel/Bladder changes <input type="checkbox"/> Difficulty Urinating 	<p>3</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bladder/Urinary Tract infections <input type="checkbox"/> Menstrual Difficulties/Irregularities <input type="checkbox"/> Constipation <input type="checkbox"/> Indigestion <input type="checkbox"/> Belching/Reflux <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids ----- <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Arm Pain <p>4</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tingling/Numbness in Arm <input type="checkbox"/> Tingling/Numbness in Fingers <input type="checkbox"/> Cold Hands 	<p>4</p> <ul style="list-style-type: none"> <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Chest pain/Tightness ----- <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Fainting <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Headaches: Frequency _____ <input type="checkbox"/> Migraines: Frequency _____ <input type="checkbox"/> Sight Sensitivity <input type="checkbox"/> Loss of Smell/Taste <input type="checkbox"/> Fever <p>5</p>	<p>6</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nervousness <input type="checkbox"/> Irritability <input type="checkbox"/> Fatigue <input type="checkbox"/> Stress <input type="checkbox"/> Tension <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Hot/Cold Sweats ----- <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Hives <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <p>7</p>
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Name: _____ Date of Birth: _____ Date: _____

Medical History						Medical History					
	Self	Siblings	Mom	Dad	GPs		Self	Siblings	Mom	Dad	GPs
ADD/ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis - <i>Type</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth Trauma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Low/High.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones/Fractures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer - <i>Type</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol - High.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuritis/Neuralgia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder Problems/Removal.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric/Reflux/Ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/contacts.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune System - Weak.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.....	<input type="checkbox"/> Yes
Blood pressure check.....	<input type="checkbox"/> Yes
Bone density.....	<input type="checkbox"/> Yes
Eye exam.....	<input type="checkbox"/> Yes
MRI.....	<input type="checkbox"/> Yes
Spinal x-ray.....	<input type="checkbox"/> Yes

Name: _____ Current Date: _____ Reassess Date: _____

What is your story? Take time to reflect on your life events from birth to the present time. What have your life events been? Start with birth moving through the life stages. Some examples are a difficult birth, accidents, marriage, divorce, deaths, starting a business, job changes, and financial issues.

BIRTH TO 15 YEARS: _____

15 TO 30 YEARS: _____

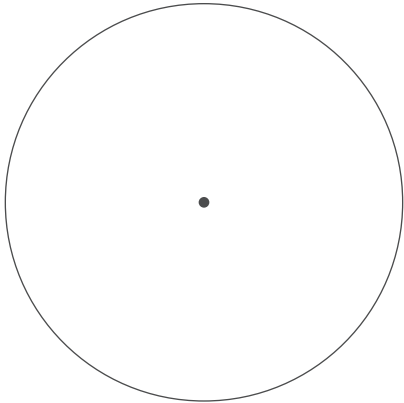
30 TO 40 YEARS: _____

40 TO 50 YEARS: _____

50+ YEARS: _____

MY HYDRATION	
<i>What is your average daily intake? (oz.)</i>	
Water _____	Alcohol _____
Caffeine _____	Soft Drinks _____
Juice _____	Energy Drinks _____
Milk _____	Other (write in) _____

RECREATIONAL ACTIVITIES, SPORTS PLAYED, HOBBIES	
1. _____	<input type="checkbox"/> past <input type="checkbox"/> present
2. _____	<input type="checkbox"/> past <input type="checkbox"/> present
3. _____	<input type="checkbox"/> past <input type="checkbox"/> present

MY FUEL	
<i>Think about how you eat in a typical week. Indicate what percent you eat of each of the following. (feel free to print this out and graph the chart)</i>	
<ul style="list-style-type: none"> • Processed Foods % _____ • Dairy % _____ • Animal Protein % _____ • Grains % _____ • Fruits % _____ • Vegetables % _____ • Good Fats % _____ 	

MY WELLNESS PRACTICES
<i>In the past 3 years, have you had...</i>
<input type="checkbox"/> Blood analysis / lab work
<input type="checkbox"/> Blood pressure check
<input type="checkbox"/> Bone density scan
<input type="checkbox"/> Cardiovascular stress test
<input type="checkbox"/> Flexible sigmoidoscopy
<input type="checkbox"/> Hearing test
<input type="checkbox"/> Mammogram
<input type="checkbox"/> Pap/pelvic exam
<input type="checkbox"/> Prostate exam
<input type="checkbox"/> Spinal exam
<input type="checkbox"/> Dental exam

MY MEDICAL PRACTICES
<i>Mark the wellness disciplines you use.</i>
<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Dental Care
<input type="checkbox"/> Exercise / Movement Classes
<input type="checkbox"/> Eye Care
<input type="checkbox"/> General Medical
<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Meditation / Prayer
<input type="checkbox"/> Nutritional Counseling
<input type="checkbox"/> Psychological Counseling
<input type="checkbox"/> Yoga

Name: _____ Date of Birth: _____ Date: _____

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.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, and exercises. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to a staff member.

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.

Exercise: The entire body benefits from this therapy, both physically and psychologically. Exercise improves digestion, increases energy levels and promotes the reduction of stress.

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 treatment program.

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

Printed Name: _____

Thank you for choosing our office for your wellness care. We are committed to providing you with high quality health care. The services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. 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.

SELF PAY: If you are not insured by a plan we participate with OR choose to self pay, payment in FULL is expected at each visit.

INSURANCE: Vitality Chiropractic participates with Blue Cross Blue Shield and Unitedhealthcare. **Knowing your chiropractic insurance benefits is your responsibility.** As a courtesy we verify your insurance information and benefits for chiropractic services only. It is the policy of this office to extend to our clients the courtesy of assigning chiropractic insurance benefits directly to you. We are happy to extend this credit to you so that you can follow through with all the care necessary. The following are important points of consideration to be aware of:

1. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company and we are required by law to collect co-payments and deductible payments at the time of service. Please assist us in compliance with our obligations by paying your co-payment and deductible payment at each visit. In the event that you do not pay your co-payment or deductible payment at the time of service, we will charge the credit card on file for such co-payment or deductible amount.
2. If you are seeing our doctors on an "out of network" basis, you will be subject to out of network rates. In this event, you may request a "Super bill" so that you may submit it to your insurance company for out-of-network reimbursement.
3. Patients whose treatment visitation schedule is once per month or less, may no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous wellness plans to allow you to continue needed care.

BALANCES DUE: Your insurance plan is required to send you an Explanation of Benefits (EOB), which will state any balance remaining to be paid by you. **Beginning May 1, 2017**, if your insurance carrier assigns any additional patient responsibility amounts after the claim is processed; **we will use your credit card on file for this payment. Please take note of the following:**

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 your contact shall include a voice message from us to you if we are unable to reach you.
3. If your credit/debit card on file expires or otherwise becomes uncollectible, we will expect you to promptly provide a new credit/debit card.
4. If for any reason we are unable to collect payment in full via credit/debit card on file you will receive notice requiring immediate payment for services. If we do not receive payment in full for the balance due, a second and last notice will be provided. **If after the second and last notice we do not receive payment in full for the balance due, your account may be forwarded to collections**, and you hereby agree that if Vitality Chiropractic and Family Wellness, LLC places your account with an agency or attorney for collection, you will pay Vitality Chiropractic and Family Wellness, LLC all of its costs and expenses in collecting monies owed by you to the extent allowed by applicable law.

PATIENT BILLING: You will receive a receipt of all charges upon request. By executing this Financial Policy and Patient Authorization, you hereby guarantee payment of all charges from Vitality Chiropractic and Family Wellness, LLC for medical services and treatment provided.

1. **We accept the following payment methods: Cash, Check, VISA/MasterCard, Discover and American Express.**
2. **An additional \$25.00 will be added to your account if a check is returned for insufficient funds.**
3. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.
4. If after insurance has processed and your account acquires a credit and no outstanding services are pending, a refund check will be mailed with a receipt to you to confirm your payment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

...continued on next page...

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 Vitality Chiropractic and Family Wellness, 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 Vitality Chiropractic and Family Wellness, 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

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

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

The goal of this office is to provide you with the finest quality of care available. If you have any questions with regard to your health care or any of our policies, please let us know.

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

Printed Name: _____

Credit Card Info

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

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

Name on Card: _____

Last Name: _____ First Name: _____

Date of Birth: _____ / _____ / _____

Insurance 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.

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 nonconfidentially, 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.